Understanding Nurse Turnover Intention: The Role of Nationality and Leadership in a Public Hospital in the Kingdom of Saudi Arabia

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Abstract

Background

A global nursing shortage is impacting countries worldwide, leading to competition across and within healthcare systems. In the Kingdom of Saudi Arabia (KSA), nurse turnover is a major challenge, with an estimated rate of 20%, significantly higher than in the United Kingdom, United States, and Australia. KSA is undergoing a significant transformation under Vision 2030, and nurse retention plays a central role in these efforts. Like other hospitals in KSA, King Fahad Armed Forces Hospital (KFAFH) faces shortages due to high turnover. The aim of this research was to investigate the factors contributing to nurse turnover intention and develop evidence-based retention strategies for the nursing workforce within KSA healthcare settings.

Methods

A multiple methods research design was employed. First, a Qualitative Evidence Synthesis (QES) was conducted to identify research gaps and inform research design. Then semi-structured interviews were conducted with thirteen staff nurses and six nurse leaders at KFAFH. Thematic analysis was conducted at both stages of the research. Findings were interpreted through comparison with current models to assess theoretical fit. Finally, a novel model was constructed and evaluated, and recommendations for potential interventions were developed.

Findings

Three main themes arose from the analysis: Institutional, Leadership, and Personal Factors, with 14 subthemes. Saudi and non-Saudi nurses differed across Diversity Issues, Families, Workload, Lifestyle, and Opportunities. Leaders and staff differed only in relation to Leadership Positions. A novel nurse turnover intention model was developed, emphasising hierarchical and interconnected relationships among Institutional, Leadership, and Personal Factors.

Recommendations

Recommendations include affording special status under Vision 2030 for non-Saudis and their families with rights to housing, education, and business opportunities. Separate Continuing Professional Development (CPD) pathways for Saudi and non-Saudi nurses are also recommended. These recommendations are expected to address turnover intention among staff and leadership in the nursing workforce and thereby improve retention.

Acknowledgements

First, I would like to express my sincere gratitude to my supervisors, Dr. Emily Wood and Professor Andrew Booth, for their continuous guidance, support, and encouragement throughout my entire PhD journey. Their expertise and thoughtful feedback were invaluable every step of the way.

I am deeply thankful to my mother and sister, who were always there for me when I needed them, offering care, patience, and strength during the most difficult times.

To my husband, Mohammed, and our three children, Abdulaziz, Tia, and Nawaf, thank you for believing in me and standing by my side through every stage of this journey. You were my motivation and my constant reminder to keep going.

Finally, I would like to thank all the nurses who contributed to this research. I am truly grateful for their time, honesty, and generosity in sharing their experiences.

Dedication

To my father,

I lost you during this journey, but I carried you with me every step.

You remain in my heart, always.

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Chapter 1 - Introduction

1.1 Introduction

Global nursing shortages continue to place significant pressure on healthcare systems worldwide, affecting workforce stability and the quality of patient care (Drennan & Ross, 2019; Ren et al., 2024). A key contributor to these shortages is nurse turnover, which has been widely reported across healthcare systems globally (Drennan & Ross, 2019; Lazzari et al., 2022; Mafula et al., 2025; Wubetie et al., 2020). Turnover intention reflects a nurse's reported likelihood to leave their organisation within a specified period of time, whereas actual turnover refers to confirmed exits from the workplace (Lazzari et al., 2022; Wubetie et al., 2020).

Turnover intention is considered a key predictor of actual turnover, although the relationship between the two has been questioned. It is widely used in research as it precedes actual departure, enabling opportunities for early intervention (Lazzari et al., 2022; Wubetie et al., 2020). Estimates of turnover intention among nurses vary widely, ranging from 3% to 75% across different healthcare settings and countries (Adams et al., 2021; Al-Ahmadi, 2014; Albalawi et al., 2024; Bae, 2023; Boamah et al., 2023; Campbell et al., 2020; Cull et al., 2020; Fournier et al., 2022; Henshall et al., 2021; Iheduru-Anderson, 2020; Jones et al., 2024; Kelly et al., 2021; Mahoney et al., 2020; McNiven et al., 2021; Norful et al., 2023; Nowrouzi-Kia & Fox, 2020; Ohue et al., 2021; Qureshi et al., 2020; Theodosius et al., 2021).

Globally, the pooled prevalence of turnover intention among nurses is approximately 38.4%, while the pooled turnover rate is 15.2% (Mafula et al., 2025). This gap indicates that while many nurses consider leaving, only a proportion follow through. Because nurses migrate away from less favourable working conditions to countries with better opportunities, nursing shortages impact different countries differently (Drennan & Ross, 2019).

The Kingdom of Saudi Arabia (KSA) has not been spared from this global shortage and continues to experience significant demand for nurses. Turnover in KSA is estimated at about 20%, which is higher than what is reported in the United Kingdom (10%), the United States (14%), and Australia (15%) (Albalawi et al., 2024). In KSA, the healthcare system is situated around a large public sector that operates alongside a growing private healthcare sector (Albougami et al., 2020; Al-Hanawi et al., 2020; Almalki et al., 2011). KSA researchers have studied different nurse populations working in KSA, and have reported many common factors that lead to turnover, which include low salary, poor working conditions, and lack of career opportunities (Falatah & Salem, 2018). More recently, a 2024 review found that difficulties with work–life balance, few opportunities for professional development, and limited career progression play a major role in driving nurse turnover intention in KSA (Alqahtani et al., 2024).

1.2 Turnover and Turnover Intention

While turnover and turnover intention are related concepts, understanding the distinction between them is important because each reflects a different stage in the departure process and therefore requires a different type of response. Table 1.1 presents the definitions used in this thesis.

Table 1.1. Definitions

Term	Definition
Turnover	Withdrawal of an employee from the employing organisation that is permanent in nature (Gan & Voon, 2021)
Turnover Intention	Considered an antecedent to voluntary turnover (Gan & Voon, 2021). Turnover intention starts when an employee initially considers permanently leaving the organisation, intending to stop their membership in the organisation (Gan & Voon, 2021).
Retention Failure	The failure of an organisation to retain its employees (Gan & Voon, 2021).
Workforce Mobility	Human mobility that involves the crossing of geographical borders as part of establishing residence in a different area for the reasons of employment (Tirca & Bujor, 2024).

Conceptually, turnover intention is treated as an individual-level cognitive state that reflects a nurse's consideration or plan to leave their current position, whereas turnover refers to the observable behavioural outcome of exiting an organisation. Workforce mobility provides the broader structural context within which these processes occur and may influence both turnover intention and subsequent turnover when alternative opportunities are available. Turnover is therefore understood as an outcome that may arise

from retention failure, where organisational structures, policies, or working arrangements are insufficient to support staff retention. In this thesis, turnover intention is the primary outcome of interest, while turnover is treated as a downstream behavioural outcome that cannot be measured directly within this study.

The gap between turnover intention and actual turnover is substantial. A recent meta-analysis reported that while the pooled prevalence of turnover intention among nurses is 38.4%, the pooled turnover rate is only 15.2%, suggesting that many nurses who consider leaving do not ultimately do so (Mafula et al., 2025). From a policy and organisational perspective, turnover intention therefore remains highly relevant because it represents the stage at which intervention is still possible. Reducing turnover intention is widely viewed as a key strategy for mitigating turnover and stabilising the workforce (Hu et al., 2024; Lee, 2022).

1.3 Background

The majority of studies of nurse turnover and turnover intention in KSA have been quantitative. They have focused on different occupational and demographic subgroups, and many have used different surveys and measurement instruments as part of their study design. In contrast, the qualitative studies are considered in Chapter 2.

Social and cultural attitudes toward nursing in KSA have been identified as an early driver of turnover intention, particularly among Saudi male nurses. Mahran and colleagues (2012) surveyed male Saudi nursing students in KSA to see if public perception of nursing would

lead them to want to leave the profession. The survey found that 87% of the students reported at least one parent disagreeing with their choice of career. The authors recommended that an improvement in public image of the profession is required to prevent turnover among Saudi male nurses (Mahran et al., 2012). In another quantitative study, Alonazi and Omar (2013) analysed data from 254 exit questionnaires from nurses who left the Paediatric Department at Prince Sultan Military Medical City, Riyadh, and found that almost 40% left for "family reasons" (Alonazi & Omar, 2013). However, the study did not specify the nature of these family reasons, which may have included factors relating to either the immediate family or wider family obligations.

Poor pay, weak leadership, and lack of organisational commitment consistently emerge across large-scale studies as the primary institutional drivers of turnover intention. Al-Ahmadi (2014) developed a comprehensive survey asking about many potential factors that may increase turnover and turnover intention in nurses, and administered it to 5,423 nurses in 80 hospitals in 12 KSA regions. The results revealed many factors working together to encourage nurses working in KSA to leave their current positions, including lack of organisational commitment, poor pay, lack of good leadership and recognition on the job, and low job satisfaction. The strongest discouragement of turnover was the lack of better employment opportunities in KSA (Al-Ahmadi, 2014). However, it is important to distinguish between different forms of turnover, including local movement between hospitals and broader regional, national, or international turnover, as these may be driven by different factors.

Similar themes were reflected in a quantitative study of moral distress and turnover intention in critical care nurses in a large public referral hospital in Riyadh (Abumayyaleh et al., 2016). This study, used the Hamric Moral Distress Scale (MDS) and the Turnover Intention Scale (TIS) to measure moral distress and turnover intention respectively, finding both to be simultaneously high (Abumayyaleh et al., 2016).

Another quantitative study focused on the effect of nursing leadership styles on job satisfaction in nurses working in the critical care units of Aseer Central Hospital in Abha, KSA (Alshahrani & Baig, 2016). These authors used the Multifactor Leadership Questionnaire (MLQ-5X) to have staff nurses describe the leadership styles of the head nurses to which they report (Alshahrani & Baig, 2016). Interestingly, the authors found that most of the leadership displayed either transformational (ideal) or transactional (acceptable) leadership styles (Alshahrani & Baig, 2016). Risk factors found for turnover in nurses working in KSA in other studies, such as pay, fringe benefits and nature of work, were not related to leadership styles (Alshahrani & Baig, 2016). Even though leaders apparently had acceptable leadership styles, nurses were on average only moderately satisfied with their work (Alshahrani & Baig, 2016).

These findings on high rates of transformational and transactional leadership styles, which are important to prevent nurse turnover in work environments, were confirmed by another author group who studied a sample of 219 nurses and nurse managers from two hospitals in KSA (Al-Yami et al., 2018). Their study, which used the MLQ to measure leadership

styles and the Organisational Commitment Questionnaire (OCQ) to measure organisational commitment, found that transformational leadership was the strongest contributor to organisational commitment, both of which are preventive of turnover (Al-Yami et al., 2018). Another quantitative study conducted among 279 nurses in KSA explored the relationship between leadership styles and nurse turnover intention (Alasiry & Alkhaldi, 2024). In their study, the researchers found that transformational leadership was protective against turnover (Alasiry & Alkhaldi, 2024). Although transformational leadership is linked to positive outcomes, its presence in a KSA nursing context appears to be limited. Recent studies continue to report poor leadership practices, lack of recognition, and limited involvement in decision-making, all of which contribute to dissatisfaction and turnover (Al-Ahmadi, 2014; Alrwili, 2022).

Next, a low level of quality of nurse work life, as measured by the Brooks' survey of quality of nurse work life (QNWL), was hypothesised by Kaddourah and colleagues (2018) as being the cause of turnover intention in nurses working at King Fahad Medical City in Riyadh. These authors conducted a quantitative study where they administered the QNWL and the Anticipated Turnover Scale (ATS) to 364 nurses and found that while only 54.7% were dissatisfied with the quality of their work life, 94% indicated turnover intention (Kaddourah et al., 2018). In fact, all of the nurses who reported satisfaction with their work life also indicated their intention to turnover (Kaddourah et al., 2018). Another quantitative study used four different measurement tools to examine the drivers of nurse turnover and found that job satisfaction and self-efficacy are positively associated with nurse retention

(Alshaibani et al., 2024). A quantitative survey administered on social media to nurses working in KSA measured turnover intention with the TIS, job satisfaction with the McCloskey/Mueller Satisfaction Scale (MMSS), affective commitment (meaning strong emotional tie to the organisation), and relational coordination (meaning skills at managing relationships in a way to get tasks done) (Falatah & Conway, 2019). Their study found that affective commitment, job satisfaction, and relational coordination can positively impact turnover intention, but these findings were not particularly new and seemed consistent with what had previously been found (Falatah & Conway, 2019).

From 2018, a body of quantitative studies on this topic added little to prevalent knowledge, mainly because the studies measured the same risk factors that had been measured previously using a combination of measurement instruments, some established and others novel (Al Muharraq et al., 2022; Albougami et al., 2020; Al-Mansour, 2021; Soqair, 2021). Albougami and colleagues (2020) surveyed 318 staff nurses working in two KSA public hospitals and found that quality-of-life (QoL) dimensions such as physical and mental health, as well as low salary and being non-Saudi were risk factors for turnover intention. Al-Mansour (2021) conducted a survey of over 1,000 KSA healthcare workers including 340 nurses, and found that while stress led to turnover intention, support reduced the effect of stress.

Al Soqair (2021) also studied the impact of management style, Quality of Nursing Work Life (QNWL), organisational factors and individual factors as related to nurse turnover in

nurses working in KSA, and found that positive management styles, QNWL, and organisational factors were protective against turnover. In contrast, individual factors could lead to turnover. Al Muharraq and colleagues (2022) quantitatively measured negative acts (workplace bullying) and how those were related to turnover intention at a medical city in Riyadh. They found that the cumulative rate of bullying was 33.4% with a positive significant correlation between bullying and turnover intention (Al Muharraq et al., 2022).

Authors of other quantitative studies since 2018 on nurse turnover in KSA have developed their own surveys instead of using established instruments. One research team developed a survey drawn from the literature asking around fifty items pertaining to reasons non-Saudi nurses might want to leave their positions at eight MoH hospitals (Alreshidi et al., 2021). Main reasons for turnover were related to wage benefits, workload factors, inadequate housing and hospital facilities (Alreshidi et al., 2021). Another quantitative study of nurses at King Fahad Armed Forces Hospital (KFAFH) found that as workload increased, job satisfaction decreased, and this led to turnover intention (Attar & Alsharqi, 2021). A different quantitative study of nurses working in KSA found that higher job satisfaction and feelings of job security were protective against turnover (Falatah et al., 2021).

We can conclude from the above that while diverse factors contributing to nurse turnover and turnover intention in KSA have been identified and measured, the dominance of quantitative approaches has offered limited insight into the lived experiences of nurses.

This lack of contextual depth highlights the need for qualitative research to better understand the underlying reasons behind nurse turnover and turnover intention.

1.4 The Nursing Workforce in KSA

To understand the scale of the turnover challenge in KSA, it is important to first consider the composition and size of the nursing workforce within which these pressures operate. The nursing workforce in KSA grew by approximately 9% between 2019 and 2023, whereas population growth over the same period was around 12% (Kattan & Al-Hanawi, 2025). The nurse to population ratio showed little change and remained at approximately 6 to 6.6 nurses per 1,000 population. Available data indicate that nurse numbers in KSA remain lower than those reported in many Organisation for Economic Co-operation and Development countries, including the United States, Canada, and the United Kingdom (Kattan & Al-Hanawi, 2025). By 2023, just over 44% of the nursing workforce in KSA were Saudi nationals, reflecting a gradual increase in Saudization over time, while non-Saudi nurses continued to make up the majority of the workforce (Kattan & Al-Hanawi, 2025). Saudization refers to the national workforce localisation policy that sets targets to increase the proportion of Saudi nationals employed across public and private sectors (Albejaidi & Nair, 2021). This composition differs by sector, with Saudi nurses employed mainly in Ministry of Health facilities, while only around 6–7% work in the private sector (Kattan & Al-Hanawi, 2025).

1.5 Saudi vs. Non-Saudi Nurses in KSA

Saudi and non-Saudi nurses occupy structurally different positions within the KSA healthcare system, and this distinction shapes their experience of work, their contractual conditions, and ultimately their turnover intention in different ways. Most studies examining nurse turnover and turnover intention in KSA do not acknowledge the differences in needs between Saudi vs. non-Saudi nurses and have therefore not generated clear or actionable recommendations for addressing this issue. Authors suggest that these two groups have different rates of turnover and turnover intention, with non-Saudi nurses generally reporting higher turnover intention, largely due to nationality-based differences in salary, employment conditions, and discrimination (Albalawi et al., 2024; Alluhidan et al., 2020; Alreshidi et al., 2021; Soqair, 2021). Across both groups, it is important to consider that only a proportion of those expressing turnover intention will actually leave (see Figure 1.1).

Figure 1.1. Example of a Model of Turnover Intention and Turnover

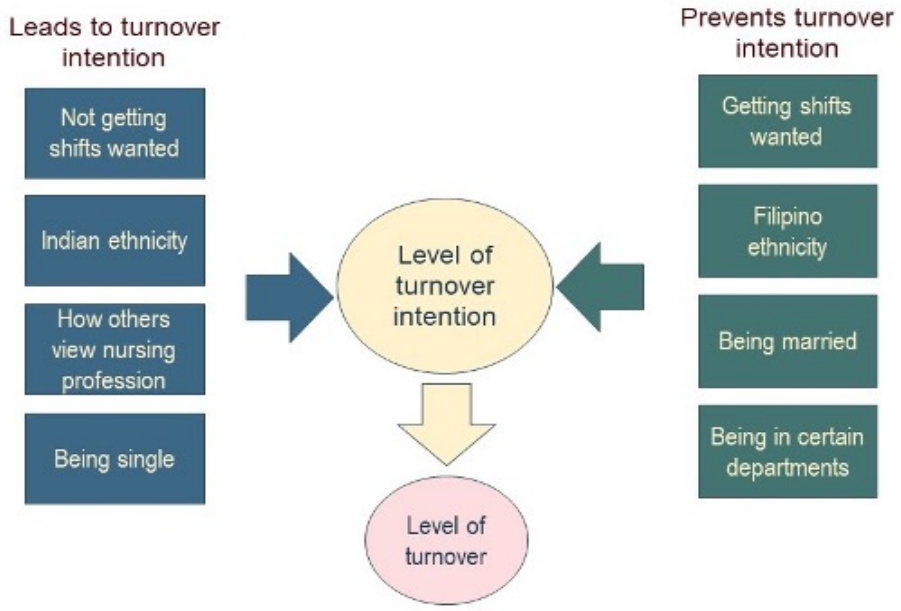


Figure 1.1 cannot include all potential risk or protective factors for nurse turnover and turnover intention in KSA; it includes just a few factors gleaned from the literature for the purposes of demonstrating the model (Albougami et al., 2020; Al-Dossary et al., 2012; Alonazi & Omar, 2013; Alzailai et al., 2021; Baazeem & Yates, 2018; Falatah & Salem, 2018; Mahran et al., 2012). As seen in the model, the goal is to reduce turnover intention to as low a level as possible, thereby reducing the proportion of turnover. The distinction between intention and actual departure illustrated in Figure 1.1 is particularly relevant in the KSA context, where site-specific turnover data are not publicly available, making intention the only measurable indicator of workforce instability.

The Saudi Health Council (2019) estimated the turnover rate in KSA to be 20%. Actual turnover rates across hospitals under the jurisdiction of the Ministry of Health (MoH), National Guard Health Affairs (NGHA), and private and military sectors are not publicly available due to confidentiality restrictions. Data from the study site were formally requested for the study period and prior to it; however, access was denied on confidentiality grounds.

Nevertheless, there is no indication that the study site differs substantially from other public or military hospitals in KSA, where nurse retention remains a persistent challenge. The decision by hospital leadership to invite this research further reflects organisational recognition of turnover as a significant concern.

The absence of site-specific data does not undermine the relevance of the study; rather, it reinforces the need for qualitative investigation to understand the factors shaping turnover intention in this context. Any efforts to address nurse turnover at the study site would therefore need to be evaluated internally. The analytical basis for the Saudi vs. non-Saudi distinction is examined in detail in Chapter 3.

1.6 Saudi Vision 2030 and the Saudization Policy

The structural differences between Saudi and non-Saudi nurses described above are shaped in part by KSA's national workforce policy, Vision 2030. Vision 2030 is KSA's long-term government reform programme aimed at reducing reliance on oil revenues by diversifying the economy and developing multiple sectors, including healthcare, education, tourism, and industry (Al-Hanawi et al., 2020; Kingdom of Saudi Arabia, 2017). One of its priorities

is to support and grow the national workforce by implementing the Saudization policy, which sets localisation targets to increase the number of Saudi nationals working across all sectors of the economy, including healthcare (Albejaidi & Nair, 2021; Kingdom of Saudi Arabia, 2017). In healthcare, this goal comes with challenges, as the system has depended heavily on non-Saudi professionals, especially in specialised roles (Almansour et al., 2023). Within the healthcare sector, Vision 2030 has driven reforms to prepare the healthcare system for the growing demands of an expanding and ageing population (Alluhidan et al., 2020). The global shortage of nurses has led to competition between countries, and even between healthcare systems within countries, to recruit and retain nurses (Alluhidan et al., 2020). Achieving Vision 2030's goals will require more than policy changes; it also means building up the skills of Saudi healthcare workers and creating real, long-term career opportunities for them, challenges that are directly reflected in gaps identified in the literature (Al-Hanawi et al., 2019; Mani & Goniewicz, 2024).

Alluhidan and colleagues (2020) estimated that in 2018, there were 184,565 nurses in KSA, and only 38% of them were Saudi citizens. The authors pointed out how this situation relies on the ability to retain non-Saudi nurses in the workforce in order to prevent shortages (Alluhidan et al., 2020). They offer policy solutions that align with Vision 2030 priorities to address these workforce challenges. First, continuing skills development should be emphasised (Alluhidan et al., 2020). Next, there needs to be more flexibility in recruitment, so that the mix of Saudi and non-Saudi nurses is specialised to address the needs of the

patients in the healthcare system (Alluhidan et al., 2020). These workforce challenges highlight the importance of aligning retention strategies with Vision 2030 priorities.

1.7 Explanation of Problems and Gaps

Despite the volume of research on nurse turnover and turnover intention in KSA, significant gaps remain in the evidence base. While there are many quantitative studies about nurse turnover and turnover intention in KSA, there are few qualitative studies (Abumayyaleh et al., 2016; Al Muharraq et al., 2022; Al Soqair, 2021; Al-Ahmadi, 2014; Albougami et al., 2020; Alonazi & Omar, 2013; Alreshidi et al., 2021; Alshahrani, 2022; Alshareef et al., 2020; Al-Yami et al., 2018; Alzahrani, 2022; Attar & Alsharqi, 2021; Kaddourah et al., 2018; Mahran et al., 2012). As a result, the literature has identified many associated factors but has provided limited insight into how these factors are experienced, interpreted, and negotiated by nurses within their everyday working lives.

A further gap is that Saudi and non-Saudi nurses are often studied together, despite their different employment pathways, contractual conditions, and wider social circumstances within the KSA healthcare system. This integrated approach limits understanding of how turnover intention may be shaped differently across these groups. Similarly, limited attention has been given to differences between nurse leaders and staff nurses, despite the likelihood that leadership position shapes both experience and decision-making in relation to turnover intention.

In addition, although previous studies have identified multiple contributors to turnover intention, they have not produced a sufficiently context-specific explanation of how these factors interact within the KSA setting, nor have they generated clear, evidence-based strategies that can be implemented in practice. Commentators have therefore called for site-specific qualitative research to provide deeper contextual understanding and support the development of potential interventions (Albalawi et al., 2024; Chowdhury & Shil, 2021; Falatah & Salem, 2018). This study addresses these gaps by examining nurse turnover intention qualitatively within a military hospital in KSA, with specific attention to nationality, leadership position, and the development of a context-specific explanatory model and retention strategies.

1.8 Significance and Rationale

This study is significant in recognising that KSA is experiencing national challenges with nurse turnover, and that site-specific research is necessary in order to address this issue at specific hospitals such as King Fahad Armed Forces Hospital (KFAFH) (Albalawi et al., 2024; General Directorate for National Health Economics and Policy, 2019). The rationale is to develop findings, relevant to the management of KFAFH, that can inform interventions to address nurse turnover at this site. It is acknowledged that findings from this research may not be directly transferable to other clinical sites experiencing nurse turnover in KSA. Hence, this study is illustrative rather than representative. While national workforce and healthcare policies are applied consistently across KSA hospitals, the way these policies are implemented and experienced varies by organisation, leadership, and

workforce context. For this reason, the findings of this study illustrate how national policy translates into everyday practice at the organisational level, rather than being representative of outcomes across all Saudi hospitals.

1.9 King Fahad Armed Forces Hospital (KFAFH)

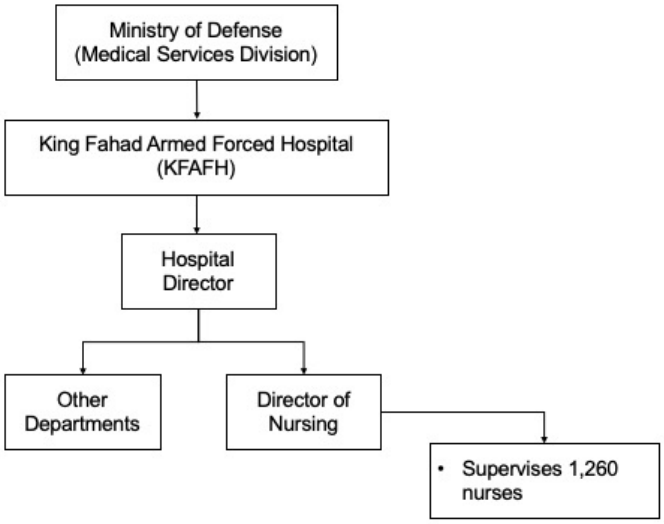
King Fahad Armed Forces Hospital (KFAFH) is an education and military hospital located in Jeddah, on the west coast of KSA (King Fahad Armed Forces Hospital, n.d.). KFAFH, like other hospitals in KSA, is challenged by high levels of nurse turnover.

As KSA is a kingdom, the government is centralised into ministries. All of these ministries operate within broadly similar structures, and different public healthcare facilities are managed by different ministries (Almalki et al., 2011). Therefore, ministry-controlled hospitals adhere to the same clinical protocols and similar regulatory frameworks. KFAFH is a military hospital that operates within a governance and regulatory framework shared with other military hospitals in KSA, particularly those under the Ministry of the National Guard Health Affairs (NGHA) (Ministry of National Guard Health Affairs, n.d.). Details about these aspects of KSA military hospitals are confidential for national security reasons. As a result, KFAFH is not presented as statistically representative of all hospitals in KSA, but as a relevant case through which to explore nurse turnover intention within a military healthcare context. KSA military hospitals collectively number over 3,000 beds, with a workforce including over 7,000 nurses, and responsibility for over 50,000 inpatient

admissions and over 2 million outpatient visits in 2021 (Ministry of National Guard Health Affairs, n.d.).

The 530-bed KFAFH facility services personnel and family members of the Saudi military (King Fahad Armed Forces Hospital, n.d.). The centre offers primary, secondary and tertiary care including a cardiac centre, and serves as a teaching hospital (King Fahad Armed Forces Hospital, n.d.). The study site employs approximately 1,260 nurses in 30 units (see Figure 1.2).

Figure 1.2. Nursing Organisational Chart for KFAFH



Turnover and turnover intention have previously been studied at this hospital, though the findings were limited in scope (Attar & Alsharqi, 2021). While this previous study explored

reasons for non-Saudi nurse turnover, the measures produced many Likert scale results that were not translated into clear, actionable intervention strategies (Attar & Alsharqi, 2021). There is therefore a need for rigorous studies to be conducted at KFAFH to meet a research gap across educational and military hospitals in KSA, of which KFAFH is one (Alshmemri, 2014).

A further limitation of previous research at KFAFH is that only non-Saudi nurses were examined, leaving the needs of Saudi nurses unaddressed and preventing any comparison between the two groups (Attar & Alsharqi, 2021). Another challenge is that while using validated instruments to measure concepts like turnover intention is generally a sound strategy, at times, these instruments do not always capture what needs to be measured and may produce conflicting results. This predominance of instrument-based approaches has limited the depth of understanding available on this topic. Qualitative research on this issue is lacking, and such approaches are therefore needed to develop a deeper understanding of the factors shaping turnover intention among nurses in KSA.

1.10 Rationale for the Site

The Director of Nursing at KFAFH invited the researcher to conduct this study in response to these concerns, recognising the need for site-specific qualitative investigation, and expressed willingness to apply the findings to practice.

1.11 Researcher Positionality

Prior to commencing data collection, the researcher reflected on her positionality in relation to the study. This doctoral study was funded by Umm Al-Qura University, the researcher's employer. The researcher had no formal professional relationship with KFAFH or the Director of Nursing at KFAFH before this study. The researcher and the Director of Nursing met at an academic conference, where the researcher was invited to conduct her doctoral study on nurse turnover intention at KFAFH in order to provide guidance based on the study findings. The Director is a Saudi nurse manager, and the researcher is a Saudi health services researcher with no prior relationship with KFAFH. The Director of Nursing was not included as a participant because they were identifiable and due to a conflict of interest, as they acted as the gatekeeper for recruitment.

Before beginning data collection, it was anticipated that participants might be influenced by the researcher's nationality and non-nurse status. As all participants were nursing staff or nurse leaders, it was expected that participants might perceive the researcher differently due to her non-nurse background. Saudi nursing staff and leaders were therefore expected to feel at ease with the researcher due to their shared cultural background, while non-Saudi nurses might be guarded in their responses. The researcher's Saudi background also meant that national healthcare and workforce policies, such as Saudization, would not need to be explained in detail, which was anticipated to allow participants to speak directly about their experiences.

1.12 Study Aims and Objectives

The aim of this research was to investigate factors contributing to nurse turnover intention and to develop evidence-based retention strategies for the nursing workforce within KSA healthcare settings. To achieve this aim, the following objectives were developed:

1- Conduct a Qualitative Evidence Synthesis (QES) to identify gaps in research on nurse turnover and turnover intention in KSA.

2- Identify factors related to turnover intention through semi-structured interviews, informed by the QES findings.

3- Examine how issues of nationality and leadership impact nurse turnover intention at KFAFH

- How do these factors vary by Saudi vs. non-Saudi nationality?
- How do these factors vary by leadership vs. staff nursing position?

4- Develop a novel model to explain the factors contributing to nurse turnover intention, based on the findings of the thematic analysis.

5- Recommend strategies that KFAFH can implement to increase retention and reduce nurse turnover intention among nurses at all levels of employment.

1.13 Overview of the Thesis

This chapter has introduced the topic of nurse turnover and turnover intention, established the KSA context, and identified the gaps that this study addresses. Chapter 2 presents the

qualitative evidence synthesis, which synthesised primary qualitative research on nurse turnover and turnover intention in KSA and directly informed the design of the primary study. Chapter 3 presents the methodology, including the philosophical underpinnings, study design, and methods of data collection and analysis. Chapter 4 presents the thematic findings, organised under three themes, Institutional Factors, Leadership Factors, and Personal Factors, and examines how these were experienced differently by Saudi and non-Saudi nurses and by nurse leaders and staff nurses. Chapter 5 presents the analytical findings, evaluating theoretical models and developing a novel KSA-centric model of nurse turnover intention. Chapter 6 presents the discussion, evidence-based recommendations, and conclusions of the thesis.

1.14 Chapter Summary

This chapter has introduced the topic of nurse turnover and turnover intention, beginning with the global context and key definitions of workforce concepts. The quantitative literature on nurse turnover and turnover intention in KSA was then reviewed, establishing what is known about the drivers of this problem. The composition of the nursing workforce in KSA was examined, followed by an overview of turnover patterns among KSA nurses and the structural distinction between Saudi and non-Saudi nurses. Saudi Vision 2030 and its implementation of Saudization were then discussed in relation to their implications for the nursing workforce. Gaps in the literature were identified, and the significance and rationale for this study were established. The study site, King Fahad Armed Forces

Hospital, was described, and the researcher's positionality was addressed. The chapter concluded with the study aims and objectives and an overview of the thesis structure.

Chapter 2 - Qualitative Evidence Synthesis (QES)

2.1 Introduction

Chapter 1 outlined the conceptual distinction between turnover and turnover intention, as defined in Table 1.1. The qualitative evidence synthesis (QES) presented in this chapter adopts these definitions and examines turnover and turnover intention within the KSA nursing literature.

The QES is presented as a standalone chapter because it represents a substantial body of work that directly informed the design and analytical focus of the primary qualitative study reported later in this thesis. Specifically, the QES was undertaken to synthesise what is already known about nurse turnover and turnover intention in the KSA context, to identify gaps in the evidence base, and to inform the development of the interview guide, analytical focus of the study, and conceptual framing of the empirical study.

The QES was published as:

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The QES follows a structured format consistent with qualitative synthesis methodology, ensuring transparency and replicability in how evidence was identified, selected, and interpreted. The findings are presented as analytical themes and highlight gaps in the

literature, which informed the design of the primary qualitative study reported in Chapter 3.

2.2 Introduction to the Qualitative Evidence Synthesis

Keeping clinical facilities staffed with nurses is a worldwide problem. In a 2021 meta-analysis, researchers identified a total of 18 cross-sectional surveys representing 23 countries of intensive care unit (ICU) nurse turnover intention, and found that the pooled prevalence rate of turnover intention was 27.7% (Xu et al., 2023). Nurse shortages impact different countries differently, with nurses migrating away from less favourable working conditions in one country to countries with more resources offering more opportunities (Drennan & Ross, 2019).

Nurse turnover in hospitals in the Kingdom of Saudi Arabia (KSA) has been studied for about the last 10 years, because it is an ongoing problem that accelerated during the COVID-19 pandemic (Alsadaan et al., 2021; Alzahrani, 2022; Falatah, 2021). The results from several quantitative studies show that when job satisfaction is low, turnover intention increases (Albougami et al., 2020; Al-Dossary et al., 2012; Alshareef et al., 2020; Falatah & Conway, 2019). Also, negative experiences in the work environment, such as low quality-of-life (QoL) at work, bullying at work, or having a supervisor with poor leadership skills has also been shown to measurably increase turnover intention in many studies (Al Muharraq et al., 2022; Al-Ahmadi, 2014; Albougami et al., 2020; Almalki et al., 2012; Al-Mansour, 2021; Alshareef et al., 2020; Soqair, 2021; Suliman et al., 2020).

Like every country, the Kingdom of Saudi Arabia (KSA) needs nurses. The KSA healthcare system is comprised of a large public infrastructure alongside a growing private one (Albougami et al., 2020; Almalki et al., 2011). The public sector is primarily managed by the Ministry of Health (MoH) which includes primary, secondary, and tertiary healthcare facilities providing services free of charge to Saudi citizens. On the other hand, the private sector provides healthcare services for both Saudi and non-Saudi patients on a fee-for-service basis (Al-Hanawi et al., 2020). Although KSA has its unique challenges, it essentially is competing in the global nursing shortage for nurses (Falatah & Salem, 2018).

An important consideration when examining the nursing workforce in KSA is pathways to employment for Saudis vs. non-Saudis. According to Alluhidan and colleagues (2020), as of 2018, there was a total of 184,565 nurses in KSA, but only 70,319 (around 38%) were Saudi citizens. Approximately 62% of the nurses working in KSA are female, but 90% of non-Saudi nurses are female, reflecting the cultural value in KSA for wanting a same sex nurse for care (Alluhidan et al., 2020). Non-Saudi nurses are considered guest workers, and their employment is arranged through agencies; these individuals are predominantly Indian, Filipino, and Malaysian (Alluhidan et al., 2020). Therefore, they have different needs than Saudi nurses, including requiring salary, housing, transportation, and other support as defined in an employment contract (Alluhidan et al., 2020).

Nurses who are Saudis are less likely to be staff nurses and more likely to be in leadership, even though there are few Saudi nurses trained as advanced practice nurses (APRNs)

(Alluhidan et al., 2020; Alreshidi et al., 2021). Also, Saudi nurses are more likely to work for MOH health facilities compared to non-Saudi nurses (Alluhidan et al., 2020).

The last ten years of research into this issue has revealed differences between the needs of Saudi vs. non-Saudi nurses working in KSA, and therefore, factors leading to turnover and turnover intention are slightly different in these two populations. One survey of non-Saudi nurses at eight MOH hospitals recruited by WhatsApp (n = 639) had 97% female participants, and 72% were staff nurses (meaning very few leaders) (Alreshidi et al., 2021). In that study, over 82% had a bachelor's degree, and 67% had at least 5 years of experience (Alreshidi et al., 2021). The largest ethnic groups were 44% Filipino and 50% Indian (Alreshidi et al., 2021). However, most studies over the last ten years do not acknowledge that these two groups have completely different needs from a nursing work environment and profession, and so they fail to stratify their analyses by these two groups (Al-Mansour, 2021; Alshareef et al., 2020; Soqair, 2021).

Many studies have been conducted of different nurse populations in KSA, and many of the same factors have been reported as leading to turnover intention, such as poor working conditions, low pay, and lack of opportunity for advancement (Falatah & Salem, 2018). Further, nurses working in KSA may have personal needs and demands, such as for child-care or for job security, that are not being met by the employment arrangement (Al-Ahmadi, 2014; Aljohani & Alomari, 2018; Soqair, 2021). A recent survey of a 1,200 bed

tertiary hospital in Riyadh found that almost 80% of the nurses were non-Saudi, which is consistent with estimates from other recent studies (Al Muharraq et al., 2022).

Even with these studies, certain gaps remain in the literature. It is not clear what factors disproportionately influence Saudi compared to non-Saudi nurses in terms of turnover and turnover intention. This is because these groups are often analysed together, so separate findings are not reported. Although many articles exist about nurse turnover in nurses working in many different countries include KSA, there is no summary of what has been found specifically about KSA with respect to turnover and turnover intention, and how factors leading to turnover may differentially impact Saudis compared to non-Saudis.

2.3 Aims

The primary objective of this qualitative evidence synthesis is to explore factors causing turnover and turnover intention in nurses working in KSA in both Saudi and non-Saudi nurses. It is to identify ways to prevent turnover and reduce turnover intention in the KSA nursing workforce among both Saudi and non-Saudi nurses by identifying and synthesising themes from the results of qualitative studies on this topic to provide a deeper understanding of the unique challenges faced by both Saudi and non-Saudi nurses.

2.4 Methods

2.4.1 Selection of Qualitative Evidence Synthesis (QES) design

The QES is one approach to reviewing studies that is systematic, but it has the limitation of only being able to include qualitative studies (Flemming et al., 2019). However, this focus on qualitative data makes it particularly suitable for this study, as it allows for the synthesis of data to provide rich insights that align with the research questions.

2.4.2 Search methods for identification of studies

The intention of the search strategy was to be comprehensive, and the single country focus made this feasible. MEDLINE/Ovid/PubMed, Web of Science, PsychINFO, CINAHL, and Google Scholar (GS) underwent a structured search for articles. The final electronic search strategies were developed using these key terms: ("Nurses" OR "Nursing staff" OR "Nursing workforce" OR "Registered nurses" OR "Saudi Arabia nurses") AND ("Nurse turnover" OR “turnover” OR “Nurse retention" OR “retention” OR "Job satisfaction" OR “Nurse turnover intention” OR "Turnover retention") AND ("Workplace experience" OR "Job experiences" OR "Organisational culture" OR "Work-life balance" OR "Career satisfaction" OR "Job stress" OR “Prevent turnover” OR “Reduce turnover intention”) AND ("Qualitative research" OR "Grounded theory" OR "Phenomenological research" OR "Ethnographic study" OR "Case study" OR "Qualitative analysis"). In MEDLINE/Ovid/PubMed, Web of Science, PsychINFO, and CINAHL, these were executed as keyword searches, because that type of search looks through all fields of the citation record, including title and abstract (Falagas et al., 2008). By contrast, GS is

programmed to be a keyword search, so in GS, only keyword searching was used (Falagas et al., 2008; Gehanno et al., 2013).

Databases generally are programmed to do a “smart search”, where keywords like “nurse” are searched along with other iterations of the same word, such as “nursing” and “nurses” (Falagas et al., 2008). Because the search was executed in all these databases including GS, it is believed that no sources were missed. The following date range was searched with these limits applied: Years 2016 through 2022.

Search criteria were entered into these databases, and all the pages of the results were reviewed manually by one author (SA) to evaluate inclusion and exclusion criteria. This author retrieved the full text of all items identified as potentially relevant and placed them in an electronic library. A different author (AB) re-executed the search strategy and validated the screening and selection process. The co-authors assessed these items independently and resolved disagreements by discussion and did not need to involve a third person. The researcher and the co-authors agreed on study selection.

First, abstracts and titles were reviewed, and articles that clearly did not meet inclusion and exclusion criteria were ruled out. Next, the remaining underwent full-text screen for inclusion and exclusion criteria, and a final determination was made.

Where the same study, using the same sample and methods, had been presented in a peer-reviewed article and a thesis or dissertation, The researcher chose the thesis or dissertation

version of the study, and excluded the article version of the study. This was to ensure study representation was unbiased, and that the unit chosen provided the most primary data.

2.4.3 Selection Criteria

The search strategy was informed by the SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research type) tool, rendering the following search terms: "Saudi Arabia", nurse, turnover, retention, job satisfaction, qualitative (Cooke et al., 2012).

Table 2.1 documents the SPIDER method used.

Table 2.1. SPIDER Results

Item	Search Terms
Sample	nurse, working in Saudi Arabia
Phenomenon of Interest	nurse turnover, reasons for nurse turnover, nurse turnover intention, nurse job satisfaction, nurse retention
Design	thematic, ethnography, framework synthesis, phenomenology
Evaluation	attitudes, perception, opinion, suggestion, recommendation, experience
Research Type	qualitative, mixed-method

From the results of the SPIDER tool (Cooke et al., 2012) in Table 2.1, the selection criteria were developed. The dates chosen for searching were from 2016 to 2022, when the research was conducted. The date 2016 was chosen because it marks the beginning of Vision 2030, a countrywide strategic plan in KSA (Alsufyani et al., 2020).

The topic of interest was turnover and turnover intention in nurses working in KSA. As part of this, the topics of job satisfaction, working environment, nurse retention, and related topics were studied as they relate to turnover and turnover intention in nurses working in KSA. Due to the implementation of Saudi Vision 2030 in 2016, the items included in the review were published between the year 2016 and the last complete year (2022) (Kingdom of Saudi Arabia, 2017). Items included reported primary qualitative studies or mixed-methods studies with a qualitative component. The participants in the studies were nurses working in KSA at any level (managers, staff, etc.). This included native Saudis as well as non-Saudi nurses, as long as they are working in any healthcare setting in Saudi Arabia when the study was done. The researcher did not exclude studies based on an assessment of methodological limitations but instead used this information about methodological limitations to assess confidence in the review findings.

The researcher included primary studies that used qualitative study designs, or a qualitative study design as part of a larger mixed-methods study. The qualitative study designs could include ethnography, phenomenology, case studies, grounded theory studies, and qualitative process evaluations. The researcher included studies that used both qualitative

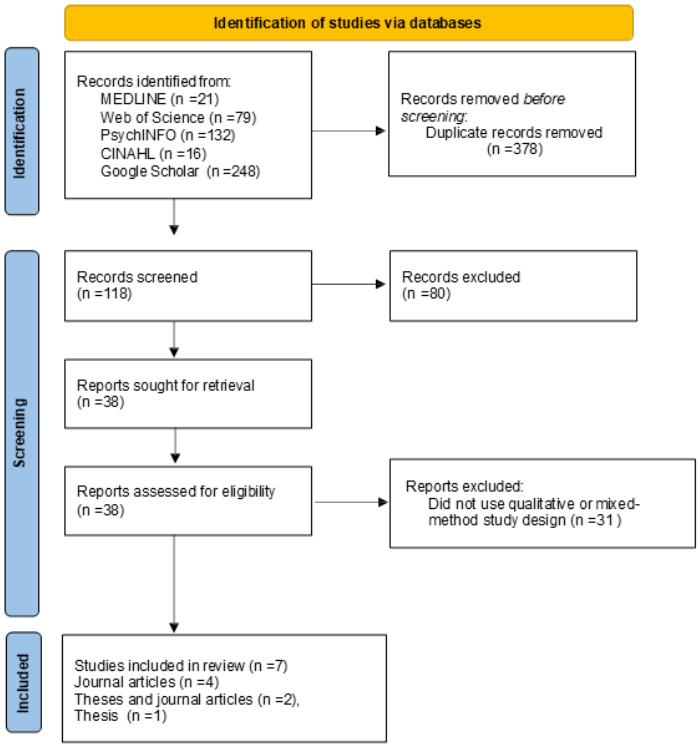
methods for data collection (e.g., focus group discussions, in depth interview, observation, diaries, document analysis, open-ended survey questions) and qualitative methods for data analysis (e.g. thematic analysis, framework analysis, grounded theory). The researcher excluded studies that collected data using qualitative methods but did not analyse these data using qualitative analysis methods (e.g., open-ended survey questions where the response data are analysed using descriptive statistics only).

The researcher included published studies in the peer-reviewed literature or theses or dissertations. The studies could be published in either English or Arabic. The researcher included mixed methods studies where it was possible to extract the data that were collected and analysed using qualitative methods.

2.4.4 Data Collection and Analysis

Qualitative evidence synthesis aims for variation in concepts rather than an exhaustive sample, and large amounts of study data can impair the quality of the analysis (Booth et al., 2018). Once the researcher identified all studies that were eligible for inclusion, the researcher assessed whether their number or data richness was likely to represent a problem for the analysis, in which case the researcher would consider selecting a sample of studies. However, the country-specific scope suggested at the design stage that a comprehensive sample for Saudi Arabia may be feasible to review in this qualitative evidence synthesis. Figure 2.1 includes the PRISMA flow chart.

Figure 2.1. PRISMA flow chart



As shown in Figure 2.1, seven articles were selected.

First, data was collected about each study. These data points included: Title, authors, year of publication, what database they were present in, type of publication (thesis/dissertation which were identified in GS or peer-reviewed journal article), study design (qualitative or mixed-methods with a qualitative component), method of data collection, and whether or not a framework was used for study design. Post-hoc, the following data were collected: Setting, number of participants, participant characteristics, and data collection method.

Next, original verbatim text extracts from the studies of inclusion were copied from the studies and placed on an Excel spreadsheet. If original verbatim text extracts were not available and only themes, these were extracted and placed on the spreadsheet.

The method chosen to assess the methodological limitations of included studies was adapted from several articles. First, the original article on the Critical Appraisal Skills Programme (CASP) was reviewed (Long et al., 2020), along with evidence from the literature related to Cochrane reviews and qualitative research (Flemming et al., 2019; Noyes et al., 2018). Next, how the CASP was adapted for use in a particular study was reviewed (Karimi-Shahanjarini et al., 2019). To address the unique characteristics of qualitative research, it was decided to adapt the modified CASP tool to assess methodological limitations (Malpass, 2009). The reviewer was required to classify the article based on seven items that are supposed to be completely addressed for a study to have a high methodological appraisal (see Appendix A). Once ratings for all seven items had been completed for all included studies, an overall assessment of the methodological limitations was undertaken (see Appendix B).

Two authors (SA and AB) independently reviewed each article and completed the CASP tool. Next, these authors met for a consensus conference, and reviews were resolved by agreement.

2.4.5 Data Management, Analysis, and Synthesis

In order to determine which type of synthesis to choose – framework, thematic, or meta-ethnography – the researcher applied the RETREAT framework recommended in the Cochrane handbook, and used by other researchers (Booth et al., 2018). A thematic synthesis seemed to be the most applicable choice, so this approach was selected. The researcher synthesised themes using the approach for thematic qualitative data analysis described by Burnard and colleagues (2008). The data collection was done by author (SA). Briefly, first, direct quotations from participants reported under the heading "results" of each included study were transferred to an Excel spreadsheet. These verbatim text extracts were transferred along with information about the themes on which they were placed in the original studies. Next, for each study, an initial coding framework was developed. Specifically, a code was developed for each theme expressed in each verbatim text extracts, and these were coded for each study. The data was recorded in an Excel spreadsheet.

Data were collected from journal articles first, and from theses second. This was to make data collection efficient, in that each successive data collection sought to standardise the themes being identified. Saturation of themes took place during the analysis. Once this analytic step was complete, there was an initial coding framework for all studies of inclusion. At that stage, the identified themes were merged into a final coding framework, which will be presented in the results section as the final synthesis. All the included studies did not use a framework

2.4.6 Assessing confidence in the review findings

The researcher and the second author (SA and AB) used the GRADE-CERQual (Confidence in the Evidence from Reviews of Qualitative research) approach to assess confidence in each finding (Lewin et al., 2018). GRADE-CERQual assesses confidence in the evidence, based on the following four key components.

1. Methodological limitations of included studies: the extent to which there are concerns about the design or conduct of the primary studies that contributed evidence to an individual review finding.

2. Coherence of the review finding: an assessment of how clear and cogent the fit is between the data from the primary studies and a review finding that synthesises those data. By cogent, this refers to evidence that is well supported or compelling.

3. Adequacy of the data contributing to a review finding: an overall determination of the degree of richness and quantity of data supporting a review finding.

4. Relevance of the included studies to the review question: the extent to which the body of evidence from the primary studies supporting a review finding is applicable to the context (perspective or population, phenomenon of interest, setting) specified in the review question.

After assessing each of the four components, the researcher and the second author made an assessment of the overall confidence in the evidence supporting the review finding. The researcher and the second author judged the confidence as high, moderate, low, or very low. The final assessment was based on consensus between the researcher and the second author (see Appendix C). All findings started as high confidence and were then graded down if there were important concerns regarding any of the GRADE-CERQual components.

2.5 Results

After criteria were applied, nine articles representing seven studies were included in the analysis, arranged according to year of publication. The articles were all in English. Table 2.2 summarises studies of inclusion, while additional details can be found in the supplementary table

Table 2.2. Studies of Inclusion

ID	First Author	Year	Study Design	Setting	Number of Participants	Participant Characteristics	Qualitative Data Collection Method	Data Analysis Method
1	Alotaibi	Article: (2016)	Quantitative non-experimental, descriptive research	Seven hospital sites, each of which represented a different region of Saudi Arabia	271	Saudi nurses at hospital sites (e.g., non-Saudi nurses excluded)	Open-ended questions on a questionnaire	Thematic
2	Almansour	Thesis: (2017) Article: (2022)	Mixed methods	Three major government hospitals in Saudi Arabia	26	Nurses selected from different nationalities, including Saudi	Semi-structured interview	Thematic
3	Aljohani	Article: (2018)	Mixed methods	Saudi Ministry of Health recruitment office	124	Filipino nurses applying to work in Saudi	Short answer on a questionnaire	Thematic
4	Saleh	Article: (2018)	Qualitative	Medical city in Saudi Arabia	35	Saudi and non-Saudi nurses working at the institution	Semi-structured interview	Thematic
5	Alshareef	Thesis: (2019) Article: (2020)	Mixed methods	Hospitals in Jeddah and Mecca cities	245	All nurses employed at these sites were sent an anonymous survey	Open-ended questions on a questionnaire	Thematic

ID	First Author	Year	Study Design	Setting	Number of Participants	Participant Characteristics	Qualitative Data Collection Method	Data Analysis Method
6	Shatnawi	Thesis: (2020)	Mixed methods	Two hospitals in Riyadh	19	All Intensive care nurses (Saudi and non-Saudi)	Semi-structured interview	Thematic
7	Al-Nusair	Article: (2022)	Mixed methods	Major private medical/surgical hospital in Saudi Arabia	20	Immigrant nurses	Semi-structured interview	Thematic

Note: Further information on the studies included is available in the supplementary table.

Supplementary Table. 2.3: Characteristics of included studies

ID	First Author	Year	Participant Characteristics
1	Alotaibi	Article: (2016)	Area/Unit of Work: Not mentioned. Years of Work: Not mentioned. Designation: Not mentioned.
2	Almansour	Thesis: (2017) Article: (2022)	Area/Unit of Work: Not mentioned. Years of experience: 19.2% (<5 years), 34.6% (5-10 years), 46.2% (>10 years). Designation: Not mentioned.
3	Aljohani	Article: (2018)	Area/Unit of Work: 22.86% Medical/surgical, 22.86% Cardiac centre, 11.43% Oncology centre, 14.29% Emergency room, 28.57% Intensive care unit. Years of Work: 1-15 years. Designation: Ward staff.
4	Saleh	Article: (2018)	Area/Unit of Work: 80.6% hospitals, 19.4% primary healthcare. Years of Work: 50% (1-3 years), 31.4% (4-6 years), 18.5% (>6 years). Designation: Not mentioned.
5	Alshareef	Thesis: (2019) Article: (2020)	Area/Unit of Work: Not mentioned. Years of Work: Not mentioned. Designation: Not mentioned.
6	Shatnawi	Thesis: (2020)	Area/Unit of Work: Intensive and critical care units in two teaching hospitals. Years of Work: 36.9% (1-5 years), 52.6% (6-10), 10.5% (>10 years). Designation: Not mentioned.
7	Al-Nusair	Article: (2022)	Area/Unit of Work: 5 medical surgical units and spinal cord injury units, 5 emergency department, hemodialysis unit, and outpatient clinics, 5 intensive care unit, pediatric unit, and operation room, 5 brain injury, women's health, and stroke units. Years of Work: The average years of experience were 10.0 years (SD = 6.9 years). Designation: Staff nurses and charge nurses.

As shown in Table 2.3, four of the studies were published as journal articles only (1, 3, 4 and 7), two were published as both theses and journal articles (2 and 5), and the remaining study was published only as a thesis (6).

Table 2.4 presents the themes and subthemes from the Final Coding Framework

Table 2.4. Themes and Subthemes from the Final Coding Framework

Theme	Subthemes
Relationships with Supervisors/ Leads	Leadership Interactions Management Support
Workplace Equity	Perception of Nursing Profession Concepts of Seniority Involvement in Decision-Making Salary Professional Disrespect Opportunities for Educational/Career Development Personnel Policies Social Support
Work Assignments/ Workload	Night and Weekend Shifts Emotions Caused by Work Language of Communication at Work Job Satisfaction
Quality of Life	Living Accommodations Recreational Activities Work Transportation
Saudi Society	Islamic/Saudi Norms and Policy Family Support

As shown in Table 2.4, there were five main themes, and each one comprises between two and nine subthemes. The process of deriving the themes was inductive. These themes and subthemes are explained below. However, as a preface to this section, it is important to distinguish between the terms “leadership” and “management”. Leadership could be seen as having vision, inspiration, and passion, and using these traits to lead teams, while management could be seen as the act of creating and managing processes that are aimed at maximising efficiency and delegating authority (Aleksoski et al., 2020). Therefore, leaders fail at leadership if they fail to have vision, inspiration and passion, and managers fail at management if they do not create and manage efficient processes, and do not delegate authority well.

2.5.1 Relationships with Supervisors/Leads

The first theme captures relationships between supervisors or leads and their reports, and includes two subthemes: leadership interactions, and management support. All of the included studies consistently reported that the relationships between supervisors/leads and subordinates were considered to be poor. Staff described constant leadership conflicts and felt a lack of support from management:

“There is a gap between us and our head nurse; she does not listen to us.” (Alotaibi et al., 2016).

“It’s stressful situation because….there is lack of support from the management that the staff can’t be protected by the organisation with the lack of support." (Shatnawi, 2020).

As acknowledged previously, “leadership” and “management” are different concepts. A healthcare setting could have excellent leaders who are poor managers, and vice versa. It may be that management is easier than leadership, and therefore, there are fewer challenges. This review found however ample evidence of both extensive management and leadership complications in the Saudi healthcare environment.

2.5.1.1 *Leadership Interactions*

Although these findings cover seven different studies, it is important to point out that one of them, by Saleh (2018), focuses almost exclusively on the dominance of ineffectual leadership styles seen in the Saudi healthcare system, and how they impact nursing. This study highlighted how these ineffectual leadership styles appear to be common, and complicate the caregiving environment in which nurses operate (Saleh et al., 2018).

> *“I wish the head nurse can be proactive ... just don’t listen to one particular group of people, but to everyone ... I know it’s difficult.” (Saleh et al., 2018).*

Nevertheless, as shown under the Management Challenges section, the other studies reviewed additionally provide ample evidence of serious complications with leadership throughout the Saudi healthcare system.

One common issue with leadership, expressed independently of management issues, is that professional medical colleagues are not expected to treat nurses with respect.

"Another weak point here in this country, is that the doctors just give us orders and instruction and never look at us as colleagues, and [the doctors and other leadership] look at us as lower than them and assume they are the superior and the leader…" (Shatnawi, 2020).

"If we have an issue, we are not allowed to go talk to the directors…. There is a chain of command. They're getting worse and worse; there are no changes..." (Almansour, 2017).

As evidenced by these verbatim extracts, in general, leadership would allow and even cultivate this environment of professional disrespect. Unfortunately, this professional disrespect also in some instances would metastasise into racism.

"Unfair leadership dominant by race." (Alshareef, 2019)

2.5.1.2 *Management support*

As mentioned earlier, one study focused exclusively on leadership style, and that is because although management and leadership are different concepts, they are inextricably linked (Saleh et al., 2018). If a manager has difficulty executing the most basic management tasks, it is unlikely they will be able to be a successful leader. Such examples of management failures were abundant in the studies reviewed. First, there were instances of managers abusing nurses.

"My boss controls us, he does not manage us. I am being manipulated and psychologically abused by my boss. Every meeting is a chance for him to treat us badly, depending on his mood... I hate coming to work." (Almansour, 2017).

"My nurse manager embarrasses us, and if someone makes even a little mistake, everyone will be disciplined, which is unfair…I left that area because of her." (Almansour, 2017).

Next, there were instances of managers not protecting nurses who were abused.

"I feel very bad and stressed because sometimes you can't accept that kind of abuse you face from family with the lack of support from the hospital.". (Shatnawi, 2020).

"….my colleagues working with me at night duty has been abused and that time I called the supervisor to explained it to patient by Arabic but what he has done??? Nothing…." (Shatnawi, 2020).

Another theme in the area of poor management was not showing the nurses that they were appreciated.

"Well I never received an appreciation letter, nor have I ever been appreciated...the doctors get appreciated even though the nurse plays a key role and that is unfair…that

really upsets me and makes me depressed and think about leaving this hospital." (Shatnawi, 2020).

" I never received any thank you letter or been recognised even I am a hard worker…" (Shatnawi, 2020).

Other cases of poor management that were less severe centred around setting up an inefficient workplace and ineffectively delegating.

"……we are not well staffed and sometimes you feel that you need to have some extra staff with the extra tasks we are having……. But the management refuse and we manage it ourselves." (Shatnawi, 2020).

"My nurse manager is unfair...My head nurse prefers her friends in assigning weekends off. She is unsupportive and discriminatory." (Almansour, 2017).

Although these verbatim text extracts present evidence of management failures in the Saudi healthcare workplace, in many places, the evidence also demonstrates leadership failures. Managers who treat nurses abusively, or do not protect them from occupational risks, are not even fulfilling the basic management objectives. Those who are able to fulfil basic management objectives may lack skills and be inefficient at routine tasks such as scheduling and ensuring proper patient flow. This lack of management in this setting leads to high levels of stress as reported by these nurses.

2.5.2 Workplace Equity

Workplace Equity was a main concern in all of the included studies, as nurses at all levels reported multiple types of discrimination. This theme comprised eight subthemes.

2.5.2.1 *Perception of Nursing Profession*

The first subtheme, which relates to how the nursing profession is perceived, captures how some in Saudi society look down on nurses, and do not think Saudi women should be involved in that profession.

> *"The image of female Saudi nurses is still low; most people still do not have enough respect for them" (Alotaibi et al., 2016).*

2.5.2.2 *Concepts of Seniority*

The second subtheme relates to the concept of seniority in the workplace, or that experience in a field should lead to greater credit and credentials. Staff nurses in included studies complained of having a lot of experience in the Saudi nursing context, but not receiving any credit for their experience:

> *"There is no value placed on sincerity and skills" (Alshareef, 2019).*

2.5.2.3 *Involvement in Decision-Making*

The third subtheme under the Workplace Equity theme describes involvement in decision-making. Nurses at all levels who were interviewed for included studies complained that they were often shut out of decision-making, either by physicians or administrative leaders.

"The main factors that influenced his decision to leave his job was not sharing in decision-making" (Alshareef, 2019).

2.5.2.4 *Salary*

A fourth subtheme is linked to salary, in the studies, nurses of all levels uniformly reported challenges with low salary. Importantly, they describe how nurses could achieve a higher salary by playing racial politics. One nurse described a preference for nurses from Canada and the US, saying that they are paid a higher salary for the same work.

"…. there are different categories of salaries depending on from where you come. If you come from Canada and the US, your salary is top-top……. I think that is not fair." (Almansour, 2017).

Two nurses expressed intention to turnover simply because of this salary discrimination:

"The salary is not fair compensation between we Filipinos and other nationalities. I am going to Europe or Canada." (Almansour, 2017).

Many expressed the need for leadership to step in and fix the problem of salaries being based up on race or ethnicity, and that this was a prominent reason to consider leaving the Saudi healthcare system as a workplace:

"Salary scale and benefits should be same for all nationalities and should only be fixed on the basis of position but not nationality.... Salary enhancement should be standardised.... [nor] on the basis on ethnicity, race and nationality." (Alshareef, 2019)

2.5.2.5 *Professional Disrespect*

Another subtheme conveys how nurses relate to professional disrespect in the workplace context. Participants in the studies reviewed consistently reported poor relationships with physicians:

"Another weak point here in this country, is that the doctors just give us orders and instruction and never look at us as colleagues, and they look at us as lower than them and assume they are the superior and the leader. That's the worst thing and makes you stressful because such a relationship can affect the care provided to patients. And this stress is added to your job and your day." (Shatnawi, 2020).

Sometimes this professional disrespect was directed to nurses from nurses. One nurse expressed her disgust at the unprofessional favouritism displayed by her manager:

"My nurse manager is unfair…… My head nurse prefers her friends in assigning weekends off. She is unsupportive and discriminatory." (Almansour, 2017).

Finally, certain sets of policies and norms comprise the final three subthemes of the Workplace Equity theme.

2.5.2.6 *Opportunities for Educational/Career Development*

First, nurses emphasised the subtheme of opportunities for work-related education and career development throughout the studies and consistently complained that these were lacking in the Saudi context.

"I have a Diploma of Nursing and there is not one university within Saudi Arabia that will consider my previous study…." (Alotaibi et al., 2016).

2.5.2.7 *Personnel Policies*

Next, nurses complained that personnel policies related to pregnancy and childbirth make it difficult to start a family, making them consider suspending their work in the profession during childbearing.

"There is not any consideration for working mothers during the pregnancy period, [or any] maternity leave or leave for sick days for kids. Moreover, there is no day care for the babies to make it easy for the mothers to work" (Alshareef, 2019).

2.5.2.8 *Social Support*

Finally, as many of these nurses are ex-patriots, policies that lead to social support are very important to them. Throughout the included studies, nurses complained consistently about the lack of social support in the workplace:

> *"If you are alone and you feel pressure at work, you do not have anyone to express it to…I wanted to go as I missed my family in Malaysia..." (Almansour, 2017).*

2.5.3 Work Assignments/ Workload

This theme relates to how work assignments and workload are distributed among the nurses in the Saudi healthcare workplace. Throughout the studies, nurses repeatedly reported unequal or excessive work assignments and workload. This theme relates to four subthemes.

2.5.3.1 *Night and Weekend Shifts*

The first subtheme relates to night and weekend shifts, which nurses prefer to avoid because the work is more stressful during those shifts. In the included studies, nurses repeatedly reported unfairness in the distribution of these shifts among the staff, in that Saudis complain about being assigned to work these shifts:

> *"…the night shift is hard for me and my family." (Almansour, 2017).*

"Most Saudi nurses want to work morning duties. They do not want to work at night. This is a problem..." (Almansour, 2017).

2.5.3.2 *Emotions Caused by Work*

The second subtheme is emotions caused by work, which in this case were all in the negative direction toward work-related stress and burnout. Work-related stress was mentioned frequently in the verbatim text extracts in the studies reviewed.

"I have no time to take my break completely, the unit is always full and the patients here are very sick and busy, this caused me high level of stress all the times." (Shatnawi, 2020).

2.5.3.3 *Language of Communication at Work*

Another subtheme related to this theme relates to the language of communication used at work. The official language in the workplace is English, and though many individuals from all over the world convene in the Saudi healthcare workplace, they are all expected to communicate in English. In the studies reviewed, non-Saudi nurses expressed frustration with the lack of fluency of Saudi nurses in English, and complained that it was hard to communicate with them in English at work.

"...We have our job descriptions, but teaching English is not part of our job description. We have become teachers, and it creates more work for us." (Almansour, 2017).

2.5.3.4 *Job Satisfaction*

Finally, job satisfaction was mentioned over and over in the studies reviewed. When the topic came up, the tone was always negative, in that nurses were experiencing a lack of satisfaction in their job:

> *"There are not enough nurses so we have a lot of work to do, which decreases job satisfaction" (Alotaibi et al., 2016).*

2.5.4 Quality of Life

The fourth primary theme was quality-of-life, and whenever it was discussed, it was in the negative. Three areas where nurses repeatedly reported lack of or low quality-of-life in the included studies contribute the three subthemes to this theme: living accommodation, recreational activities, work transportation, and other facilities or provisions.

2.5.4.1 *Living Accommodations*

Non-Saudi nurses must rely on their employer for living accommodation and those nurses complained that these were consistently less than adequate.

> *"First, it's really the accommodations.…We have problems. The washing machine did not work for months, and we washed our clothes manually. Finally, I bought my own [washing machine] as if you waited for the machine to be repaired, it would take months." (Almansour, 2017).*

"The problem is the accommodations. The room should be for only two [occupants], but we [have] three..." (Almansour, 2017).

2.5.4.2 *work transportation*

Non-Saudi nurses also complained about transportation issues, such as delays that disrupt their schedules.

"The biggest problem for us is transportation. They [the coaches] are always late. They do not come on time…" (Almansour, 2017).

2.5.4.3 *Recreational Activities*

In terms of recreational activities, Saudi society has traditionally not cultivated the types of public recreational activities seen in Western countries, so non-Saudi's may find themselves bored. Although it is changing currently, even Saudi nurses who have studied abroad agree that there can be low quality-of-life in Saudi due to lack of recreational activities. One even stated that having more recreational activities available would probably prevent turnover:

"We don't have recreation activities. It is not like at other hospitals…. They have a lawn tennis court…which I can truly say would help encourage people to stay". (Almansour, 2017).

"No extracurricular activities, no gym and no swimming pool" (Alshareef, 2019).

2.5.5 Saudi Society

Saudi society is unique in many ways, but is generally considered conservative and traditional, with strict cultural norms. Because these cultural norms are so strict, even modern Saudis often feel pressure as a result of them, which is the final theme identified.

2.5.5.1 *Islamic/Saudi Norms and Policy*

Saudi nurses complained of societal pressure for them to live up to certain ideals while performing as a nurse, while non-Saudi nurses complained of society pressure from a country whose norms were not completely consistent with theirs.

> *"…. I do feel that I have been discriminated against as a female in the country as I can't go out any time and I can't drive either, and that is what really stresses me out."*
>
> *(Shatnawi, 2020).*

2.5.5.2 *Family Support*

For the non-Saudis, an important subtheme was family support, in that they felt especially isolated from their family if the family could not join them in Saudi. The pressure from cultural Saudi norms made this separation more difficult. Societal norms and practices arising from Islam were identified as a second subtheme and a source of pressure on these nurses. While many were Muslim themselves, those who were not felt uncomfortable participating in Muslim practices such as wearing an abaya.

"We women feel inferior, we cannot drive, and we need to wear an Abaya (covering all the body and hair with a special dress and head cover) and cannot go out alone. We need to be accompanied by our relative and at the same time; we are not allowed to bring our family because of visa restrictions and because of feeling of homesick and missing family members." (Shatnawi, 2020).

2.6 Discussion

This qualitative evidence synthesis revealed three findings: leadership challenges, complex webs of discrimination, and Saudi societal factors place pressure on Saudis and non-Saudis (see Appendix C). These overall findings were expressed as five themes and 19 subthemes relating to factors causing turnover and turnover intention in nurses working in KSA. Most of the participants interviewed in the qualitative analyses included in this review reported many challenges in the healthcare occupational setting in KSA that would encourage nurse burnout and turnover and discourage recruitment and retention.

This review however looks beyond nursing to the systemic issues in the KSA healthcare workplace reported first-hand by the nurses in these studies. While it was known that poor nursing management was one important cause of nurse turnover in KSA (Soqair, 2021), this review illustrates how management in KSA healthcare appears to have broken down at all levels, not just in nursing. Also, while discrimination and bullying has been documented in nursing in KSA (Al Muharraq et al., 2022; Alsadaan et al., 2021), this review illustrates how complex and multi-faceted these systems of discrimination and

bullying really are, and how difficult they may be to dismantle. Finally, while it was known that non-Saudi nurses experience societal pressure when in KSA which can increase turnover intention (Alsadaan et al., 2021), this review illustrates a more complex impact of the culturally restrictive Saudi society on all nurses. While non-Saudi nurses complain of having to conform to Saudi society, even Saudi nurses reported a conflict between workplace demands and societal expectations.

Our conceptual framework provided valuable insights in exploring nurse turnover, capturing nuances that traditional summaries often overlook. This framework enabled us to integrate diverse findings systematically, revealing patterns and connections not previously recognised. Through this framework, we identified significant factors that contribute to nurse turnover, enriching our overall understanding. To that end, after reviewing the themes and the findings, any interventions aimed specifically at reducing nurse turnover in KSA in the last decade have essentially failed, and this is likely because systemic change is needed to correct this problem (Albougami et al., 2020; Alonazi & Omar, 2013; Soqair, 2021). This systematic change could start at the bottom - with each individual healthcare leader at each organisation. If all current leaders in healthcare were encouraged to undergo retraining to gain the necessary skills needed for dismantling these systematic problems, this would be the first step toward reform (De Brún et al., 2019).

Although much evidence exists in the literature that exposes and explains the drivers of nurse turnover and turnover intention, few evidence-based studies of interventions to

reduce nurse turnover and turnover intention are available for consideration. A recent realist review recommended the following solutions to be implemented by nurse leaders place emphasis on fostering social connectedness, provide the environment for professional practice autonomy, use methods to cultivate a healthy workplace culture, and identify ways to support professional growth and development (Cardiff et al., 2023). The articles included in this review were all observational, in that they did not test any interventions (Cardiff et al., 2023). A study from South Korea assembled a focus group of nurses to provide suggestions of ways to reduce turnover (Yun & Yu, 2021), and other writing in the literature consists of thought leaders proposing potential solutions or doing demonstration projects (Clemmons-Brown, 2023; Perkins, 2021). Alshahrani (2022) recommended general solutions for nurse turnover in KSA, including changing the negative image of nursing, improving nurse working conditions, improving wages, and finding ways to retain aging nurses. However, no results from evidence-based, practical interventions were included (Alshahrani, 2022). A recently published doctoral dissertation reports the findings of a qualitative study where US nurses were asked about successful turnover reduction strategies (Cozart, 2024). The participants recommended improving employee communication, motivating lower-level nurses by making them a priority, improving organisational culture, and having competitive wages (Cozart, 2024).

2.7 Policy Implications

The findings suggest that KSA healthcare leaders should rethink how management are trained, and how healthcare is organised, given the leadership challenges identified in this

review. Addressing the serious problem of the management challenges in healthcare would likely have a strong, positive impact on the other two findings that relate to discrimination and societal pressure. Having top-tier managers working with healthcare clinicians and staff would improve the working conditions immensely and may simply reduce discrimination through strong leadership at all levels. Also, high quality managers have strategies to reduce stress in the workplace and could help both Saudi and non-Saudi workers feel more comfortable in the face of societal pressures.

Knowing this, we would recommend that KSA implement a Leadership Development Programmes at the countrywide level. These programmes should provide training in areas such as effective management skills, and strategic thinking. Additionally, these programmes should support continued education to prepare nurse leaders with the resources needed for addressing workplace challenges and promoting a positive workplace environment. Implementing these programmes would empower nurses and encourage their professional growth and career advancement. Furthermore, KSA should promote recreational activities for non-Saudi nurses within the healthcare organisation to enhance their wellbeing. Such a nationwide programme for nurses would be consistent with KSA's current strategic plan called Vision 2030, which seeks to reform the healthcare system to meet the growing demands of an aging and expanding population (Alluhidan et al., 2020).

2.8 Limitations

This qualitative evidence synthesis is not without limitations. First, although the quality of research methods was comparable across all the studies included, ultimately study quality was not perfect. As shown in Appendix, B, out of seven articles, three had major methodological flaws, and this likely impacted this paper's findings. These studies - three of which were in thesis format, so were dissertation topics – lacked a succinct summary of what was found. This led to challenges in synthesising all the themes from the different items. Also, the qualitative evidence was different from studies that were mixed methods and included surveys with open-ended questions compared to studies where the data was obtained from interviews.

2.9 Conclusions

In conclusion, this qualitative evidence synthesis revealed three overarching findings related to causes of turnover and turnover intention in nurses working in KSA. This setting includes a mix of Saudis and non-Saudis who follow different pathways to employment. Further, the background Saudi culture places specific types of societal pressure on both Saudi and non-Saudi nurses.

These findings call for KSA leaders to address overall leadership challenges at all levels in healthcare, to intervene on serious problems with discrimination in the workplace and take action to reduce the societal pressure felt by both Saudi and non-Saudi nurses in the occupational setting. Any interventions over the past decade to reduce turnover and

turnover intention in nurses working in KSA likely failed due to the persistent poor conditions in the overall KSA healthcare working environment. While KSA leaders are strongly encouraged to intervene on these systemic issues, it is recommended that they prioritise improving leadership and professionalism at all levels of the healthcare system first. By focusing on alleviating the leadership challenges, interventions by KSA leaders may also result in a positive impact on discrimination and societal pressure in the workplace.

2.10 Using the QES to Inform the Study Design

Several specific findings from the Qualitative Evidence Synthesis (QES) directly informed the design of the primary study, including decisions related to sampling, data collection, analysis, and the formulation of the research questions. First, the QES demonstrated that the experiences of staff nurses differed qualitatively from those of nurse leaders, with distinct sources of dissatisfaction and different reasons for turnover intention reported across these groups. In the reviewed studies, staff nurses focused on workload, scheduling, and immediate supervisory relationships, whereas nurse leaders emphasised role strain, lack of authority, and limited organisational support. This finding informed the sampling strategy of the primary study by requiring the inclusion of both staff nurses and nurse leaders, rather than treating nurses as a single homogeneous group. It also informed the analytical strategy, as findings from staff nurses and nurse leaders were compared analytically to identify differences in experiences of turnover intention.

Second, the QES identified consistent qualitative differences between Saudi and non-Saudi nurses in relation to employment conditions, contractual security, career progression, and societal pressures. These differences were repeatedly reported across studies but were rarely analysed explicitly or comparatively in the original research. This gap directly informed the decision to structure sampling to include both Saudi and non-Saudi staff nurses and nurse leaders, and to analyse and compare their perspectives. Data collection tools were therefore designed to explicitly prompt reflection on Saudi and non-Saudi status, allowing participants to describe how nationality shaped their experiences of leadership,

workload, recognition, and retention through open-ended discussion, rather than treating nationality as a background demographic characteristic.

Third, the QES showed that while many qualitative and mixed-methods studies identified factors associated with turnover intention, few extended their analyses to consider practical or organisational responses to these problems. This gap informed the analytical focus of the primary study by incorporating questions about what participants believed could realistically reduce turnover and support retention and by treating the development of evidence-based retention strategies as a central aim of this research. In addition, many studies relied primarily on survey instruments or limited qualitative components and, as a result, did not fully capture nurses' lived experiences within KSA healthcare organisations.

The QES therefore highlighted a broader lack of contextual depth in the current literature. This gap informed the decision to use a qualitative interview-based design for the primary study, allowing nurses to describe their experiences in detail and to introduce issues not captured through currently available tools. The aims and objectives outlined in Chapter 1 therefore reflect a deliberate response to these limitations, through comparative examination of Saudi and non-Saudi nurses, staff nurses and nurse leaders, and through the development of evidence-based retention strategies grounded in qualitative evidence.

2.11 Chapter Summary

This chapter presented the qualitative evidence synthesis, which formed the first phase of this PhD study and established the evidential foundation for the primary qualitative research that followed. The synthesis identified three overarching findings: leadership challenges at all levels of the KSA healthcare system, a complex web of workplace discrimination, and societal pressures affecting both Saudi and non-Saudi nurses, findings that have rarely been examined comparatively across these groups in research to date. These findings directly informed the design of the primary study, including decisions related to sampling, data collection, and the formulation of research questions. The methodology underpinning the primary qualitative study is presented in Chapter 3.

Chapter 3 - Methodology

3.1 Introduction

This chapter describes and justifies the methodology and research methods employed in this study. As established in the background and qualitative evidence synthesis (Chapters 1 and 2), research on nurse turnover and turnover intention in the Kingdom of Saudi Arabia (KSA) is dominated by quantitative designs that have focused on measurable risk factors using standardised instruments. While these studies have identified associations between turnover intention and factors such as low job satisfaction, poor leadership, and inadequate compensation, they have consistently failed to explain how these factors interact within the KSA context, or to generate actionable, site-specific retention strategies. These limitations are not only empirical but methodological, as quantitative approaches are unable to capture how nurses themselves experience and interpret the conditions that drive their intention to leave. In response, this study adopted a qualitative, interpretivist approach, using semi-structured interviews for data collection and reflexive thematic analysis for data analysis.

The chapter begins by describing the research philosophy underpinning the study, including the epistemological and ontological positions adopted, followed by the rationale for selecting a qualitative descriptive design. Alternative study designs are then considered and their rejection justified. The chapter next outlines the study setting, participant selection, sampling strategy, and recruitment process, including inclusion and exclusion

criteria and the pilot study conducted. Data collection and transcription procedures are then described, followed by an account of the analytical approach, covering both thematic analysis and framework development. A discussion of trustworthiness and ethical considerations follows, alongside a section on researcher reflexivity. The chapter concludes with a summary of the methodological decisions taken and their relevance to the study aims.

3.2 Research Philosophy

For this research, in terms of philosophy, a qualitative, exploratory method incorporating an interpretative epistemology with social constructivist theory as its ontological viewpoint was utilised. Two fundamental approaches are used when analysing qualitative data: the deductive approach, and the inductive approach (Burnard et al., 2008). While deductive approaches use a structure or predetermined framework, this was considered too restrictive for the study aims (Burnard et al., 2008). Therefore, an inductive approach was used to derive insights from the actual qualitative data collected (Burnard et al., 2008).

3.2.1 Epistemological Position

This research is guided by an interpretivist epistemological stance, which recognises that knowledge is subjectively constructed rather than objectively discovered (Creswell & Poth, 2018). Interpretivism acknowledges that human experiences cannot be understood through positivist approaches that seek universal laws or generalisations (Creswell & Poth, 2018). Instead, it values the subjective meanings that individuals create through their lived

experiences and social interactions (Denzin & Lincoln, 2011). This epistemological position is particularly appropriate for this study because understanding nurse turnover and turnover intention in the context of the KSA healthcare system requires that the researcher deeply engage with the subjective experiences, cultural nuances, and personal meanings that nurses attach to their professional decisions. The interpretive approach allows for recognition that multiple realities exist, constructed through the varied experiences and perspectives of participants (Schwandt, 2014).

3.2.2 Ontological Position

Ontologically, this research is grounded in social constructivism, which posits that reality is socially constructed through human interaction, language, and shared meanings (Berger & Luckmann, 2016). This perspective recognises that phenomena such as nurse turnover and turnover intention cannot be understood independent of social context (Gergen, 2015). Instead of being seen as objective realities, nurse turnover and turnover intention should be seen as constructs shaped by cultural, historical, and social factors (Gergen, 2015). Social constructivism aligns with the aim of this research with respect to exploring how nurses working in KSA construct meaning around their professional experiences, and the decisions they make within their unique cultural and organisational contexts (Berger & Luckmann, 2016; Gergen, 2015).

Social constructivism can be contrasted with realist approaches, which assume an objective reality exists independent of human perception (Burr, 2015). Social constructivism acknowledges that there are roles for culture, power relations, and institutional contexts in

shaping an individual's experiences and decisions (Berger & Luckmann, 2016; Burr, 2015; Gergen, 2015).

3.2.3 Methodological Approach

The epistemological and ontological positions adopted in this research naturally led to an inductive methodological approach. An inductive approach was used to derive insights from the actual qualitative data collected, allowing themes to emerge organically from participants narratives rather than imposing predetermined categories (Braun & Clarke, 2019; Charmaz, 2014). This methodological choice aligns with both interpretivism's focus on understanding subjective meanings and social constructivism's emphasis on how meanings are constructed within specific contexts. While this approach is time-consuming, it is comprehensive and most applicable when little is known about the study phenomenon (Burnard et al., 2008; Creswell & Poth, 2016), as is the case with nurse turnover intention in the KSA healthcare system.

3.3 Qualitative Research Design

The study employed a qualitative exploratory methodology, which is well-suited for examining underexplored themes (Burnard et al., 2008). The exploratory qualitative approach was chosen for studying nurse turnover intention in KSA due to limited research and the need for deeper understanding. This method allowed for a thorough exploration of nurses' personal experiences and motivations. Additionally, its flexibility enabled the identification of complex cultural, organisational, and individual factors unique to the Saudi healthcare context.

A thematic analysis approach was used, which is a flexible method for identifying and analysing patterns within qualitative data. Thematic analysis can be used within various qualitative methodologies, such as ethnography, phenomenology, or grounded theory, it is also commonly applied as an independent method (Braun & Clarke, 2006; Burnard et al., 2008). In this study, reflexive thematic analysis was conducted on qualitative data derived from interviews, allowing themes to be developed inductively through the researcher's active engagement with the data (Braun & and Clarke, 2019).

3.4 Rationale for using Qualitative Method

As outlined in Section 3.2, this study adopts an interpretivist epistemology and a social constructivist ontology, both of which support the use of qualitative methods to explore how individuals construct meaning through lived experience. The main reason for using qualitative methods in this study was that it was felt that the research questions could not be answered with quantitative methods (Busetto et al., 2020). As shown in Chapter 1, many quantitative studies do not provide sufficient depth to understand the phenomenon. Qualitative methods are particularly useful for assessing complex multi-component systems to help understand how they function, including what works, for whom, when, how and why (Busetto et al., 2020).

3.5 Challenges of Qualitative Methods Approaches

As described earlier, a central challenge in qualitative methods is that it is time-consuming to conduct interviews and analyse transcripts (Burnard et al., 2008). Another challenge is

that the findings of a qualitative study are often criticised for their lack of ability to generalise outside of the group on which the findings were developed (Burnard et al., 2008; Busetto et al., 2020). Questions of replicability are also posed against qualitative designs (Burnard et al., 2008; Busetto et al., 2020). This is why sufficient depth and richness of data are important, ensuring the credibility and completeness of the findings (Braun & and Clarke, 2019; Braun & Clarke, 2021b; Hennink et al., 2019). Despite these recognised limitations, qualitative designs remain necessary in order to understand a phenomenon that could not be understood using quantitative research (Burnard et al., 2008; Busetto et al., 2020).

3.6 Study Design Selection

The qualitative descriptive study design is widely used in nursing research (Villamin et al., 2025). It does not aim to study the lived experiences or culture of the participants and is not aimed at developing theory (Villamin et al., 2025). Instead, it is a flexible study design that weaves together methods from different qualitative study designs but is focused instead on gaining a comprehensive understanding of a particular phenomenon while based on the rich experiences reported first-hand from the participants (Villamin et al., 2025). For this reason, the qualitative descriptive study design was selected for the current study.

The study was designed as a qualitative interview-based study rather than an organisational case study. While a case study approach was considered, it was not adopted because organisational case studies require the integration of multiple sources of contextual and documentary data, such as internal policy documents, workforce statistics, staffing records,

and organisational performance data. Access to these forms of data was formally requested but could not be granted due to confidentiality and institutional restrictions.

As a result, the study was designed to focus on staff nurses' and nurse leaders' experiences of turnover intention, rather than on a comprehensive organisational analysis of KFAFH. This approach allowed for an in-depth exploration of how turnover intention is experienced and interpreted within a single organisational setting, while remaining proportionate to the data that could be ethically and practically accessed.

Alternative research approaches were also considered, including grounded theory (GT), phenomenology, ethnography, mixed-methods designs, and focus group methods. In GT, data collection and analysis are conducted in an emergent iterative process for the purposes of developing a theory (Urcia, 2021; White & Devitt, 2021). As the ultimate purpose of the current study was not to develop a theory to explain turnover or turnover intention in staff nurses and nurse leaders working in KSA, GT was ruled out as a potential approach (Urcia, 2021; White & Devitt, 2021). Phenomenological approaches on the other hand aimed at gaining deep understanding of the fundamental dimensions of a particular phenomenon based on the essence of the study participants' lived experiences (Urcia, 2021). As the intention of the current study was not to understand the fundamental dimensions of the lived experience of staff nurses and nurse leaders working in KSA engaged in turnover, phenomenological approaches were ruled out.

Ethnographic approaches are intended to take place with the participants in their natural setting with the goal of deeply understanding the participants (White & Devitt, 2021).

Ethnographies may offer a more holistic approach compared to focus groups and other traditional qualitative designs (White & Devitt, 2021). As the intention of the current study was not to deeply understand the participants in their natural setting but was more focused on the phenomenon of turnover intention, ethnography was ruled out as a design approach.

Mixed-methods research (MMR) refers to research with both a qualitative and quantitative component (Dawadi et al., 2021). As stated in Chapter 1, many quantitative studies have previously researched nurse turnover and turnover intention, and the gap in the literature relates specifically to qualitative research. For this reason, MMR approaches for the design of the current study were ruled out.

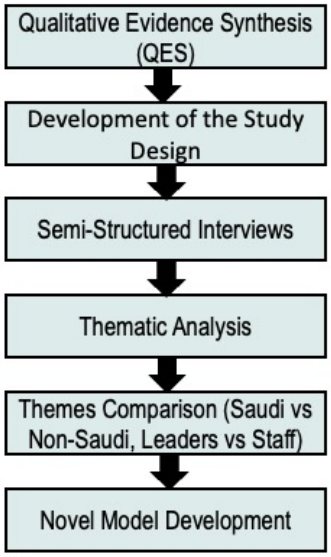
In focus group designs, data are collected from several participants at the same time (Akyıldız & Ahmed, 2021). The advantage of this approach is that the focus group setting allows participants to have synergy and influence each other in the discussion (Akyıldız & Ahmed, 2021). The downside is that the group context compromises privacy and can make participants fearful of discussing sensitive topics (Akyıldız & Ahmed, 2021). As factors influencing turnover intention may originate with the employer, and expressing negative opinions about the employer may compromise employment, focus groups were not considered appropriate because participants may have felt unable to speak openly about a sensitive topic, or uncomfortable about expressing their true feelings in a group setting. As the current study was intended to use the experiences reported by participants to better understand how to address the issue of turnover intention of nurses working in KSA, the

qualitative descriptive study design was determined to be the most suitable and was selected.

3.7 Overview of the Research Process

The research process followed a sequential design in which findings from each stage directly informed the next, ensuring that the primary qualitative study was grounded in current evidence rather than developed in isolation. Figure 3.1 presents an overview of the research process. The study began with a published qualitative evidence synthesis (QES), which was used to identify research gaps and inform the development of the study design (Almubark et al., 2025). Semi-structured interviews were then conducted with nurse leaders and nursing staff. The transcripts were analysed using reflexive thematic analysis. These findings were used to explore differences between Saudi and non-Saudi nurses, as well as between leaders and staff, and informed the development of the novel model presented in Chapter 5.

Figure 3.1. Overview of the Research Process



3.8 Analytical distinctions: Saudi vs. non-Saudi nurses

As established in the literature review and reinforced by findings from the qualitative evidence synthesis (QES), nationality has consistently been identified as a structurally significant factor shaping nurses work experiences and turnover intentions within the KSA context. This section justifies the Saudi nurse vs. non-Saudi nurse analytic distinction by providing evidence from the literature, including national workforce statistics (Al Muharraq et al., 2022; Alluhidan et al., 2020; Alreshidi et al., 2021; Kattan & Al-Hanawi, 2025). While it is acknowledged that participants of different genders or from different age groups or sectors of healthcare may have different perspectives, the reason the Saudi vs. non-Saudi status is emphasised in this study is because nurses experience different employment pathways and contexts depending upon their status as a Saudi or non-Saudi

staff nurse or nurse leader (Al Muharraq et al., 2022; Alluhidan et al., 2020; Alreshidi et al., 2021; Kattan & Al-Hanawi, 2025).

Employment pathways in the nursing workforce are different for Saudis compared to non-Saudis in KSA, and this needs to be considered when exploring turnover intention. According to a report by Alluhidan and colleagues (2020), only about 38% of the nurses in KSA in 2018 were Saudi citizens, comprising 70,319 out of a total of 184,565 nurses. This report found that while 62% of the nurses overall were female, 90% of the foreign nurses were female, reflecting Saudi cultural preferences for having a same-sex nurse for care (Alluhidan et al., 2020). Non-Saudi nurses are required to have their employment arranged through an agency; these individuals are mostly from India, the Philippines, and Malaysia (Alluhidan et al., 2020). Saudi nurses are more likely to be in leadership roles and less likely to serve as staff nurses, notwithstanding a lack of trained Saudi advanced practice nurses (APRNs) (Alluhidan et al., 2020; Alreshidi et al., 2021). Research shows different workforce compositions depending on the healthcare sector, in that Saudi nurses are more likely to work in an MoH healthcare setting compared to non-Saudi nurses (Alluhidan et al., 2020; Kattan & Al-Hanawi, 2025). A survey in a 1,200 bed tertiary hospital in Riyadh found that almost 80% of the nurses were non-Saudi, which aligned with other published estimates (Al Muharraq et al., 2022).

The demographic profile of non-Saudi nurses in KSA further illustrates how structurally distinct their working conditions are from those of Saudi nurses, with implications for how turnover intention develops differently across the two groups. A survey of non-Saudi

nurses was conducted at eight MoH hospitals using WhatsApp (n = 639); 97% of the participants were female, and 72% were staff nurses (Alreshidi et al., 2021). In the survey, over 82% reported having a bachelor's degree, and 67% reported they had at least 5 years of experience (Alreshidi et al., 2021). The ethnic groups were predominated by Filipinos (44%) and Indians (50%) (Alreshidi et al., 2021).

In 2023, Saudi nurses represented 44.22% of the nursing workforce, with non-Saudi nurses constituting the remaining 55.78% (Kattan & Al-Hanawi, 2025). Nevertheless, most studies on this topic fail to recognise that Saudi and non-Saudi nurses differ in what they need from the nursing work environment and profession, such that authors do not separate these two groups in their analysis (Al-Mansour, 2021; Alshareef et al., 2020; Soqair, 2021).

Although factors such as gender, age, and healthcare sector have been shown to shape nurses' experiences, these characteristics do not structure employment conditions in KSA in the same way as Saudi vs. non-Saudi status. In the KSA context, nationality determines key aspects of employment, including contractual security, access to benefits, career progression, and leadership opportunities. Gender and age differences operate within these nationally defined employment frameworks, rather than independently of them. For this reason, Saudi vs. non-Saudi status provides an analytically meaningful distinction for understanding turnover intention within the KSA nursing workforce.

While the findings in this study were grouped according to the Saudi vs. non-Saudi distinction because this distinction emerged from the QES and was consistently supported

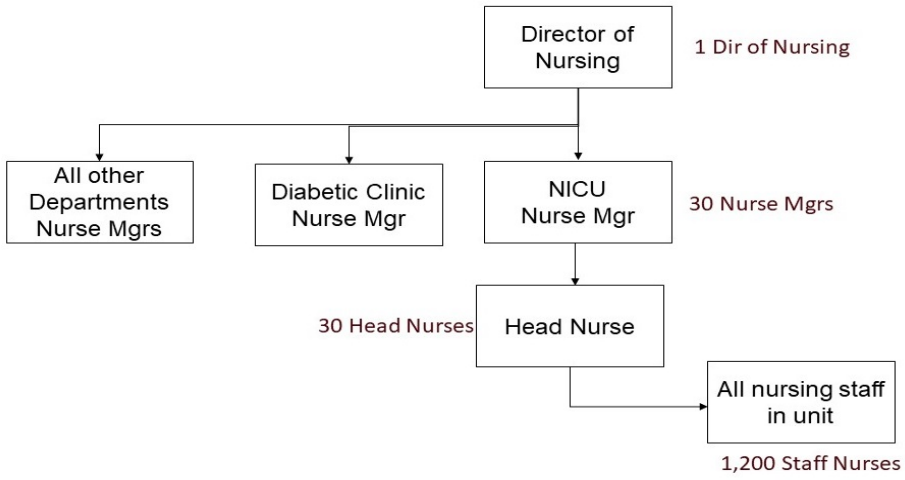
by the literature as a key structural feature of the KSA nursing workforce, it is recognised that this analytical approach has limitations. Grouping participants into Saudi and non-Saudi categories may fail to capture differences between non-Saudi nationalities, as nurses from different countries may have distinct cultural backgrounds and professional expectations. Nevertheless, the purpose of this distinction was not to suggest that all non-Saudi nurses have homogeneous experiences, but rather to examine the structural differences in employment conditions, career pathways, and organisational contexts shaped by Saudi vs. non-Saudi status within the KSA healthcare system.

3.9 Methods

3.9.1 Participants and Setting

As shown in Figure 1.2, KFAFH is organised into departments under the Hospital Director, and the Director of Nursing heads one of these departments. All of the nurses in the hospital system report to this department (see Figure 3.2).

Figure 3.2. Nursing Organisational Chart for Units at KFAFH



As shown in Figure 3.2, of the 30 units with nurses in them, each has a Nurse Manager who runs the unit, and reports to the Director of Nursing. Each of the 30 units also has a Head Nurse, who reports to the Nurse Manager. Finally, each unit has staff nurses, and the size of the nursing staff depends on the activities of the unit. All the staff nurses report to the Head Nurse, who reports to the Nurse Manager in this structure, so essentially, the same management structure operates in each unit, regardless of size and amount of patient care activity.

For the purposes of this study, the following occupational categories were considered "nurse leadership": Nurse Managers, and Head Nurses. The staff nurses were considered "nursing staff".

In this study, two separate data collection efforts were conducted: one aimed at nursing leadership at KFAFH, and one aimed at staff nurses. Because of their positions and experience, nursing leadership were asked slightly different interview questions than the staff.

Participants were recruited through email invitations to staff nurses and nurse leaders. When responses to the initial emails were limited, the researcher went on-site and attended nursing stations to introduce the study and invite participation. A purposive sampling strategy was employed throughout to recruit Saudi and non-Saudi nurses, including both staff nurses and nurse leaders, in line with the study aims. As recruitment progressed, an imbalance in nationality representation was identified. Targeted recruitment was therefore focused on approaching nursing stations where staff were predominantly from underrepresented nationality groups, to ensure maximum variation across the sample.

3.9.2 Data Saturation and Sample Adequacy

Within reflexive thematic analysis, saturation is conceptualised as an analytic judgement informed by the richness, coherence, and explanatory power of the developing analysis (Braun & Clarke, 2021b). In this approach, saturation does not imply exhaustive coverage of all possible perspectives or numerical repetition across participants but indicates that the analysis is sufficiently developed to address the research aims in a coherent and meaningful way. Loyal and Amri (2026) argue that saturation depends on the epistemological and analytic orientation of the study rather than operating as a universal procedural standard. In line with this and with Braun and Clarke's (2021a) reflexive thematic analysis approach, judgements about saturation in this study were guided by whether the analysis was sufficiently developed to address the research aims, rather than by numerical indicators.

The absence of new codes in the final interviews was therefore used as a supportive indicator, but was not treated as a defining criterion, as reflexive thematic analysis prioritises analytic depth and interpretive coherence over code frequency or numerical thresholds (Loyal & Amri, 2026). Saturation was assessed through continued engagement with the data and repeated evaluation of theme coherence, rather than through externally verifiable stopping rules or numerical endpoints (Loyal & Amri, 2026). On this basis, saturation was judged to have been reached when additional interviews no longer extended the analytic framework or generated new insights relevant to turnover intention. During the later stages of data collection, participants narratives consistently reinforced previous codes and themes across Institutional, Leadership, and Personal Factors, with no new areas of

conceptual significance emerging, indicating that sufficient analytic depth had been achieved to address the research questions.

A total of nineteen participants were interviewed, comprising thirteen staff nurses and six nurse leaders. These participants contributed data relevant to two primary analytic comparisons aligned with the study objectives, namely Saudi and non-Saudi nurses, and staff nurses and nurse leaders. The higher proportion of non-Saudi nurses reflects the demographic composition of the nursing workforce in KSA, where expatriate nurses constitute a substantial proportion of staff (Kattan & Al-Hanawi, 2025). As described in the "Participants and Setting" section and illustrated in Figure 3.2, leadership roles represent a small proportion of the nursing workforce at KFAFH, and the smaller number of nurse leaders reflects organisational role distribution rather than sampling imbalance. For this reason, saturation in qualitative analysis relates to whether the analysis is sufficiently developed, rather than to numerical balance between groups. Differences in subgroup size therefore influence how comparisons are interpreted, not whether saturation has been achieved (Loyal & Amri, 2026).

In reflexive thematic analysis, analytic sufficiency is established through interpretive judgement rather than through procedural or structured techniques, as the approach does not assume that qualitative data reach a fixed endpoint (Braun & Clarke, 2021a, 2021b). On this basis, numerical saturation tables or frequency-based demonstrations are not

appropriate, as they risk misrepresenting how qualitative analysis is conducted (Loyal & Amri, 2026).

3.9.3 Inclusion and Exclusion Criteria

This study was predominantly conducted in English. However, two Saudi staff nurses used Arabic terms during their interviews, as they felt more comfortable expressing certain points in their native language. The researcher translated these interviews from Arabic to English to ensure that the original meaning and context were preserved as accurately as possible. The inclusion and exclusion criteria were as follows.

Inclusion Criteria

- Must be currently employed as either a staff nurse or nurse leader at KFAFH at the time of the interview.
- Must be willing to be interviewed and recorded at the KFAFH researcher's office or virtually via Google Meet.

Exclusion Criteria

- The Nursing Director was not eligible to participate.
- Individuals under age 18 were excluded.
- Individuals who first began work at KFAFH in the year of data collection (2023) were not eligible.

3.9.4 Pilot study

A pilot study was conducted to ensure that the interview materials were clear, understandable, and capable of eliciting relevant and meaningful responses for the study. To that end, one staff nurse and one nurse leader were recruited from an MoH hospital in KSA not otherwise connected with KFAFH to review the study materials. They were asked their opinions of each study question. Both the staff and the leader agreed that the wording of materials was understandable and did not make any recommendations for changes.

3.10 Data Collection

3.10.1 Study Recruitment and Consent

To identify individuals interested in study participation, a survey link was sent to potential participants for them to complete with their contact information if they were interested in being contacted by the researcher (see Appendix D for nurse leaders, and Appendix E for nursing staff). Efforts were made to recruit both Saudis and non-Saudis given the differences seen in their concerns about turnover intention represented in the literature. During recruitment, an e-mail was sent to staff and leaders, explaining the study and the process for participation. When the researcher received contact information for a potential participant, she contacted them to arrange an interview.

An initial e-mail was sent November 1, 2023, and by December 15, 2023, six individuals had been recruited. These individuals were interviewed remotely via Google Meet. Initial response to remote recruitment was limited, likely due to workload demands and

inconsistent internet access during shifts. To address this, the study was conducted on site from December 23, 2023, through January 13, 2024. Conducting the study on site allowed for direct engagement with staff and better scheduling flexibility. Eleven interviews were conducted on site. The researcher left the site, and afterward, conducted two more remote interviews, bringing the total number of participants to nineteen.

Each potential participant at that time was assigned a provisional study identification number (study ID). After data collection, the participant was assigned a pseudonym for the purpose of presentation of findings.

3.10.2 Consent, Eligibility and Enrolment

When the participant attended the arranged meeting (either remotely or in person), a written consent process was completed. A study ID was used to identify the participant during recruitment, consent, and enrolment. The interviews were recorded using two Olympus DS-5000 digital voice recorders. Two devices were used to ensure that no data were lost in the event of technical failure, for both in-person and remote interviews. The interviews were transcribed by the researcher and labelled with the corresponding Study ID.

Through the written consent process, eligibility for the study was confirmed. At the end of the written consent process, the potential participant indicated whether they provided informed consent to participate. If they consented to participation, they were considered

enrolled, and data collection activities commenced. The written consent process preserves the anonymity of the staff nurse or nurse leader.

3.10.3 Data Collection and Transcription

After the participant underwent the consent process and consented, the researcher asked them to complete a short questionnaire of demographic and occupational information (see Appendix F for nurse leaders, and Appendix G for nursing staff). Next, the researcher conducted the recorded interview (see Appendix H for nurse leader interview questions, and Appendix J for nursing staff interview questions). Each interview lasted between approximately 25 and 45 minutes, depending on the depth of participant responses and the flow of the conversation. After the interview, the researcher transcribed the interviews, identifying them by study ID. After the transcription process, the transcripts were anonymised by removing any names that are used in the interview and other potentially identifiable information such as wards.

The interviews were recorded via Google Meet and also on a standalone recording device not connected to the internet. The recordings were then transcribed into Word documents. These were saved on an external hard drive not connected to the internet. Transcripts remained on this drive until they underwent the anonymisation process. After anonymisation, these transcripts were moved to the U drive at the University of Sheffield to undergo final analysis.

3.11 Data Analysis: Thematic Analysis

A reflexive thematic analysis was conducted, following the six-phase approach outlined by Braun and Clarke (2006, 2021a), involving familiarisation with the data, where each transcript was read and re-read to gain an in-depth understanding of the participants experiences, generating initial codes, where each meaningful unit of data was labelled to capture what was relevant across the dataset, searching for themes, where the initial codes were examined to consider how they clustered together into broader organisational ideas, reviewing themes, where the candidate themes were checked against the coded data and full dataset to ensure they accurately reflected the participants perspectives, defining and naming themes, where each theme was refined and given a clear name that captured its essential meaning in relation to the research questions, and producing the report, where the final themes were written up with supporting data extracts to present the key findings.

In this study, analysis began as each transcript became available. For each respondent, transcripts were analysed using software (NVivo). Each set of respondent statements was assigned one or more initial codes. As more initial codes were assembled, codes were continuously revised and organised as patterns began to emerge from the data. Once coding was completed for all transcripts, the researcher reviewed and compared codes across all transcripts to identify overarching themes. These themes represent the final findings of the study and capture key patterns expressed across participants experiences.

3.12 Data Analysis: Framework Development

To develop a framework to support the themes that were identified, first, several current theories were considered. These include Social Exchange Theory, Herzberg's Two-Factor Theory, Price's Model, and the Job Demands-Resources model (Bakker & Demerouti, 2007; Bierstedt, 1965; Dabscheck, 1994; Gannon, 1978). However, after careful examination of these models against the findings of the current study and in the context of KSA's healthcare system, it was found that none of these models offered an adequate framework. For this reason, a novel model was developed to explain the thematic study findings.

To develop the model, the final themes were reviewed and organised into the three main themes identified in this study: Institutional, Leadership, and Personal Factors. The themes were reviewed again to explore how the issues were described and how they related to each other. Patterns were identified across the subthemes, and links were drawn based on how participants described their experiences. The model was developed to reflect these relationships and to remain grounded in the empirical data.

Two other models were also directly compared with the novel model developed in this study, and their limitations were highlighted in relation to the current findings. These include an earlier model developed to explain turnover behaviour in general and a model to explain nurse turnover during the COVID-19 epidemic (Podsakoff et al., 2007; Tolksdorf et al., 2022). Finally, the novel model was critiqued and applied to its source data.

3.13 Appraisal of Candidate Theoretical Frameworks

This section briefly describes the reasons why the models listed above, namely Social Exchange Theory, Herzberg's Two-Factor Theory, Price's Model, and the Job Demands-Resources model, were found to be insufficient as frameworks for the design of this study. A more thorough description of these theories and why they were ultimately rejected as frameworks for findings interpretation is presented in Chapter 5.

These models were selected for initial consideration because each captures a different explanatory dimension of nurse turnover, including relational fairness (Social Exchange Theory), motivational dynamics (Herzberg's Two-Factor Theory), organisational determinants (Price's Model), and workload-resource balance (JD-R Model). Table 3.1 summarises these models and the reasons for their rejection as primary frameworks.

Table 3.1. Theoretical Models Considered and Reasons for Rejection

Model	Core Focus	Why It Was Considered	Reason for Rejection
Social Exchange Theory	Viewing work as an exchange of benefits and costs	Considered because it is commonly used to explain workplace participation and retention	Rejected because findings from the literature and the QES showed that nurses and nurse leaders did not experience the workplace as a simple equation of benefits and costs. Nursing was described as a lifelong profession, with many valued aspects such as patient care, and teamwork. While salary was a concern, it was not the fundamental driver of turnover,

			making the theory overly simplistic for this context.
Herzberg's Two-Factor Theory	Separation of satisfiers and dissatisfiers	Considered due to its widespread use in nursing turnover research	This theory was rejected for two reasons. First, satisfiers and dissatisfiers are tightly associated in nursing practice, as shown in Chapters 1 and 2, where factors such as management, workload, burnout, and salary are all linked through resource constraints. Second, this entanglement meant the theory could not adequately support the study's second research aim, limiting its usefulness for developing actionable retention strategies.
Price's Model	Determinants and correlates of turnover	Considered because it provides an organisational perspective on turnover	Rejected due to its high level of context dependence and complexity. Attempts to apply the model in nursing settings resulted in an overwhelming number of determinants and limited engagement with correlates, reflecting current literature without offering clear guidance for intervention.
JD-R Model	Relationship between job demands and job resources	Considered because it addresses workload and organisational strain	Rejected because high job demands and limited job resources made the model difficult to apply meaningfully. Empirical applications often focused only on job demands, producing descriptive conclusions that could be

			drawn from the literature, limiting its ability to inform practical solutions.

Table 3.1 summarises the key theoretical frameworks considered and the reasons for their rejection. While each model offers useful insights into aspects of turnover, none adequately account for the complexity, interdependence, and contextual specificity of turnover intention within the KSA healthcare system. A detailed evaluation of these models in relation to the study findings is presented in Chapter 5.

3.14 Trustworthiness

Trustworthiness comprises four components: credibility, transferability, dependability, and confirmability (Ahmed, 2024; Braun & Clarke, 2022; Nowell et al., 2017; Stahl & King, 2020). This section provides evidence that the current research aligns with the concept of trustworthiness by examining these four components in relation to study design (Ahmed, 2024; Braun & Clarke, 2022; Nowell et al., 2017; Stahl & King, 2020).

First, credibility in trustworthiness refers to the degree to which the findings from the study accurately reflect the experienced reality of the participants (Ahmed, 2024; Stahl & King, 2020). Since it is only possible to evaluate this through how the participants have expressed themselves, theoretically, it is challenging to fully assure credibility in qualitative research (Ahmed, 2024; Nowell et al., 2017; Stahl & King, 2020). Nevertheless, several strategies have been proposed to support credibility, including prolonged engagement, member checking, reflexivity, triangulation, and peer debriefing, which are described here (Ahmed, 2024; Nowell et al., 2017; Stahl & King, 2020).

Prolonged engagement refers to spending sufficient time working with participants in order to build rapport with them, enabling the researcher to deeply understand their perspectives (Ahmed, 2024; Nowell et al., 2017; Stahl & King, 2020). Prolonged engagement took place in this research study, as the researcher spent approximately three months collecting data, with the last month collecting data on site at KFAFH. Being on site allowed the researcher to meet members of the nursing community and gain their trust and rapport.

Member checking refers to allowing participants to review the transcripts from their interviews to verify their viewpoints were accurately expressed (Ahmed, 2024; Nowell et al., 2017; Stahl & King, 2020). While some scholars argue this increases credibility, others point out that the power dynamics between the researcher and the participant may come into play during the member checking process and cause the participants to withdraw information delivered honestly during the data collection process, where rapport was at its highest (Ahmed, 2024; Nowell et al., 2017; Stahl & King, 2020). Checking in with participants after their interview can have an effect of distorting their original reports through the power dynamics perceived by the researcher (Ahmed, 2024; Nowell et al., 2017; Stahl & King, 2020). Member checking is not advised if the process may traumatise participants by forcing them to relive negative events (McKim, 2023). Further, member checking is often considered annoying to the participant and therefore they refuse to participate, and for this reason, typically little is gained in terms of data or understanding from member checking activities (McKim, 2023). It is acknowledged that even the idea of member checking being a way to assess validity is fraught with assumptions about the

participant's reality and how knowledge is actually produced (Ahmed, 2024; Braun & Clarke, 2022; Stahl & King, 2020). The current research involved the sensitive topic of staff nurses and nurse leaders reporting about potential issues with their employers, and privacy was of utmost concern. Further, many reported negative events that they would not want to relive through the member checking process. Given the philosophical concerns surrounding member checking and the heightened concern for privacy, member checking would not be used in the study as a way to assess credibility.

Reflexivity refers to the researcher acknowledging their personal biases and preconceptions while engaging in the research process (Ahmed, 2024; Braun & Clarke, 2022; Nowell et al., 2017; Stahl & King, 2020). This includes how the contact was maintained between the researcher and participants, and the background of the researcher in terms of how they will interpret the findings of the analysis (Busetto et al., 2020). There are no prescriptive ways to approach reflexivity, and researchers recommend a variety of strategies (Ahmed, 2024; Braun & Clarke, 2022; Nowell et al., 2017; Stahl & King, 2020). Reflexivity was achieved in this study through the researcher maintaining reflective notes throughout the process and working collaboratively with her supervisors during thematic analysis. In this case, the researcher is a professional from KSA, but is not a nurse. The researcher is female, and the participants were both male and female. For this reason, reflexivity was used to remain attentive to how the researcher's professional background, nationality, and gender might shape interpretation, particularly in relation to participant openness and power dynamics.

Triangulation refers to cross-verifying findings through other data sources beyond the interviews conducted as part of data collection (Ahmed, 2024; Braun & Clarke, 2022; Nowell et al., 2017; Stahl & King, 2020). In this study, limited triangulation was achieved through informal on-site observations during data collection. Triangulation was limited because leaders at KFAFH did not want to give access to private information about how the organisation operated.

Peer debriefing refers to engaging with colleagues and experts who study the same topic and who reviewed and critically engaged with emerging interpretations and findings (Ahmed, 2024; Braun & Clarke, 2022; Nowell et al., 2017; Stahl & King, 2020). Peer debriefing took place as part of the research process through regular discussions with the supervisory team, who reviewed and challenged interpretations and developing findings. In summary, credibility was achieved in the current study through prolonged engagement, reflexivity, triangulation, and peer debriefing.

The second component of trustworthiness, transferability, is defined as the degree to which findings from the study can be extrapolated to different situations or contexts (Ahmed, 2024; Nowell et al., 2017; Stahl & King, 2020). Specifically, transferability has to do with research communication, so that those engaging with the research findings will be able to determine how well they may fit other research situations or contexts (Ahmed, 2024; Nowell et al., 2017; Stahl & King, 2020).

Two approaches to demonstrate transferability in qualitative research include thick description and sampling strategies (Ahmed, 2024; Nowell et al., 2017; Stahl & King, 2020). Thick description refers to providing sufficiently detailed information so that those engaging with the research completely understand the setting and context, and to ensure the research is thoroughly described (Ahmed, 2024; Nowell et al., 2017; Stahl & King, 2020). The current study provides thick description of this research through the current chapter, which fully describes the research methods, along with two chapters (Chapter 4 and Chapter 5) that are devoted to presenting both thematic and analytical findings. Sampling strategies that ensure transferability refer to including enough information in research communication for readers to understand what type of participants were recruited, how they were recruited, and the setting in which the research took place (Ahmed, 2024). This information is included in this chapter, thus providing evidence of transferability.

The third component of trustworthiness is dependability, which requires the researcher to demonstrate that throughout the research process, research decisions, techniques, approaches and procedures are well-documented (Ahmed, 2024; Nowell et al., 2017; Stahl & King, 2020). Dependability is essentially an effort to provide evidence to other researchers that the research was conducted in a trustworthy and transparent manner (Ahmed, 2024; Nowell et al., 2017; Stahl & King, 2020). Two strategies that are employed to demonstrate dependability are keeping methodological documentation as the research proceeds, and creating audit trails that document research decisions, changes in procedures throughout the research study, and data analysis processes (Ahmed, 2024; Nowell et al.,

2017; Stahl & King, 2020). Through the thesis process, methodological documentation and audit trails were kept and shared with supervisors, meeting the criteria for dependability in qualitative research.

Finally, the last component of trustworthiness is confirmability, which means ensuring that the findings reflect the participants perspectives and the data rather than the researcher's personal assumptions (Ahmed, 2024; Nowell et al., 2017; Stahl & King, 2020). Confirmability in this research was demonstrated through peer debriefing and reflexive practices, ensuring that the findings were grounded in the data rather than the researcher's assumptions (Ahmed, 2024; Nowell et al., 2017; Stahl & King, 2020).

3.15 Ethical Considerations

This project received review from two ethics boards. The first was the ethics board at King Fahad Armed Forces Hospital (KFAFH), because the project took place at KFAFH, and the second was the ethics board at the University of Sheffield Research Ethics Committee (UREC). This is because the researcher is participating in a doctoral programme at the University of Sheffield. In accordance with UREC policy, the project first underwent ethical review and received approval from KFAFH's ethical board, which took approximately three weeks to complete (see Appendix K). Subsequently, this information was submitted to UREC for review, and approval was granted within two weeks. UREC ultimately determined that KFAFH qualified to be added to its approved list of facilities at which to conduct research and thus approved the study (see Appendix L).

3.16 Risks and Ethical Challenges to the Project

Originally, it was planned that recruitment of nurses to participate in the study would take place remotely, and they would be interviewed using online tools. However, this led to a low response rate. Among those who responded, the interviews were disrupted from time to time by a poor internet connection. For this reason, it was necessary to travel to KFAFH on site to complete recruitment and conduct the data collection interviews.

The employees of KFAFH were interviewed at their worksite about their work, and this placed them at risk of being identified as a study participant. It also put them at risk of losing their employment if a data breach from the study were to occur. A further risk was that the interview may have been emotionally challenging for some participants. Participants experiencing high levels of burnout or stress may have found it distressing to discuss their experiences. A third consideration was that there might have been a risk to the researcher, in having to listen to many negative stories.

These risks were mitigated in several ways. First, to mitigate the risk of breach of privacy, the Director of Nursing was not involved with the study, except to support it. The researcher's office was established in a nursing ward, where the Director of Nursing and other leaders did not typically go. The private research office was soundproof and without windows. While employees were given the opportunity to complete an online survey to indicate their interest in the study, and to have an online interview to offer a higher level of anonymity, they were also encouraged to come physically to the researcher's office to indicate their interest. Only a study ID was used to identify them on all study material.

After the study ended, the study ID was replaced with a pseudonym (used in Chapter 4 - Findings).

To mitigate the risk of participants having a negative experience in the interview from being burned out or stressed, this risk was stated clearly on materials used for recruiting nurses to participate in the study. Further, if a respondent became upset during the interview, the interviewer was to end the interview. No interviews were terminated due to participant distress.

To mitigate the risk of the researcher becoming burned out or stressed from hearing negative stories, the timeline for the study was carefully set up to allow for time between interview appointments. This gave the interviewer respite between interviews, and space to analyse the themes in the responses in between interviews. The interviewer's supervisors also supported her and helped her to decide how to respond to challenges from lack of recruitment of study participants.

Many participants preferred face-to-face interviews. To support this, interviews were arranged for a private office, which provided a quiet and private space where participants felt comfortable speaking openly. It was also important to speak at an early opportunity with the hospital staff who were helping coordinate the study and make sure there was a suitable space arranged ahead of time. Although the ethical review process was smooth, these practical steps still required planning and flexibility. These are important considerations for future students conducting similar research in hospital settings.

All interviews were conducted in English as it is the primary working language in hospitals in KSA. However, in two interviews, the participant used some Arabic terminology in some parts of the interview. Several considerations were made as to how to handle these interviews. It was decided against excluding the interview from data analysis, because it would have resulted in the exclusion of a lot of data, and given the small available sample, these data could not be discarded. It was determined that the interview should be kept, and the Arabic words be translated into English. Typically, in research studies, this would follow a translate-back-translate procedure (McKenna, 2022). However, in this case, putting the few statements in Arabic within an English interview would compromise the interpretability of the statements being made by the participant and could compromise privacy (Squires, 2009; Temple & Young, 2004). Therefore, the researcher conducted the translation of these Arabic statements. The researcher is bilingual in Arabic and English with professional familiarity with the KSA healthcare context, and the surrounding English dialogue provided sufficient context in each case to support accurate interpretation. The number of Arabic expressions was small and embedded within otherwise English interviews, which limited the risk of misinterpretation. Nevertheless, the absence of back-translation or a second bilingual checker is acknowledged as a limitation with potential implications for language validity.

3.17 Reflexivity

Reflexivity refers to the relationship between the researcher and the research they are conducting (Busetto et al., 2020). This includes how the contact was maintained between

the researcher and participants, and how the researcher's background may shape the interpretation of findings (Busetto et al., 2020). In this case, the researcher is a health professional from KSA but is not a nurse. The researcher is female, and the participants included both males and females. Since the researcher is not a member of the professional group being researched and did not work at KFAFH but was granted access to conduct the study on site, participants may have felt more comfortable sharing their perspectives openly, although this could not be assumed uniformly across all participants.

The researcher anticipated that many of the participants in the study would make statements similar to those made in the studies reviewed in the QES in Chapter 2. The researcher expected, however, that these statements would refer specifically to KFAFH, and therefore pertain specifically to that context. For example, the researcher expected that the participants would refer to specific departments, supervisors, and types of work done at KFAFH. The researcher's professional identity is that of a female professional Saudi academic in the health services research domain who grew up in KSA and is bilingual in English and Arabic. Therefore, the researcher anticipated that non-Saudi participants might have been more guarded in their expression of reasons for turnover intention than the Saudi participants. This was considered a potential challenge to the data analysis process, in which it may have been that Saudi participants were more forthcoming than non-Saudi participants in their speech. These assumptions informed how the data were interpreted, particularly when considering differences in openness and depth between Saudi and non-

Saudi participants and were treated as part of the analytic context rather than as limitations of the data.

For participants, the researcher being external to KFAFH and not a nurse reduced concerns about internal reporting, professional judgement, or organisational repercussions. In addition, the researcher's Saudi background meant that national healthcare and workforce policies, such as Saudization, did not need to be explained in detail, allowing participants to speak directly and efficiently about their experiences within these policy frameworks.

3.18 Chapter Summary

This chapter has outlined the methodological foundations of this qualitative study exploring nurse turnover intention among Saudi and non-Saudi staff nurses and nurse leaders at King Fahad Armed Forces Hospital (KFAFH) in the Kingdom of Saudi Arabia. Grounded in an interpretivist epistemology and social constructivist ontology, the research adopted reflexive thematic analysis as the analytic approach used to interpret interview data. Data were collected through semi-structured interviews with nineteen participants at KFAFH, purposively sampled to ensure representation across Saudi and non-Saudi nurses and across staff nurses and nurse leaders.

Ethical protocols were followed carefully across two institutional review processes, at KFAFH and at the University of Sheffield, and the practical challenges of recruitment and data access were acknowledged and addressed.

Data collection was conducted using semi-structured interviews, chosen for their ability to support open but focused dialogue on a sensitive topic. This choice was informed by ethical and practical considerations, as well as the study's epistemological stance. The process included attention to consent, transcription, and participant confidentiality. Data analysis followed a recursive and reflective process, moving through familiarisation, coding, theme development, and interpretation, supported by NVivo software.

Researcher reflexivity was maintained throughout the project, with attention paid to positionality, nationality, and power dynamics. Challenges relating to recruitment and institutional data access were addressed openly and reflectively. By highlighting these aspects, the chapter offers transparency and situates the research within the organisational realities of conducting qualitative work in a military hospital setting in KSA. These methodological choices directly shape how the findings are presented and interpreted in the following chapter. In particular, the reflexive thematic analysis approach foregrounds participants narratives and highlights shared patterns of meaning across Saudi and non-Saudi nurses and across staff and leadership roles. The following chapter presents the findings.

Chapter 4 - Findings

4.1 Introduction

The previous chapter outlined the methodological approach adopted for this study, including the use of reflexive thematic analysis to explore the turnover intention of nurses working at King Fahad Armed Forces Hospital (KFAFH) in the Kingdom of Saudi Arabia (KSA). This chapter presents the findings of that analysis and draws on the perspectives and experiences of the participants to address the research aims of examining the factors that contribute to nurse turnover intention within this military healthcare setting.

Throughout the interviews, the study sought to understand how each participant experienced their workplace and what drove their consideration of leaving their position. In exploring these narratives, the analysis identified that although each participant held their own perspective, common themes took shape through interpretive engagement with the data, revealing institutional, leadership, and personal conditions that shaped turnover intention across the sample. Many nurses described similar pressures; however, certain pressures appeared more prominent among specific groups, particularly differences in the experiences of Saudi and non-Saudi nurses, and between nurse leaders and staff nurses.

Drawing on these shared patterns, the findings discussed in this chapter reveal both the structural conditions and relational dynamics that participants described as driving their intention to leave. This chapter begins by presenting the demographic characteristics of the participants, followed by the thematic findings organised under three main themes,

Institutional Factors, Leadership Factors, and Personal Factors, each comprising subthemes that provide deeper insight into nurses' experiences. The chapter then examines how these themes were experienced differently by Saudi and non-Saudi nurses and by nurse leaders and staff nurses. A cross-theme synthesis is presented to highlight the overarching patterns and connections across the themes. In Chapter 5, these findings will be examined in relation to prevalent theoretical models of turnover, leading to the development of a novel KSA-centric model of nurse turnover intention.

4.2 Demographics

Nineteen staff nurses and nurse leaders from KFAFH participated in the study (see Table 4.1).

Table 4.1. Demographics

Category	Level	n (%)
All	All	19 (100%)
Occupational level	Leader	6 (32%)
	Staff	13 (68%)
Gender	Male	3 (16%)
	Female	16 (84%)
Nationality	Saudi	7 (37%)

	Filipino	8 (42%)
	Indian	3 (16%)
	South African	1 (5%)

As shown in Table 4.1, approximately one third of the participants interviewed were leaders (n = 6, 32%), with the remainder being staff. As described in the methods section, leaders were defined as holding titles such as Nurse Manager or Head Nurse. The staff nurses were considered "nursing staff". Participants self-identified their roles during the interview, specifying whether they held a leadership or staff position. The Director of Nursing was not included as a participant, partly because they were identifiable and partly due to a conflict of interest, as they acted as the gatekeeper for recruitment.

The majority of the participants were female (female n = 16, 84%). The largest nationality group interviewed was Filipino (n = 8, 42%), followed by Saudi (n = 7, 37%), Indian (n = 3, 16%) and South African (n = 1, 5%). In this study, non-Saudi nurses were well represented and broadly reflective of national workforce patterns, which indicate that non-Saudi nurses make up approximately 56% of the nursing workforce in KSA, with the main source countries being the Philippines and India (Almansour et al., 2023; Kattan & Al-Hanawi, 2025).

It would have been possible to provide a detailed characterisation of each participant, including their nationality, how many years they spent in KSA, their role at KFAFH, and their expressed turnover intention. However, disclosing this information would present a serious privacy risk to the participants, and could impact their employment status. For this reason, such a characterisation of the participants has been deliberately withheld. This approach follows established qualitative guidance on anonymisation and deductive disclosure in small, single-site studies (Braun & Clarke, 2021a; Kaiser, 2009; Saunders et al., 2015).

Table 4.2 provides a list of interview participants along with their assigned study ID, occupational category (leader or staff), gender, nationality, and pseudonyms that were assigned for the purpose of reporting findings in the study. To protect anonymity, nationalities were grouped into Saudi and non-Saudi.

Table 4.2. Interviewees

Study ID	Category	Gender	Nationality	Pseudonyms
1	Leader	Male	Saudi	Omar
2	Leader	Female	Non-Saudi	Katie
3	Leader	Female	Non-Saudi	Maria
4	Leader	Female	Non-Saudi	Tala

5	Leader	Female	Saudi	Shatha
6	Leader	Female	Saudi	Reem
7	Staff	Male	Non-Saudi	Ahmed
8	Staff	Female	Non-Saudi	Aurora
9	Staff	Female	Non-Saudi	Christina
10	Staff	Male	Non-Saudi	Mohammed
11	Staff	Female	Non-Saudi	Jasmin
12	Staff	Female	Non-Saudi	Alma
13	Staff	Female	Saudi	Rana
14	Staff	Female	Saudi	Maram
15	Staff	Female	Saudi	Noura
16	Staff	Female	Saudi	Lama
17	Staff	Female	Non-Saudi	Rachna
18	Staff	Female	Non-Saudi	Shalini
19	Staff	Female	Non-Saudi	Kavita

As shown in Table 4.2, six leaders and thirteen staff were interviewed. Both groups included male and female participants from diverse nationality backgrounds, reflecting the demographic diversity of the nursing workforce at KFAFH.

4.3 Thematic Analysis

The findings presented in this chapter reflect participants reported experiences of turnover intention rather than actual turnover behaviour, consistent with the definitions outlined in Chapter 1. Each interview transcript was analysed. Meaningful units (e.g., phrases or lines) were identified in relation to their surrounding context, and then assigned one or more codes. To develop the themes, similar codes were combined across participants to generate themes, which constitute the final thematic structure of the study (Braun & Clarke, 2019; Braun & Clarke, 2006). The summary of themes appears in Table 4.3.

Table 4.3. Summary of Themes

Theme	Subtheme	Saudi vs. Non-Saudi*	Leaders vs. Staff*
Institutional Factors	Compensation		
	Diversity Issues	X	
	Families	X	
	Leadership Positions		X
	Workload	X	

	Work Role		
Leadership Factors	Leadership and Management Style		
	Recognition		
	Speaking Out		
	Staff Expectations and Management		
Personal Factors	Lifestyle	X	
	Opportunities	X	
	Personal Time		
	Wellbeing		

*Indicates the subtheme applies to the designated research question/comparison.

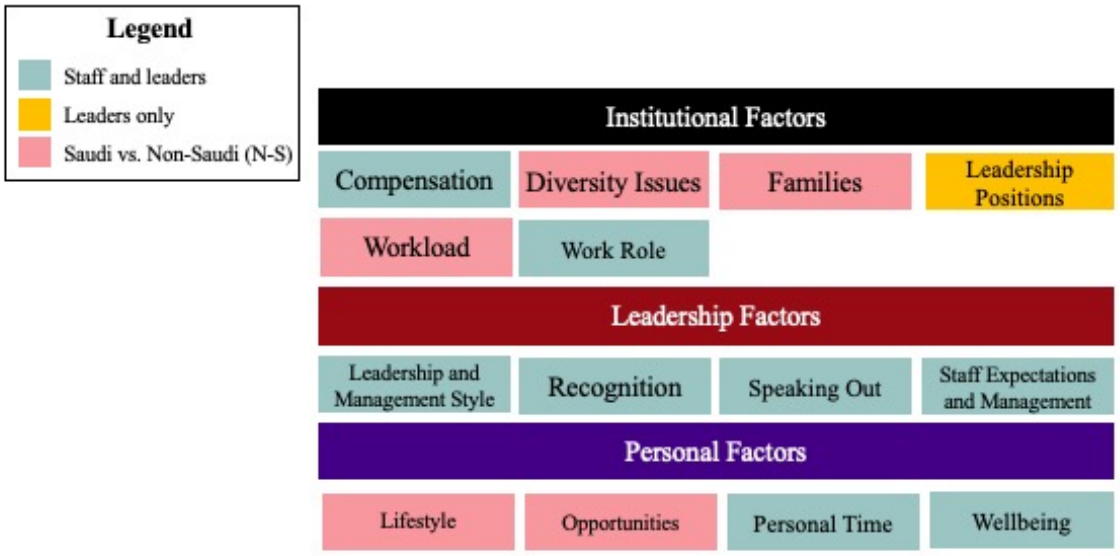
As shown in Table 4.3, the analysis identified 14 subthemes organised under three main themes: Institutional Factors, Leadership Factors, and Personal Factors. Under the Institutional Factors, six subthemes were identified. One subtheme illustrates differences between leaders and staff, specifically Leadership Positions. Additionally, three subthemes revealed distinctions between Saudis and non-Saudis, namely Diversity Issues, Families, and Workload.

Under the Leadership Factors, four subthemes were identified. No distinctions were identified between Saudis and non-Saudis or between staff and leaders.

Finally, at the bottom of Table 4.3, four subthemes were identified under the Personal Factors. Two subthemes, Lifestyle and Opportunities, revealed distinctions between Saudi and non-Saudi nurses. None of the subthemes under the Personal Factors showed differences between staff and leaders.

To aid in interpretation of these themes and subthemes, Figure 4.1 was developed.

Figure 4.1. Themes and Subthemes



The following section explores how these subthemes relate to nurse turnover intention.

4.4 Themes and Subthemes

As shown in Table 4.3 and Figure 4.1, the 14 subthemes identified were organised under three overarching themes: Institutional Factors, Leadership Factors, and Personal Factors. These are listed in alphabetical order to facilitate navigation. In this section, subthemes are presented under their respective themes. Each subtheme is subsequently re-examined to explore the perspectives of Saudi and non-Saudi nurses in relation to the research questions. Finally, these subthemes are further examined to explore differences between leaders and staff.

4.5 Factors Influencing Turnover Intention

The findings are organised under three themes, Institutional Factors, Leadership Factors, and Personal Factors, reflecting the conditions and experiences that participants identified as shaping their intention to leave.

4.5.1 Theme 1: Institutional Factors

This theme captures the organisational and structural conditions within KFAFH that shape nurses daily work environment and are described as influencing turnover intention. It focuses on organisational structures and systems rather than day-to-day leadership behaviours or personal life circumstances outside work, which are addressed in Themes 2 and 3. Institutional factors refer to systems, policies, and operational arrangements that are largely outside the individual nurse's control, and are understood to influence job satisfaction, stability, and long-term commitment to the organisation.

Across this theme, participants moved between describing their own turnover intentions and observing patterns of dissatisfaction and actual turnover among colleagues, and these distinctions are made explicit where relevant throughout the analysis. In this study, six subthemes were identified under this theme: Compensation, Diversity Issues, Families, Leadership Positions, Workload, and Work Role. Together, these subthemes illustrate that pay systems, workforce mix, family-related policies, access to leadership opportunities, workload pressures, and the clarity of professional roles combine to create ongoing strain for nurses and are described as contributing to disengagement and increased intention to leave. Participants consistently described these issues as embedded organisational problems rather than individual concerns, positioning Institutional Factors as the primary structural context shaping turnover intention in this study.

4.5.1.1 Subtheme 1.1: Compensation

This subtheme explores how compensation shaped nurses' turnover intention through salary adequacy, differential access to benefits, perceived fairness, and the availability of non-financial support. Compensation as a subtheme is connected to and exemplifies the parent theme because compensation is determined by KFAFH at the institutional level. Participants experiences indicate that compensation operated not only as an economic reward, but also as a key mechanism through which recognition, organisational justice, and institutional value were communicated.

During the interviews, several participants identified inadequate salary as a direct contributor to reduced motivation and intention to leave. Christina, a non-Saudi staff nurse, explained:

"Benefits and salaries. If we are receiving an amount that we don't see as compensating enough for our kind of work, then we lose this kind of motivation to continue in our job."

[Christina, non-Saudi staff]

Dissatisfaction with salary was not just described as a financial problem, but as a feeling that workload, responsibility, and reward were out of balance. When nurses felt their effort was not properly matched by compensation, motivation dropped and intention to leave increased. Here, participants were describing their own turnover intentions, linking perceived imbalance between effort and reward directly to thoughts of leaving. Nurses therefore did not evaluate salary solely based on the amount. What mattered was whether it was proportionate with what they believed they contributed.

Recent salary increases were described positively by some participants, particularly in relation to non-Saudi nurses:

"They managed now the salary issue it is higher." [Shatha, Saudi leader]

"We increase [the] salary." [Ahmed, non-Saudi staff]

These verbatim extracts present a negative case within the compensation subtheme. Unlike most participants, Shatha and Ahmed described salary increases as an improvement.

However, this negative case did not change the wider pattern, as uneven application of these increases continued to shape perceptions of unfairness and turnover intention.

Despite these improvements, the salary increases were not applied across all groups. Saudi nurses did not receive equivalent increases at the same time, which introduced a strong perception of inequity. Maram described this as a source of dissatisfaction:

"They only increased the salaries for them [non-Saudis] which made us Saudi nurses feel less appreciated than the non-Saudi nurses. If there was an increase in salaries, you need to be fair, and increase the salaries for all of us, because we are the same and we do the same work." [Maram, Saudi staff]

For Saudi nurses, the issue was therefore not salary level alone, but fairness in salary distribution. Being excluded from pay improvements despite equivalent responsibilities was interpreted as a lack of recognition and reduced their sense of professional worth. This perception weakened organisational attachment and was experienced as contributing to turnover intention. The selective increases therefore sent a clear message that some groups work was valued more than others.

Participants also spoke extensively about "benefits" as additional financial allowances beyond base salary. Many staff reported that KFAFH offered fewer benefits than other hospitals. Maram highlighted the absence of an infection allowance, an additional payment provided to healthcare staff exposed to infectious diseases:

"Also, the benefits, there is a lot of hospitals offer better benefits which we don't have. Especially the infection allowance; most hospital gives their nurses this allowance

because we are the most people affected by it due to our nature of work." [Maram, Saudi staff]

How compensation influenced turnover intention was further shaped by nationality-based differences in benefit eligibility. This increased dissatisfaction and contributed to higher turnover intention, particularly in high-risk clinical areas. Shalini, a non-Saudi staff nurse, emphasised that certain allowances, such as the scarcity allowance, an additional payment for Saudi healthcare staff working in shortage specialties, were restricted to Saudi nurses:

"Not the salary but this extra benefit, I mean salary and they are getting because their country but the extra things they have to [be] unified" [Shalini, non-Saudi staff]

This unequal access highlighted the imbalance in financial benefits offered to Saudi and non-Saudi nurses. For non-Saudi nurses, exclusion from these allowances was experienced as a clear form of unequal treatment that reduced their sense of being valued within the organisation. Regardless of base salary level, these inequalities undermined organisational commitment and pushed turnover intention higher. Restricting allowances by nationality was therefore experienced not merely as an administrative decision, but as a signal that some nurses were valued less than others, directly undermining organisational commitment and strengthening turnover intention.

For many participants, compensation extended beyond pay to include what the organisation offered in terms of wellbeing support. The lack of recreational activities, particularly for non-Saudi nurses, was therefore seen as another way compensation fell short and contributed to turnover. Ahmed explained:

"In my opinion on the turnover, it's ……. recreational activities, and there are some other hospitals, they have recreational activities. But for now, before we don't have, but now we increase on that" [Ahmed, non-Saudi staff]

Ahmed felt that KFAFH was in the process of increasing recreational activities, which he believed could help reduce turnover. For nurses without family or a social network outside work, recreational activities were one of the few spaces available for relaxation and connection. Ahmed's explanation therefore highlights what compensation includes. It is not only salary and allowances. What the organisation provides in terms of wellbeing, spaces for nurses to rest and connect, also shapes whether nurses stay or leave. When these were missing, isolation increased, work–life balance suffered, and working elsewhere became more appealing.

Perceptions of injustice and reduced professional recognition emerged from unequal salary adjustments and benefit distribution. The absence of recreational support further reduced nurses sense of organisational care and belonging. What strengthened turnover intention was not just dissatisfaction with pay, rather, it was the pattern across these decisions (salary, benefits, and support) that revealed how the organisation valued different groups.

4.5.1.2 Subtheme 1.2: Diversity Issues

This subtheme explores how nationality shaped nurses' experiences at KFAFH, with a particular focus on the differences between Saudi and non-Saudi nurses. Diversity issues are connected to and exemplify the parent theme because these issues are shaped by KFAFH at the institutional level. Participants described how these dynamics influenced

access to leadership, perceptions of fairness, and confidence in organisational decisions, which in turn affected turnover intention.

Participants mainly pointed to KFAFH's preference for Saudi nationals in leadership roles as the key diversity issue. Reem, a Saudi leader, described this clearly:

"I don't know any non-Saudis in leadership, because mostly the Saudization is taking place in the administration" [Reem, Saudi leader]

Rather than being based on experience or professional background, leadership appointments were widely seen as shaped by nationality. This positioned leadership as part of Saudization rather than experience-based progression and influenced how fair the system was perceived to be. This system was criticised by participants across all categories, including Saudi and non-Saudi staff as well as leaders.

Several participants emphasised that Saudi nurses were promoted into leadership positions despite having limited experience, while non-Saudi nurses with advanced clinical and managerial training remained excluded from such roles. Katie, a non-Saudi leader, described this contrast:

"Our Saudis, they've never been exposed to administrative work, they completed their degree. And then now maybe one or two years, then they become the administrators… In my country, you are a nurse, but if you moved in administration, you won't be accepted without having that Administration qualifications. You don't just get promoted to that." [Katie, non-Saudi leader]

Katie's comparison highlights how leadership decisions were being made. What this meant in practice was that nationality outweighed professional readiness.

This contrast between Saudi and non-Saudi career paths reflected a wider feeling among participants that leadership appointments at KFAFH were not based on recognised professional standards. For non-Saudi nurses in particular, the limited recognition of their training and leadership qualifications weakened confidence in the organisational promotion system and reduced motivation to remain in KFAFH.

Non-Saudi nurses consistently viewed this policy as unfair. Participants also explained that appointing Saudi leaders with limited experience created additional tension at the team level. In some cases, non-Saudi nurses who were trained for leadership found themselves supervised by Saudi leaders without formal leadership or administrative preparation. Katie explained how appointing underprepared leaders affected the hospital's reputation and contributed to a negative image that pushed nurses to leave:

"This also affects your turnover. It gives the wrong or a bad reputation about the hospital. it gives that negativity that you will never maintain your leaders likely well experience." [Katie, non-Saudi leader]

For non-Saudi nurses, being supervised by leaders perceived as less experienced intensified frustration, weakened confidence in leadership credibility, and was experienced as contributing to turnover intention. These descriptions reflected both participants own intentions to leave and their observations of colleagues disengaging or exiting the

organisation. These experiences also affected perceptions of the hospital's reputation and its ability to sustain competent leadership over time.

Across the interviews, the deployment of Saudi leaders without sufficient administrative preparation was viewed as a structural challenge rather than an isolated individual issue, indicating that capability and readiness were not the primary criteria for these roles.

These decisions communicated how leadership was defined. When nationality outweighed preparation and experience, leadership credibility was questioned by participants, and this reduced participants confidence in leadership as a fair pathway for progression. This weakened trust in organisational decision-making and made long-term commitment to the hospital harder to sustain.

Overall, these findings demonstrate that diversity-related leadership practices shaped nurses' turnover intention through perceptions of unfairness, compromised leadership competence, and weakened trust in organisational decision-making. For non-Saudi nurses in particular, these dynamics reduced organisational commitment and strengthened intention to leave.

4.5.1.3 Subtheme 1.3: Families

This subtheme explores how organisational policies and administrative processes related to family residency shaped turnover intention among non-Saudi nurses. Families are

connected to and exemplify the parent theme, as participants described limited organisational support for family-related needs as contributing to their intention to leave.

While policy in KSA allows non-Saudi workers to bring their families, participants described major procedural and institutional barriers that made it difficult in reality. As a result, prolonged separation from family emerged as a sustained source of emotional and practical strain that directly influenced decisions about whether to remain at KFAFH.

Participants described "family" primarily in relation to their immediate households and close dependants with whom they wished to live. Although family sponsorship is formally allowed under national policy, participants consistently experienced the process as restrictive in practice. Non-Saudi nurses spoke about the emotional difficulty of living away from their families. They also described how attempts to bring family members to KSA were often blocked by complicated procedures, high costs, and long waiting times. This gap between policy and practice revealed a key issue. The organisation was neither actively blocking family sponsorship nor actively facilitating it. As a result, non-Saudi nurses were left to manage these barriers alone. Participants framed these barriers as directly influencing their turnover decisions.

Limited organisational support to navigate these processes meant that staying at KFAFH became increasingly difficult to sustain. Mohammed, a non-Saudi staff nurse, explained how the administrative burden and financial cost of family visas contributed directly to nurses leaving:

"That's why they are leaving Saudi… it's a long process and expensive and we have to do the applications it's a lot of work and money." [Mohammed, non-Saudi staff]

What Mohammed described suggests that leaving KSA was framed less as a preference and more as a response to practical barriers. Participants described the process as costly, slow, and difficult to navigate, which made staying increasingly hard to sustain.

The importance of family presence was further reinforced by Aurora, a non-Saudi staff nurse, who explicitly linked her decision to remain in the organisation to the ability to live with her loved ones:

"If you were gonna ask me, what will make me retain or stay in the hospital? First, if they will give me the opportunity to stay with my loved ones." [Aurora, non-Saudi staff]

This demonstrates that having their families with them was not framed as a secondary concern but as a primary condition for retention. For non-Saudi nurses, the ability to bring their families was not simply a personal preference or lifestyle choice. It was fundamental to whether they could imagine staying long term. When family reunification was not adequately supported, this became more than a practical problem. It was experienced by participants as limiting their ability to build long-term lives.

These findings show that family-related challenges influenced turnover intention by undermining the feasibility of long-term employment for non-Saudi nurses. Prolonged separation from family weakened nurses' emotional connection to both their workplace and their wider social lives, while the financial and administrative barriers to family sponsorship made leaving increasingly likely. Participants described limited organisational

support for family reunification, which limited the ability to establish long-term, family-centred lives in KSA.

4.5.1.4 Subtheme 1.4: Leadership Positions

Leadership positions are connected to and exemplifies the parent theme because how leadership positions are arranged and populated is determined by KFAFH at the institutional level. A key issue identified within the institutional leadership structure was the regular appointment of leaders to acting roles rather than to formally recognised positions. Reem, a Saudi nurse leader, described her experience:

> *"I have to do all the work in these posts by myself without any recognition because I am still considered as acting head nurse……They don't say you're the leader but you do everything, and they don't acknowledge that or it's like my hands are tied most of the time. I don't have much authority to do and act." [Reem, Saudi leader]*

This reflected a constraint within the institutional environment, where leaders are appointed to positions, but are not given the formal title or authority required for the role, which contributed to increased turnover intention. This experience also highlighted a broader structural issue, captured by Omar, a Saudi nurse leader:

> *"If you are a leader, you need full authority for your job." [Omar, Saudi leader]*

These extracts illustrate how acting appointments placed nurse leaders in a contradictory position. Leaders were expected to carry full responsibility for leadership outcomes, yet

they lacked the formal authority needed to implement decisions, manage staff, or influence organisational processes. Leadership work was therefore experienced as constrained and unsupported rather than empowered or recognised. Here, leaders were describing their own intention to leave rather than observing turnover among staff. What Reem described illustrates how acting appointments operated in practice. They were not described as short-term or transitional arrangements, but as a routine organisational practice. Their continued use suggested limited progress towards formalising leadership. As this pattern continued, leadership positions became less attractive as pathways for advancement. This was therefore experienced as contributing to turnover intention among nurse leaders.

4.5.1.5 Subtheme 1.5: Workload

This subtheme examines how workload, staffing levels, and recruitment practices shaped turnover intention among nurses at KFAFH. Workload is connected to and exemplifies the parent theme because workload at KFAFH is determined at the institutional level, and the participants described workload as too high. This created dissatisfaction and strengthened turnover intention.

Participants consistently framed workload not as an individual performance issue, but as an institutional condition produced by chronic understaffing, patient allocation practices, and delays in staff recruitment and replacement. As a result, workload was experienced as a persistent structural pressure rather than a short-term operational issue.

Participants frequently spoke about workload as being too heavy to maintain over time, especially given the shortage of nursing staff. Patient numbers regularly went beyond what had been set out in the contract, as described by Maram, a Saudi staff nurse:

"The workload due to nurse shortage, because when you signed your contract here they tell you that your load is four patients. But after you start working, you will be shocked to have six or seven patients in one shift. So the workload is too much on me" [Maram, Saudi staff]

Staff shortages led to heavier patient loads and constant pressure in everyday work life, and for many nurses this growing gap between what they expected and what they experienced was associated with frustration, exhaustion, and turnover intention. What Maram described therefore illustrates how staffing shortages operate. The organisation had promised a specific patient load in the contract. Nurses then experienced almost double this workload in practice. For nurses, this was not simply a workload problem but was experienced as a mismatch between expectations and reality.

Kavita, a non-Saudi staff nurse, similarly linked workload pressure to patient volume:

"Sometimes we are [experiencing] more turnover because [there are] more patient [in] one day. The staff maybe they will receive two three labour patient. It's difficult" [Kavita, non-Saudi staff]

This reflects how high patient volume was experienced as physically demanding in daily practice.

Staffing was described by participants as the organisation's ability to maintain adequate nurse numbers and avoid prolonged vacancies. Many participants spoke about staffing shortages as the starting point of workload pressure. Tala, a non-Saudi nurse leader, described how this pressure became tied to turnover:

"The turnover of this hospital is very fast especially after the covid actually even before as of my experience, it's because some of these staff the complaints mostly is the work overloaded and also the long hours of working because after covid there's shortage of staff because some of them they are leaving" [Tala, non-Saudi leader]

Participants described a continuing cycle in which staffing shortages increased workload, workload strengthened turnover intention, and turnover then fed back into staffing shortages. This pattern suggested an ongoing structural issue rather than a temporary disruption. In principle, this cycle could be interrupted through sustained recruitment or workload adjustment. This suggests that workload pressures were not effectively addressed in practice. As a result, staff exited the organisation, further reducing staffing levels, intensifying workload pressures, and increasing turnover.

Noura, a Saudi staff nurse, similarly described how high nurse-to-patient ratios persisted despite collective effort:

"In my opinion, it's the staff shortage. The nurse to patient ratio is so high……. When they do the schedule of work for each nurse about their responsibilities the work is too much." [Noura, Saudi staff]

This shows that even when teamwork was present, the underlying shortage of staff still resulted in unmanageable levels of responsibility at the individual level.

Some participants acknowledged that the hospital had taken steps to improve staffing levels. Reem, a Saudi nurse leader, described measurable improvement:

"We did a good job. Honestly speaking, we are improving. Yeah, because last 2021, the unit was running with less than 50%, 40% the staffing plan. However, this year we've reached up to 60% which is a great improvement" [Reem, Saudi leader]

Rachna, a non-Saudi staff nurse, echoed this:

"The hospital they're taking new steps, highly hiring new staffs here, because most of them are leaving. I think they are also trying to solve the problem." [Rachna, non-Saudi staff]

These verbatim extracts present a negative case within the workload subtheme. Unlike most participants, Reem and Rachna described measurable improvement in staffing levels and active recruitment.

However, these improvements were widely viewed as insufficient to relieve pressure at unit level. As Reem and Maria both indicated:

"The turnover for staff nurses. Okay. We have to mention the shortage. Shortage is number one." [Reem, Saudi leader]

"Think it's more of the staffing issues, and understaffing." [Maria, non-Saudi leader]

Although recruitment was taking place, its effects were uneven across units, and for many nurses' workload pressures had not yet eased. However, recruitment without addressing workload distribution or staffing levels could not break the cycle. Improvements of 10–20% in staffing (from 40% to 60% of plan) were occurring while nurses continued to carry almost double the contracted patient loads. Recruitment progress did not appear sufficient to resolve the fundamental workload problem.

In addition to overall workload volume, non-Saudi nurses also described unequal task allocation across nationalities as a further source of strain. Christina, a non-Saudi staff nurse, explained:

"Sometimes, Saudi nurses ask us to do some task if they think they cannot do it well, which puts more workload on us." [Christina, non-Saudi staff]

Task allocation was shaped by how skill was perceived, and this often meant that non-Saudi nurses carried a heavier share of responsibility. For these nurses, workload pressure was driven not only by staffing shortages, but also by how work was organised within teams, further strengthening turnover intention. Rather than distributing work according to job descriptions or equal rotation, tasks were allocated based on perceived skill. More experienced non-Saudi nurses therefore carried more complex tasks, while less experienced nurses received lighter assignments. Participants described the use of informal skill-based allocation as a way of managing workload pressures, rather than addressing the underlying shortage. This placed additional burden on the most experienced nurses and further strengthened their intention to leave.

In contrast, Lama, a Saudi staff nurse, expressed the view that equal task distribution could ease tension across nationalities:

"If the nurses from any nationality do their work that they are supposed to do in their schedule, I think there will be no problems between them." [Lama, Saudi staff]

This suggests that workload was not only a driver of exhaustion and turnover but also a source of interpersonal tension when perceived as unevenly shared.

Workload was experienced as an ongoing structural condition rather than a temporary operational problem, shaped by persistent staffing shortages, high nurse-to-patient ratios, uneven recruitment recovery, and unequal task allocation. Recruitment had not yet addressed the underlying staffing gap. Beyond this, more experienced staff were shouldering disproportionate workload due to unequal task allocation. Nurses experienced workload not as a temporary shortage but as a permanent feature of work at KFAFH. When workload could not be reduced, staying long-term became increasingly difficult to justify.

4.5.1.6 Subtheme 1.6: Work Role

This subtheme explores how the allocation of work roles within the organisation shaped turnover intention through mismatches between nurses training, experience, and the roles they were required to perform. Work role as a subtheme is connected to and exemplifies the parent theme because roles played by workers at KFAFH are determined by KFAFH at the institutional level. Participants described work role not simply as the job title they held, but as the actual clinical area and responsibilities to which they were assigned in day-to-day practice. Assignment to unfamiliar roles outside a nurse's areas of expertise was experienced as an institutional decision that directly shaped dissatisfaction and decisions about leaving. Maram, a Saudi staff nurse, described how being moved away from her area of expertise caused her distress and dissatisfaction:

"Don't make me work at a department I don't feel comfortable working at. As someone who experience working at PICU, and the leaders made me work at paediatric ward which I did not want." [Maram, Saudi staff]

What Maram described therefore illustrates how role allocation decisions were made. She had expertise in the Paediatric Intensive Care Unit (PICU). The organisation moved her to a different clinical area, creating a mismatch between her training and her assigned role. For Maram, this indicated that her experience was not recognised and that her professional identity was not taken seriously by the organisation.

Being placed in unfamiliar clinical settings increased anxiety, reduced confidence, and weakened nurses' sense of professional control over their work environment. This indicates that role mismatch operated beyond simple workload pressures. Being assigned work outside their expertise undermined nurses' ability to practise within their specialisation. For experienced nurses like Maram, this was not simply stressful. It was discouraging because the work no longer reflected their professional preparation.

In contrast, working in a role that matched one's training and specialisation was described as an important factor supporting retention. Ahmed, a non-Saudi staff nurse, suggested that Saudi nurses were more likely to remain in post because they were often allocated roles aligned with their experience:

"Saudis, they will stay because…. they can work according to their experiences or specialisation." [Ahmed, non-Saudi staff]

For Ahmed, appropriate role allocation functioned as a stabilising factor that supported retention by maintaining alignment between nurses' skills, expectations, and daily responsibilities. What Ahmed described therefore showed that nurses who could work within their specialisation remained stable and committed. This pattern suggests that consistent role alignment could support retention, but this was not consistently achieved.

However, Maram's experience indicates that mismatched role assignment was not limited to non-Saudi nurses. Her experience shows that Saudi nurses were also affected by institutional decisions that disrupted alignment between training and clinical role. This pattern indicates that role mismatch was an organisational practice affecting all nurses, not a problem targeted at any particular group.

These findings indicate that work role functioned as an institutional driver of turnover intention through the way clinical roles were allocated. When nurses were assigned to areas that did not reflect their training or professional identity, dissatisfaction increased and intentions to leave were strengthened. Within the wider theme of Institutional Factors, work role therefore operated as another structural mechanism through which organisational decision-making shaped nurses' turnover intention at KFAFH.

Across these six subthemes, Institutional Factors emerged as the foundational context within which nurses made sense of their work and formed intentions to stay or leave. Pay systems, diversity-related policies, family residency arrangements, leadership structures, workload patterns, and role allocation were experienced as interconnected features of the same organisational environment rather than as separate issues. When these institutional conditions aligned poorly with nurses' needs, training, and expectations, they generated dissatisfaction, weakened commitment, and strengthened turnover intention. These findings position the institutional context as the primary foundation for understanding how the leadership and personal factors, discussed in subsequent themes, operate within KFAFH.

4.5.2 Theme 2: Leadership Factors

This theme captures how day-to-day leadership behaviours, management practices, and communication patterns directly shape nurses' experiences of fairness, support, and psychological safety in the workplace. Leadership factors refer to how authority is exercised at unit and departmental level, rather than formal organisational policy, and how these experiences influence turnover intention among nurses at KFAFH.

Nurses explained that their intention to leave increased when leadership was experienced as strict and unresponsive, especially when concerns were ignored, problems were not properly investigated, and pressure was applied without leaders listening to staff concerns. When their work was not acknowledged, this further strengthened their intention to leave. Many also described remaining silent about problems because they feared negative consequences, which contributed to increased turnover intention. Staff also explained that when their expectations of fair treatment, support, and protection from leaders were not met, their intention to leave increased. By contrast, when leaders were supportive, listened to staff, recognised their work, and maintained good teamwork, nurses described this as a key reason for staying in their positions. Participants consistently linked these leadership failures to turnover intention, suggesting that Leadership Factors often act as an intermediate layer translating institutional pressures into personal dissatisfaction.

4.5.2.1 Subtheme 2.1: Leadership and Management Style

Leadership and management style connects to and exemplifies the parent theme because turnover intention was shaped by how authority was enacted in everyday practice. When

leadership was experienced as unsupportive or dismissive, staff disengaged, which strengthened turnover intention. Participants distinguished between management and leadership in practice, describing management as task-oriented functions such as planning, organising, and controlling, and leadership as the relational work of motivating and supporting staff. In participants experiences, it was primarily the relational aspect, alongside how rules were enforced, that shaped turnover intention most strongly. Everyday interactions with leaders, particularly how concerns were heard and addressed, strongly shaped participants commitment to the organisation. The extracts in this subtheme include staff describing their own intention to leave and observing turnover among colleagues; these positions are indicated in the analysis.

Many participants described leaders who were perceived as unsupportive, particularly in the way they dismissed concerns and restricted opportunities for staff to speak openly. Christina, a non-Saudi staff nurse, described this pattern of interaction:

"I think one of the things that the nurse leaders should focus on is to listen to their staff, see that they are valued, and if they're anything that they want to say, then try to look on the things that they're complaining. it's not just like now, we have problems like this in the unit, ... She will just ignore what the staff is saying, not even give her time to speak out, and the leader is not listening to her." [Christina, non-Saudi staff]

Such interactions were understood not only as interpersonal failures but also as indicators of a leadership style that devalued staff input. When leaders ignored concerns, failed to

listen, and dismissed complaints, this signalled clearly that staff concerns were not valued by those in leadership roles.

This lack of consideration from leaders was consistently linked by participants to increased turnover intention. Ahmed, a non-Saudi staff nurse, directly connected repeated resignations to ineffective leadership:

> *"If you have a lot of leavers, it will alert you immediately. There's something wrong with your management. There's something wrong with your leadership style. You need to check on that. it will help to stop the staff nurses to leave." [Ahmed, non-Saudi staff]*

Ahmed positioned high turnover as a direct signal of leadership failure, suggesting that staff departures should prompt reflection rather than being accepted as routine. Poor leadership was therefore not simply a background condition but an active driver of turnover intention.

Several participants described supportive leadership, emphasising shared decision-making alongside encouragement and appreciation as key factors that motivated them to stay. Alma, a non-Saudi staff nurse, highlighted the positive effect of leaders who acknowledged staff efforts:

"Appreciate also our head nurse and nurse manager because I saw them, also how to encourage all that staff. Yeah, sometimes they're appreciating our works." [Alma, non-Saudi staff]

Being included in unit planning and problem-solving was closely linked, in staff experiences, to feeling respected by their leaders:

"We are included on every project, every performance on working in the unit. So it's being fair allocated, and the relationship, we don't have any conflict with them." [Ahmed, non-Saudi staff]

"They are involving us with the management." [Aurora, non-Saudi staff]

These descriptions revealed that daily leadership behaviours determined whether staff felt valued or dismissed, directly influencing turnover intention

In addition to lack of support, participants described overly rigid management styles as contributing to turnover intention. Maria, a non-Saudi nurse leader, explained how overly strict communication and directive behaviour created pressure:

"They're very strict. [Mimicking leaders] "They must do this, you must do that!". So some of the staff, they misunderstood these things. ... So if prompted to them that they

want to go instead of staying….They feel like too much pressure from them." [Maria, non-Saudi leader]

Perceptions of unfair judgement by leaders further weakened trust. Shatha, a Saudi leader, described how leaders sometimes formed negative impressions based on unverified information:

"If a leader hears someone speaking bad things about you or about your work, they form an idea about you. They don't investigate to see if this is true, which is very disappointing." [Shatha, Saudi leader]

Shatha described how leaders formed judgements based on hearsay without investigation. This was experienced as a breach of fairness that communicated that staff were not trusted and that their perspectives would not be heard, weakening trust across the unit.

On the other hand, positive leadership was described as supporting retention, with long-term commitment shaped by everyday leadership experiences. Jasmin, a non-Saudi staff nurse, explained this in relation to her own experience:

"One of the reasons why stayed for 16 or for 20 years in the hospitals because of my head nurse. Because she is very supportive of us. She's like a mother not a head nurse." [Jasmin, non-Saudi staff]

This verbatim extract represents a negative case within the subtheme, showing that when leadership was experienced as supportive and relational, long-term retention was sustained.

What emerged across these descriptions was a clear contrast in how leadership was enacted. Leaders who listened to and involved staff were associated with stronger retention and willingness to stay, whereas leaders who dismissed concerns or relied on judgement without engagement were associated with higher turnover intention.

4.5.2.2 Subtheme 2.2: Recognition

This subtheme examines how recognition, or the lack of it, shaped turnover intention by influencing how nurses experienced their own professional value and motivation at work. Recognition connects to and exemplifies its parent theme as when leaders recognised individuals for high-quality work, turnover intention decreased. Participants did not describe recognition as simple praise, but as whether their effort, responsibility, and contribution were genuinely noticed and taken seriously by their leaders. These descriptions were primarily expressed as personal experiences of feeling valued or undervalued and were linked to intention to leave.

Participants consistently explained that when their work was not acknowledged by leaders, motivation declined and the intention to leave increased. Tala, a non-Saudi nurse leader, linked the absence of recognition to emotional exhaustion and turnover intention:

"Leaders that did not support staff also contribute to increased likelihood of turnover. Assurance, it's the only thing I need. I need them to recognise the work I do." [Tala, non-Saudi leader]

Leaders who did not support staff contributed to an increased likelihood of turnover. Tala did not ask for reward or praise. She asked for assurance that her work mattered. The absence of this basic acknowledgement communicated that her contribution was invisible to leaders, weakening her motivation to stay. Feeling recognised was therefore described as necessary for remaining engaged at work.

This experience was not limited to nurse leaders. Alma, a non-Saudi staff nurse, expressed a similar need for acknowledgement from her leaders:

"I want others to recognise that I'm doing this great. So I want to be appreciated." [Alma, non-Saudi staff]

What Alma described reflected the same underlying need as Tala, not reward, but simple acknowledgement of effort and quality of work. This pattern therefore appeared across both staff nurses and nurse leaders, suggesting that the absence of recognition operated as a shared driver of turnover intention regardless of role.

Reem, a Saudi nurse leader, similarly described how lack of credit for work created frustration and reinforced feelings of being undervalued:

"They don't give you the accreditation that you do everything." [Reem, Saudi leader]

Nurses carried responsibility without credit. Over time, this communicated that their work did not matter within the leadership structure. This was significant for both staff nurses and nurse leaders, as both groups were managing demanding workloads without adequate acknowledgement.

Participants did not describe recognition as something that required formal systems or financial reward. Rather, it was framed as something that could be enacted through everyday leadership behaviour. Reem explicitly positioned recognition and empowerment as leadership practices that were both achievable and necessary:

"This is something within the ability, to empower us more, because when it comes to the end users, the staff nurses are the end users. They're being supported by something."

[Reem, Saudi leader]

Reem's description highlights a choice available to leaders. Recognition required no formal system or extra cost. It required leaders to notice and acknowledge staff work. Nurses understood recognition as more than simple appreciation and linked it to a sense of empowerment. Acknowledgement from leaders strengthened their confidence and connection to the organisation. Where recognition was absent, nurses felt less supported, and turnover intention increased.

Within the broader Leadership Factors theme, recognition therefore emerged as a central behavioural pathway through which leaders either strengthened or undermined nurses' decisions to stay. However, some participants described recognition as achievable through simple daily behaviour, suggesting the problem was not lack of resources but inconsistent leadership practice.

4.5.2.3 Subtheme 2.3: Speaking Out

This subtheme explores nurses' ability to voice concerns and raise issues without fear of negative consequences. Speaking out connects to and exemplifies its parent theme because when leaders at KFAFH did not respond adequately to staff speaking out, it increased turnover intention. Participants described speaking out as the act of reporting problems, disagreements, or workplace difficulties to leaders, especially when the issue might be viewed unfavourably. Fear of speaking out was closely tied to turnover intention, as participants described an environment where keeping quiet felt safer than raising concerns. The extracts here primarily reflect fear and self-protection in daily work, and include both leaders' observations of staff silence and staff describing their own hesitation to speak up.

According to Shatha, a Saudi nurse leader, the stressful environment made open communication difficult:

"The environment was really stressful, because even if they have problems, they cannot speak up." [Shatha, Saudi leader]

Shatha described an environment in which staff felt unable to raise concerns, creating a culture of silence rather than open communication. Fear therefore shaped everyday workplace interactions.

Staff described similar experiences. Alma, a non-Saudi nurse, explained that the fear was tied to reputation, documentation, and how leaders might perceive them:

"They're afraid because they don't want to leave a bad impression from the workplace. They don't want a bad record or misunderstood…maybe because if other people would transfer to another workplace, of course, you need to get a recommendation letter your new employer." [Alma, non-Saudi staff]

Alma explained that maintaining a good reputation was important, as staff needed recommendation letters for future employment. This made speaking out feel risky, reinforcing dissatisfaction and strengthening turnover intention.

Leaders also recognised these communication barriers. According to Omar, a Saudi leader, staff were more likely to write their concerns than raise them verbally, which he understood as a sign that they did not feel comfortable speaking up:

"The people…. they will keep quiet….Maybe they don't want to talk about….. Already they can write everything." [Omar, Saudi leader]

Staff choosing writing over speaking suggested that verbal communication with leaders felt too risky. That a leader recognised this indicated the silence was visible, yet the underlying discomfort remained unaddressed.

Participants described how hesitation to speak openly shaped turnover intention. Nurses who felt unable to raise concerns without consequences reported increased dissatisfaction and stronger intention to leave.

4.5.2.4 Subtheme 2.4: Staff Expectations and Management

This subtheme examines how nurses' expectations of management, and how those expectations were met or unmet in practice, shaped their work experiences and turnover intention. Staff expectations and management connects to and exemplifies its parent theme in that when leaders effectively managed expectations and met them in practice, it decreased turnover intention. Nurses described a set of expectations for their leaders, including fairness, support, respectful communication, and advocacy. Expectations alone were not described as sufficient to influence turnover intention; rather, it was whether these expectations were fulfilled in everyday practice that shaped intention to stay or leave. These extracts reflect both staff expectations based on their own experiences and leaders' views on how fair management should be enacted. This subtheme focuses on the standards nurses expected leaders to meet, rather than on leadership style itself (Subtheme 2.1) or recognition alone (Subtheme 2.2).

Alma, a non-Saudi staff nurse, described the behaviour she expected from leaders when dealing with performance and mistakes. She emphasised encouragement, dignity, and avoiding public embarrassment:

"Every time they did a good work. So I say that's good, better, lets do better. Continue doing that, and if they failed to do their work, and I don't reprimand them instead. I will just inform them……I don't want them to feel embarrassed." [Alma, non-Saudi staff]

Alma's description highlights what she expected from leaders. She wanted mistakes to be handled with dignity, not humiliation. Staff needed to feel safe making errors while learning. When leaders punished mistakes publicly, they signalled that error was shameful rather than part of learning.

A similar sentiment was echoed by Christina, another non-Saudi staff nurse, who linked confidence at work to feeling supported by both the team and leaders:

"On if we are able to stand with our team, if we are able to stand with our leader, then we feel confident enough to continue to our work." [Christina, non-Saudi staff]

From a leadership perspective, Maria demonstrated awareness of these expectations. She described the importance of listening to staff, particularly in situations involving patient complaints, and highlighted fairness in resolving conflict:

"They must also listen on what the staff need. For example, complaints. …nurses, they give everything to the patient, but then the patient is still having complaints with the staff. ….. sometimes the staff will be corrected. Sometimes the staff will be scolded…listen for the reason of the staff - why they did such a thing, and be equal in giving the solution for those conflicts that is happening between the patient and the staff, between the staff and the staff themselves." [Maria, non-Saudi leader]

What Maria described reflected her understanding that staff expected fairness and listening rather than punishment. That she felt the need to articulate this expectation suggests that these expectations were not consistently met.

Positive experiences of management support were described as protective against turnover. Aurora, a non-Saudi staff nurse, described how visible advocacy from her manager shaped her sense of value:

"My manager is protecting us. She is fighting for a right, she is fighting for her staff. So I can see that they are giving importance for us." [Aurora, non-Saudi staff]

For Aurora, seeing her manager advocate for staff was described as supporting her willingness to stay and remain engaged in her work, indicating personal retention rather than intention to leave.

Fairness and the avoidance of favouritism were repeatedly described as core management expectations. Maria emphasised that equal treatment was essential when addressing staff conflict:

"Conflict between the staff ….For example, you are my friend. I will listen to you … it must be equal treatment and fair decision in correcting all their - in addressing their problems." [Maria, non-Saudi leader]

Alongside management expectations, teamwork emerged as a closely connected condition shaping staff turnover intention. Christina described how weak teamwork across ethnic and professional groups led to emotional exhaustion and disengagement:

"One of the greatest factors, especially in my area, is the teamwork and the collaboration of staff. If the Filipino and other ethnicities, and even Saudis, are not working well, if they don't have a good teamwork, we feel burned out. We feel that we are not member of the team, and sometimes, they're feeling all it's you're overworked." [Christina, non-Saudi staff]

By contrast, positive teamwork was described as strengthening commitment and encouraging nurses to remain. Aurora, a non-Saudi staff nurse, reflected on how healthy relationships supported daily motivation:

"I enjoy working with my colleagues. We are having healthy relationship between the medical team doctors and nurses, and we nurses, we are like family. We might have some differences, but at the end of the day, we are still here working and helping each other at our best." [Aurora, non-Saudi staff]

Christina further linked teamwork directly to job satisfaction:

"If you have a good teamwork, we feel that we are happy with our job." [Christina, non-Saudi staff]

However, teamwork was described as critical, and its absence contributed to turnover intention:

"But if the teamwork fails, since we're doing procedural work, then we feel like we are in burnout and stress out, which make us think to move to different areas or even move to other hospital." [Christina, non-Saudi staff]

When leaders met expectations around listening, fairness, advocacy, and support for teamwork, staff remained, whereas when they did not, turnover intention increased. Overall, staff expectations of management, particularly around fairness, support, advocacy, and respectful treatment, operated alongside teamwork as key conditions shaping turnover intention.

Across these subthemes, Leadership Factors shaped turnover intention by shaping whether institutional pressures were buffered through fairness, listening, and recognition, or intensified through dismissal, judgement, and fear.

4.5.3 Theme 3: Personal Factors

Under this theme, four personal-level factors were identified: Lifestyle, Opportunities, Personal Time, and Wellbeing. These subthemes show how experiences beyond the workplace, alongside workplace demands, influenced nurses' decisions about staying or leaving. Lifestyle was discussed in relation to nurses' ability to adjust to life in KSA. Some participants described difficulty settling into the wider cultural and social environment. This was raised only by non-Saudi nurses, for whom not being able to see themselves living in KSA over the long term made remaining in their positions feel difficult to sustain.

Participants also described how limited opportunities for further education and barriers to family life added to the pressures they faced and contributed to intention to leave. Nurses often described feeling unsupported when they were unable to obtain personal time off. When this was combined with the everyday pressures of their role, the job felt harder to sustain, and turnover intention increased. Nurses reported experiencing burnout, which affected their physical and emotional wellbeing. Burnout, in particular, was strongly linked to turnover intention. Together, these pressures shaped how nurses evaluated their ability to remain in their roles over the longer term.

4.5.3.1 Subtheme 3.1: Lifestyle

This subtheme examines how nurses' personal lifestyles and their ability to adjust to life in KSA shaped their turnover intention. Lifestyle connects to and exemplifies the parent theme because it reflects whether nurses could align their personal expectations, social

needs, and ways of life with the realities of daily life outside work. Lifestyle was described as the wider cultural, social, and religious environment they lived in. For many non-Saudi nurses, adapting to these norms was difficult, and this was closely linked to their thoughts of leaving. Aurora, a non-Saudi staff nurse, explained how this influenced decisions about remaining:

"They don't find themselves here for a long period of time. Maybe some people are having hard time for adjustment, especially for those … who are non-Muslims or not used with this kind of culture. Maybe they want a different lifestyle, or maybe they were not able to blend well with the environment." [Aurora, non-Saudi staff]

This reflects observation of others turnover decisions (non-Saudi nurses) rather than her own intention. Participants did not describe this as strong dissatisfaction, but rather as a sense of not fully settling into the community. What Aurora described revealed something important. It was not anger or complaint about culture, but rather an inability to settle, belong, or envision a life being built there.

Ahmed, a non-Saudi staff nurse, also noted that lifestyle adjustments were harder for non-Saudis:

"Saudis they will stay because this is their country and then there is no language barrier." [Ahmed, non-Saudi staff]

What Ahmed observed pointed to a fundamental difference in belonging. Saudi nurses did not face the same challenges in imagining a long-term future because this was their home country, whereas non-Saudi nurses described ongoing difficulty feeling fully settled. This distinction shaped who could realistically imagine staying long term. This comment reflects broader turnover patterns rather than the participant's own intention to leave.

Within the lifestyle subtheme, a clear distinction emerged. Lifestyle barriers were raised only by non-Saudi participants and were not related to KFAFH but to the wider context of KSA. Non-Saudi nurses described difficulty building permanent lives culturally or socially. Without this possibility, leaving became increasingly likely. These descriptions showed how challenges with cultural adjustment and fitting into the wider environment influenced turnover intention.

4.5.3.2 Subtheme 3.2: Opportunities

This subtheme examines how the opportunities available to nurses influenced their turnover intention. Opportunities connect to and exemplify the parent theme, as unmet career opportunities shaped turnover intention. While the structural conditions that limited opportunities are addressed under Institutional Factors, this subtheme focuses on how individual nurses personally experienced and responded to these limitations in relation to their own future plans and aspirations. Participants described opportunities in terms of what their employment enabled them to pursue, particularly family-related decisions and further

education. In this subtheme, opportunities refer to external alternatives and personal future planning, such as relocation, education pathways, and long-term life options.

Participants described opportunities in terms of what their employment enabled them to pursue, particularly family-related decisions and further education

For several non-Saudi nurses, the chance to relocate with their families made leaving seem more realistic. Katie, a non-Saudi leader, reflected on how this affected turnover:

"Nurses now going abroad was another challenge of the turnover because they [non-Saudis] can move with their families." [Katie, non-Saudi leader]

What Katie described reflected the availability of alternatives elsewhere. Other countries offered what KFAFH and KSA could not, including the ability to build family lives and relocate together. For non-Saudi nurses, this opportunity made leaving more likely. Katie's comment refers to observed turnover among others rather than her own intention to leave.

Education was another area where participants felt constrained. Some nurses wanted to continue their studies but said they did not receive the support needed to do so. Ahmed, a non-Saudi nurse, explained:

"They need to support the staff nurses in terms of education. Their continued education, they need to help on that. They may be the staff nurses. They want to take a master's

degree, even though they're working…..because their head nurses ordering they don't allow them to study." [Ahmed, Non-Saudi staff]

Ahmed described how restrictions on studying while working blocked nurses from pursuing their own career goals. For ambitious nurses, the inability to advance educationally while employed made remaining in the organisation difficult to justify. When personal development was restricted, staying long-term felt incompatible with their professional aspirations.

Jasmin, also a non-Saudi nurse, described the same limitation:

"They don't allow us to continue education because you have to do your work." [Jasmin, Non-Saudi staff]

Jasmin's description reinforced this experience. The organisation prioritised immediate staffing needs over nurses' long-term development, communicating limited commitment to their progression.

Within the Opportunities subtheme, participants described limited pathways for non-Saudi nurses, including barriers to education, career progression, and family-related opportunities. In contrast, other organisations were perceived to offer these options. For nurses with ambitions beyond their current role, leaving was therefore framed as a likely next step.

4.5.3.3 Subtheme 3.3: Personal Time

This subtheme examines how nurse access to personal time off influenced their turnover intention. Personal time connects to and exemplifies its parent theme as nurses described unmet need for personal time away from KFAFH as increasing turnover intention. Nurses described personal time as necessary for their responsibilities outside work, so when requests were delayed or refused, they felt unsupported. Participants described this leave as necessary for personal or family reasons, and when access to it became difficult, their intention to leave increased.

Christina, a non-Saudi staff nurse, explained that dissatisfaction arose not simply from being denied leave, but from leaders not engaging with requests fairly:

> *"If the nurse leader able to listen in terms of their vacations….As long as the nurse leaders are able to try to solve this problem, not always allowing them to have vacation seriously, but at least even out with other staff as well." [Christina, non-Saudi staff]*

Christina did not ask for unlimited time off. She asked for leaders to listen and try to solve the problem fairly. When leaders dismissed requests without consideration, this communicated that personal needs did not matter, weakening motivation to stay.

Several participants described how these interactions influenced their intention to leave. Ahmed, a non-Saudi staff nurse, explained how refusal of personal time contributed to feelings of neglect and intention to leave:

"Sometimes also if you have a request, example the staff nurses have request, "Mam, can have an off on this day because I need to finish something?" and the leaders will just tell you, "No, you cannot, because you already asked for me for that". So sometimes, the staff nurses, they feel being neglected. So they tend to leave organisation or the unit." [Ahmed, non-Saudi staff]

When leaders refused requests without listening to the reasons, nurses felt that their personal needs were invisible. This communicated organisational disregard for individual circumstances, and for some nurses, this neglect was enough to drive leaving the unit or the organisation entirely.

Even leaders expressed that being able to grant personal time was important, exemplified by Shatha, a Saudi leader, who noted that unmet family needs could lead nurses to end their contracts early:

"They should also listen to the staff. What's they also need, because some of the staff, they have a problem with their family outside of the country. So maybe they would cut their contract only because of the family. Why we cannot help them to manage…Like give them a small leave to solve their problems and come back." [Shatha, Saudi leader]

Shatha, speaking as a leader, recognised that refusing leave drove nurses away. Rather than dismissing personal circumstances, she advocated for flexibility as a practical retention

measure. This suggested that some leaders understood the link between leave decisions and turnover intention, even when organisational practice did not consistently reflect this.

Across interviews, limited access to personal time was described as a clear source of dissatisfaction and a direct contributor to turnover intention. When nurses felt that leaders did not take their requests seriously or consider their personal circumstances, the job became harder to sustain. Granting personal time was not framed as a favour or weakness, but as a basic expression of whether the organisation cared about nurses' lives outside work. For nurses facing family, health, or personal crises, this increased the likelihood of leaving. The ability to take personal time off therefore emerged as a meaningful factor in whether nurses felt supported enough to remain in their positions.

4.5.3.4 Subtheme 3.4: Wellbeing

Participants described wellbeing as the physical and psychological capacity needed to meet daily work demands. Nurses connected their turnover intention to a decline in wellbeing, particularly when burnout affected their ability to manage their workload. Wellbeing connects to and exemplifies its parent theme as nurses described their wellbeing as being negatively impacted by their work at KFAFH, and this increased turnover intention. For nurses, burnout signalled that demands were unlikely to reduce even when staff were struggling, making it increasingly difficult to maintain a balance between work and health, and thereby strengthening turnover intention. Wellbeing was therefore an important factor shaping nurses' decisions about whether to remain.

Christina, a non-Saudi staff nurse, described how high patient volumes contributed to burnout:

"One of the greatest factors is the nurses burnout due to a high volume of patients that we are receiving. For ward nurses, they are usually complaining on nurse patient ratio, if they're having too much patients to attend." [Christina, non-Saudi staff]

Christina linked high patient volumes directly to burnout, describing it as a condition shaped by workload demands that exceeded manageable limits. She further noted that extra tasks were frequently assigned without sufficient support:

"It's more of a mental or psychological effect that they're trying to get more workload for us." [Christina, non-Saudi staff]

Across interviews, wellbeing was shaped directly by daily demands at work. As demands increased and support remained limited, nurses became emotionally and physically exhausted. When this exhaustion became unsustainable, leaving emerged as a way to protect their wellbeing, directly strengthening turnover intention.

Across these subthemes, personal factors shaped turnover intention by determining whether nurses could sustain life alongside work, or whether exhaustion, limited opportunities, and unmet personal needs strengthened their intention to leave.

4.6 Differences between Saudi and non-Saudi nurses

The analysis showed that Saudi and non-Saudi nurses did not experience their workplace in the same way, and certain factors shaped turnover intention differently across the two groups. Differences emerged when both groups discussed the same issue with different expectations, or when issues were raised by only one group. Differences in factors influencing turnover intention were identified between Saudi and non-Saudi nurses across Institutional Factors, including Diversity Issues, Families, and Workload, and Personal Factors, including Lifestyle and Opportunities. Under the Leadership Factors theme, no differences were identified between the two groups. The sections that follow outline the areas where Saudi and non-Saudi nurses differed, to show how each group's needs shaped turnover intention.

4.6.1 Theme 1: Institutional Factors

Within Institutional Factors, three subthemes revealed differences between Saudi and non-Saudi nurses: Diversity Issues, Families, and Workload. These differences showed how institutional structures and policies shaped Saudi and non-Saudi nurse turnover intention differently.

4.6.1.1 Subtheme 1.2: Diversity Issues

The main differences between Saudi and non-Saudi nurses in this subtheme related to institutional policies shaping leadership pathways, access to progression, and how expertise was recognised within the organisation. Non-Saudi nurses with advanced

qualifications and experience found themselves excluded from leadership roles, while simultaneously being expected to support newly appointed Saudi leaders who lacked equivalent preparation. Katie, a non-Saudi leader, described this dynamic directly:

> *"So with now the leadership that of the Saudis we bringing them. We have to give as much support as we can from what we know from experience from qualification of specially administration, because you will be moving now away from a floor …. that higher level it needs also a skill and knowledge of that."* *[Katie, non-Saudi leader]*

Even when non-Saudi leaders attempted to support Saudi leaders, differences in experience still remained. Katie further explains the frustration:

> *"So it's like I always hear them, a driver cannot drive the car without knowing how to drive."* *[Katie, non-Saudi leader]*

Katie described the challenge of coaching untrained Saudi leaders and the frustration this created. This meant non-Saudi nurses were expected to carry out their own roles while informally supporting Saudi leaders, signalling that their expertise was relied upon, but their careers were not prioritised.

Because non-Saudi nurses described limited opportunities for career advancement, this reduced motivation to remain at KFAFH and increased their intention to leave, as described by Aurora, a non-Saudi staff:

"For the turnover……. advancement when it come to their profession." [Aurora, non-Saudi staff]

Non-Saudi nurses described observing Saudi colleagues being promoted into leadership roles despite having less experience while they remained in the same roles, which contributed to perceptions of limited future opportunities at KFAFH.

This institutional arrangement extended beyond career progression and shaped everyday power dynamics within teams, as some Saudi nurses described feeling vulnerable or targeted because they were less experienced than their non-Saudi colleagues. Maram and Rana, both Saudi nurses, said they sometimes faced bullying from non-Saudis who were more skilled and therefore perceived as more powerful within the team:

"They have more experience than us, so we need them to learn from their experience…. Even the first time, when I started working at the hospital, when I met with our head nurse, she said don't take anything personally, because this nationality issue can be the first spark to cause a major conflict between the nurses. That's why we always try to ignore them [non-Saudi nurses]." [Maram, Saudi staff]

"There are some bullying mostly from other nationalities…..So the Saudis sometime have to defend themselves or they would leave their job because of the bullying." [Rana, Saudi staff]

For some Saudi nurses, leadership roles were described as stressful rather than rewarding. For non-Saudis, seeing this generated frustration about their own blocked chances. This dynamic created tension, which some Saudi nurses described as contributing to experiences of bullying. Both responses carried implications for turnover intention, with non-Saudis describing intentions to leave due to blocked progression, and Saudis describing pressure linked to conflict and expectations.

However, not everyone saw this as a source of division. Alma, a non-Saudi staff nurse, described it differently:

"We are very compassionate to each other. We didn't see a competition to each other. We help each other, so I don't see any problem between the non-Saudi and Saudi in our department." [Alma, non-Saudi staff]

This extract reflects a negative case in which teamwork at unit level operated without division, despite wider institutional differences. When teams worked well together, the nationality issue mattered less. When teams were weak, people used nationality as a reason for their frustration.

Participants did not describe the issue as arising from nationality itself, but from how groups were treated differently at an institutional level. Saudis were more likely to be placed in leadership and were described as receiving limited preparation for leadership roles, which contributed to tension and resentment between the two groups. As described by Aurora, a non-Saudi staff:

"Our promotions is not for everyone. Limited jobs, or post for nurse leaders, but you know, promoting a staff really motivates them." [Aurora, non-Saudi staff]

Aurora's description reflected how limited promotion pathways reduced motivation among non-Saudi nurses. When progression felt unlikely, commitment to remaining in the organisation weakened.

Differences in access to leadership opportunities inside KFAFH also created tension. Shatha, a Saudi leader, said that disagreements sometimes arose when Saudi nurses aimed for leadership or administrative roles that non-Saudis felt were not equally available to them. In this study, administrative roles refer to non-clinical hospital positions, such as research, education, and quality improvement, which are distinct from clinical leadership or management positions (e.g., Nurse Manager, Head Nurse) that involve direct oversight of nursing staff and clinical operations.

"Sometimes we have issues because some Saudis, they will come with their own opinion regarding the staff..... So this is only because the Saudis sometimes, when they want to work, they want to be a leader or take any position in the hospital administration." [Shatha, Saudi leader] "

This reinforces the broader pattern in which leadership pathways were more open to Saudis, while non-Saudis experienced limited progression, contributing both to frustration and, for some, stronger turnover intention.

These findings show that diversity-related tensions were produced by institutional pathways to leadership rather than nationality itself. Promotion practices created uneven pressures, blocked progression for non-Saudi nurses and premature responsibility for Saudi nurses. These conditions shaped perceptions of fairness, generated conflict, and influenced turnover intention in different ways across the two groups.

4.6.1.2 Subtheme 1.3: Families

This subtheme highlights differences between Saudi and non-Saudi nurses in relation to institutional conditions affecting family presence, particularly the ability of non-Saudi nurses to live with their families while working in KSA.

For many non-Saudi nurses, being able to live with their families was central to their sense of stability and purpose. Aurora, a non-Saudi staff nurse, explained that family presence was closely linked to motivation and wellbeing at work:

> *"For example, you can have families to live with you here. That will be very great, you know family is the reason why you are working, and that motivates you, and gives a meaning of your life, and it makes you a better person if you have families with you."*
>
> *[Aurora, non-Saudi staff]*

Aurora framed family presence not as a personal preference but as a fundamental source of meaning and motivation. Its absence therefore removed a core reason for staying, directly strengthening turnover intention.

Although non-Saudi nurses were permitted to bring their families to KSA, Mohammed, a non-Saudi staff nurse, explained that this was not feasible in practice:

"It's a long process, and expensive, and we have to do the applications. It's a lot of work and money." [Mohammed, non-Saudi staff]

The organisation did not actively block family sponsorship but did not provide practical support, leaving non-Saudi nurses to manage these barriers alone. In practice, this resulted in prolonged separation from family. Nurses repeatedly linked this to their assessment of whether staying at KFAFH was viable in the long term. For non-Saudi nurses, this was not simply a personal challenge but an institutional barrier that communicated limited organisational support, making long-term commitment more difficult and strengthening turnover intention.

4.6.1.3 Subtheme 1.5: Workload

As described previously, participants perceived an occupational division between Saudi and non-Saudi nurses, in which Saudi nurses were more likely to be elevated to leadership roles, while non-Saudi nurses were viewed as having stronger clinical training and experience. This perception also shaped how work was distributed among staff.

As Christina, a non-Saudi staff described, Saudis were perceived as receiving fewer work assignments, with participants linking this to differences in training:

"Sometimes most Filipinos expatriates, they tend to get high volume of workload. Which we are thinking for example the Saudis, who don't know if they can. If they're able to do this task as we do." [Christina, non-Saudi staff]

Christina's description reflects a perception that Saudi nurses had less clinical experience, which influenced how tasks were allocated, and when tasks were redistributed to non-Saudi nurses, this increased their workload and strengthened turnover intention.

On the positive side, Katie, a non-Saudi leader, noted how helpful Saudi staff are when there are patient complaints:

"I'm expatriate, I have… a language barrier. Patient wants something and then I don't understand what she's saying, but now, with a relationship with the Saudis, at least you can step in, she can page for patient's satisfaction. At least we can reach what the patient wants. So, there's a good relationship with them having them around with us." [Katie, non-Saudi leader]

Given that most patients were Saudi, participants described how Saudi nurses played an important role in communication and patient satisfaction. However, even with these strengths, many participants felt that Saudi nurses were limited in the clinical tasks they could take on independently based on perceived differences in training. As a result, heavier clinical duties remained concentrated among non-Saudis, which several nurses linked to dissatisfaction.

Workload distribution reflected informal organisational practices rather than formal job descriptions. Non-Saudi nurses carried heavier clinical loads because they were perceived as more capable in certain tasks. This uneven allocation increased strain for non-Saudi nurses and reinforced perceptions of unfairness, strengthening their turnover intention.

4.6.2 Theme 2: Leadership Factors

Differences between Saudi and non-Saudi nurses were primarily related to Institutional Factors, such as Diversity Issues, and have been addressed in the previous section. No differences were identified within the Leadership Factors theme that affected Saudi and non-Saudi nurses differently.

4.6.3 Theme 3: Personal Factors

Two subthemes within the Personal Factors theme were associated with differences in turnover intention between Saudi and non-Saudi nurses: Lifestyle and Opportunities. These subthemes are discussed below.

4.6.3.1 Subtheme 3.1: Lifestyle

Lifestyle was discussed only by non-Saudi nurses, who linked their ability to adjust to life in KSA with their intention to stay or leave. They described lifestyle not in terms of daily routine, but as the wider cultural and social environment they lived in. Several non-Saudi nurses described difficulty imagining a long-term future in KSA because they struggled to settle into the cultural and social setting.

Tala, a non-Saudi nurse leader, described how challenging this adjustment could be, especially for those unfamiliar with Saudi customs:

"Some of them, they want to go there because of the culture of Saudi Arabia….its very hard for them, especially those single nurses." [Tala, non-Saudi leader]

Other non-Saudi nurses explained that blending into the wider environment was not always possible. Aurora noted that cultural and religious differences made that difficult:

"Some people are having hard time for adjustment, especially for … those who are non-Muslims or not used with this kind of culture. Maybe they want a different lifestyle, or maybe they were not able to blend well with the environment." [Aurora, non-Saudi staff]

For non-Muslims or those unfamiliar with Saudi culture, the environment was experienced as difficult to adapt to over time.

Aurora linked lifestyle to the difficulty of establishing a stable personal life in KSA, including plans for marriage or family.

"They wanted to change lifestyle, their status." [Aurora, non-Saudi staff]

Non-Saudi staff talked about the difficulty of the cultural shift of living in KSA. They described feeling unable to build a long-term life in KSA. Without the ability to build the life they envisioned in KSA, remaining in the country felt increasingly unsustainable rather than desirable. This made leaving feel like the practical choice. Participants linked these

constraints to broader life plans, including marriage and family formation, which they felt were difficult to achieve within KSA.

However, not all non-Saudis talked about negative challenges from living in KSA. Jasmin, a non-Saudi staff nurse, expressed her appreciation for living in KSA and working at KFAFH:

"For me, I am contented with… and not only me, there are many nurses who stayed also for more than 10 years in KFAFH. So not all of us really want to go out, to go in the US or other countries….. I worked here 20 years, so its like my home now." [Jasmin, non-Saudi staff]

Jasmin described long-term adaptation, where KSA had become home and staying was realistic. For others who could not make this adjustment, the organisation offered limited support to help them stay.

Lifestyle concerns emerged as a barrier shaped by cultural fit rather than organisational practices. However, participants described limited support to assist with this adjustment. For those who struggled with the cultural environment, long-term stay felt unrealistic, strengthening turnover intention.

4.6.3.2 Subtheme 3.2: Opportunities

Differences in opportunities between Saudi and non-Saudi nurses increased turnover intention among non-Saudi nurses. Non-Saudi participants often compared what was available to them at KFAFH with what they could access elsewhere, and this played a strong role in shaping their turnover intention. Mohammed explained that many nurses were leaving because opportunities abroad felt more attractive and more achievable than those in KSA:

> *"The opportunity in the other countries. That's why we are understaffed….That's why a lot of nurses here in KFAFH are leaving, because of that opportunity in the other countries." [Mohammed, non-Saudi staff]*

For non-Saudi nurses, opportunities elsewhere meant KFAFH was less competitive. Their decisions reflected comparison with what was available elsewhere.

Alma raised a similar issue and linked staff decisions to leave with the higher salaries offered in other countries:

> *"UK and US, they give more salary than Saudi, so that's the reason the staff are leaving." [Alma, non-Saudi staff]*

Higher salaries abroad directly influenced nurses' decisions to leave. When other countries offered higher salaries, staying at KFAFH meant accepting lower pay for the same work.

For others, the issue was not only pay but the sense that career development abroad was clearer and more structured. Aurora, a non-Saudi staff nurse, explained how important competitive salary and career development were in reducing turnover at KFAFH:

"Salary, competitive job offer, like the other countries are offering. Better opportunities for growth and development, specially with your career, like promotions." [Aurora, non-Saudi staff]

For non-Saudi nurses, career pathways abroad were clearer and more achievable than advancement at KFAFH. The organisation did not offer structured development pathways comparable to those available elsewhere.

Other nurses highlighted the opportunity to obtain citizenship in other countries as a major factor influencing the decision to leave KSA. Aurora explained that this form of long-term stability was not available to them in KSA, which shaped how non-Saudis thought about their future:

"Citizenship because it will encourage people to stay and spend the rest of their working life at the end they will be having this kind of support from the government…. There are too much opportunities outside the citizenship a lot of privileges that other countries are offering." [Aurora, non-Saudi staff]

Citizenship represented a form of long-term security that was not available within the KSA context.

Non-Saudis evaluated opportunities by comparing KFAFH to what other countries offered. Higher salaries, clearer career development, and citizenship opportunities were more accessible outside KFAFH. This comparison communicated that staying long-term at KFAFH offered less than what was available elsewhere. When better opportunities existed outside, remaining appeared less viable, directly increasing turnover intention.

4.7 Differences between Leaders and Staff

One subtheme within Institutional Factors shaped the experiences of leaders differently from staff and was associated with increased turnover intention. No differences were identified between leaders and staff within the Leadership or Personal Factors themes. Differences between the two groups were therefore found only within Institutional Factors, specifically Leadership Positions, which is examined below.

4.7.1 Theme 1: Institutional Factors

Within Institutional Factors, only one subtheme revealed a distinction between nurse leaders and staff nurses: Leadership Positions. This subtheme is discussed below.

4.7.1.1 Subtheme 1.4: Leadership Positions

Leadership positions shaped turnover intention among nurse leaders through role instability, lack of formal recognition, and unclear appointment processes. Leaders did not frame concerns around access to leadership roles. Instead, they focused on the experience of holding leadership responsibilities without official designation, authority, or organisational security.

Several nurse leaders described acting as head nurses or assistant head nurses while the formal posts remained administratively assigned to individuals who had already left the organisation. Reem, a Saudi nurse leader, explained how this situation created sustained pressure and uncertainty:

"You have to post as a head nurse, assistant headers and the clinical resources……This is one of the major and the previous Head Nurse left because of that…..The unavailability of the post because the HR is keeping this position as occupied by nurses who left already so they are not hiring for it." [Reem, Saudi leader]

The organisation kept leadership posts administratively occupied by staff who had already left, which blocked formal appointments. As a result, leaders carried full responsibility without official recognition. For leaders, this communicated that their work was needed but their positions were not valued enough to be made permanent, as they were expected to perform leadership responsibilities without formal recognition.

For leaders like Reem, this arrangement created role insecurity. Expectations increased while institutional support remained limited, and leadership contributions were not formally recognised or protected. When leadership responsibilities were held without contractual clarity, leaders struggled to plan their professional future or commit to the organisation over time. Unlike staff in stable roles, nurse leaders had no clarity regarding their role or its continuation, making long-term commitment professionally risky. For them, leadership roles contributed to turnover intention because the roles were structurally unstable.

Only nurse leaders raised this issue. They described institutional uncertainty, where responsibility was not matched by recognition, authority, or formal appointment. Under

these conditions, leadership positions functioned as a retention risk rather than a source of professional advancement.

4.7.2 Theme 2: Leadership Factors

Differences between leaders and staff were identified only within Institutional Factors, particularly in relation to Leadership Positions. No differences were identified within the Leadership Factors theme.

4.7.3 Theme 3: Personal Factors

No differences were identified within the Personal Factors theme that shaped the experiences of leaders and staff differently. Both groups reported similar challenges.

4.8 Cross-Theme Synthesis

This section synthesises how the themes and subthemes interact across the hierarchy of Institutional, Leadership, and Personal Factors themes. Institutional Factors are positioned at the top of this hierarchy because they are structurally determined at the organisational level, setting the conditions within which leadership is enacted, and personal experiences emerge. Leadership and Personal Factors both occupy the second level, where Leadership Factors reflect how institutional structures are translated into everyday management behaviour, and Personal Factors reflect how nurses experience and respond to these conditions, ultimately shaping their turnover intention. The following evidence demonstrates these relationships.

Institutional Factors influenced Leadership and Personal Factors, particularly through restricted leadership pathways for non-Saudi nurses. This is reflected in Reem's and Aurora's descriptions:

"I don't know any non-Saudis in leadership, because mostly the Saudization is taking place in the administration" [Reem, Saudi leader]

"Our promotions is not for everyone. Limited jobs, or post for nurse leaders, but you know, promoting a staff really motivates them." [Aurora, non-Saudi staff]

Staffing shortages at the institutional level constrained leader's ability to grant personal time, placing pressure on leadership practice and limiting their capacity to support staff needs. This strain on leadership subsequently shaped staff experiences, as requests for time

off were frequently declined, leading to feelings of neglect and increased intention to leave. At the same time, leaders expressed a willingness to support staff, but were unable to do so due to these institutional constraints, particularly in relation to family needs. This is reflected in the following verbatim extracts:

"Sometimes also if you have a request, example the staff nurses have request, "Mam, can have an off on this day because I need to finish something?" and the leaders will just tell you, "No, you cannot, because you already asked for me for that". So sometimes, the staff nurses, they feel being neglected. So they tend to leave organisation or the unit." [Ahmed, non-Saudi staff]

"They should also listen to the staff. What's they also need, because some of the staff, they have a problem with their family outside of the country. So maybe they would cut their contract only because of the family. Why we cannot help them to manage…Like give them a small leave to solve their problems and come back." [Shatha, Saudi leader]

Participants described institutional promotion practices as contributing to diversity-related tensions at the leadership level, particularly where leadership opportunities were perceived as unequally distributed. This created both interpersonal tension and broader reputational concerns, as reflected in the following verbatim extracts:

"This also affects your turnover. It gives the wrong or a bad reputation about the hospital. it gives that negativity that you will never maintain your leaders likely well experience." [Katie, non-Saudi leader]

"Sometimes we have issues because some Saudis, they will come with their own opinion regarding the staff..... So this is only because the Saudis sometimes, when they want to work, they want to be a leader or take any position in the hospital administration."

[Shatha, Saudi leader] "

Saudi leaders were sometimes described as having limited leadership experience, which participants linked to institutional promotion practices that prioritised rapid advancement without sufficient preparation. This was described as contributing to leadership challenges that affected staff wellbeing and retention, with ineffective leadership practices leading to increased staff turnover. This sequence is reflected in the following verbatim extracts:

"Our Saudis, they've never been exposed to administrative work, they completed their degree. And then now maybe one or two years, then they become the administrators… In my country, you are a nurse, but if you moved in administration, you won't be accepted without having that Administration qualifications. You don't just get promoted to that."

[Katie, non-Saudi leader]

"If you have a lot of leavers, it will alert you immediately. There's something wrong with your management. There's something wrong with your leadership style. You need to check on that. it will help to stop the staff nurses to leave." [Ahmed, non-Saudi staff]

Severe understaffing was described as contributing to higher workload at the institutional level, which in turn negatively impacted nurse wellbeing at the personal level. This relationship is reflected in the following verbatim extracts:

"In my opinion, it's the staff shortage. The nurse to patient ratio is so high……. When they do the schedule of work for each nurse about their responsibilities the work is too much." [Noura, Saudi staff]

"The workload due to nurse shortage, because when you signed your contract here they tell you that your load is four patients. But after you start working, you will be shocked to have six or seven patients in one shift. So the workload is too much on me" [Maram, Saudi staff]

"One of the greatest factors is the nurses burnout due to a high volume of patients that we are receiving. For ward nurses, they are usually complaining on nurse patient ratio, if they're having too much patients to attend." [Christina, non-Saudi staff]

At the institutional level, structural and HR constraints limited leaders' ability to effectively perform their roles, which reduced their capacity to recognise staff contributions, ultimately contributing to increased turnover intention. This relationship is reflected in the following verbatim extracts:

"You have to post as a head nurse, assistant headers and the clinical resources……This is one of the major and the previous Head Nurse left because of that…..The unavailability of the post because the HR is keeping this position as occupied by nurses who left already so they are not hiring for it." [Reem, Saudi leader]

“Leaders that did not support staff also contribute to increased likelihood of turnover. Assurance, it’s the only thing I need. I need them to recognise the work I do.” [Tala, non-Saudi leader]

"I want others to recognise that I'm doing this great. So I want to be appreciated." [Alma, non-Saudi staff]

Participants described institutional arrangements as offering limited support for non-Saudi nurses to live with their families in KSA, which contributed to turnover intention at the personal level, as nurses sought opportunities that allowed family relocation. This is evident in the following verbatim extracts:

“That’s why they are leaving Saudi… it’s a long process and expensive and we have to do the applications it’s a lot of work and money.” [Mohammed, non-Saudi staff]

“Nurses now going abroad was another challenge of the turnover because they [non-Saudis] can move with their families.” [Katie, non-Saudi leader]

Low salary at the institutional level was described as contributing to turnover intention, particularly among non-Saudi nurses who sought better-paid opportunities. This is illustrated in the following verbatim extracts:

“Benefits and salaries. If we are receiving an amount that we don't see as compensating enough for our kind of work, then we lose this kind of motivation to continue in our job.” [Christina, non-Saudi staff]

"UK and US, they give more salary than Saudi, so that's the reason the staff are leaving." [Alma, non-Saudi staff]

Together, these extracts show how low salary reduced motivation and led nurses to compare opportunities elsewhere, strengthening turnover intention.

This section demonstrates how themes interconnect, showing the hierarchical relationship between Institutional, Leadership, and Personal Factors. These relationships are integrated into the novel model in Chapter 5, with Table 5.1 providing analytical justification.

4.9 Chapter Summary

This chapter has presented the findings of the thematic analysis conducted on interview data from nineteen participants at KFAFH. The demographic characteristics of the sample were presented first, situating the findings within the workforce context of a military hospital in KSA. Three overarching themes and fourteen subthemes were developed: Institutional Factors, Leadership Factors, and Personal Factors. Together, these themes capture the structural conditions, relational dynamics, and personal circumstances that participants described as shaping their intention to leave.

The chapter also examined how these experiences differed across the two primary comparisons of this study. Differences between Saudi and non-Saudi nurses were identified across Institutional and Personal Factors, while differences between nurse leaders and staff nurses were found only within the Institutional Factors theme. These comparisons revealed

that turnover intention is not experienced uniformly across the workforce but is shaped by nationality and role in distinct ways.

The chapter concluded with a cross-theme synthesis illustrating how Institutional, Leadership, and Personal Factors interact hierarchically, with institutional conditions shaping both leadership practices and personal experiences at KFAFH. The following chapter builds on these findings by appraising relevant theoretical models of turnover and turnover intention, before developing a novel KSA-centric model grounded in the empirical findings presented here.

Chapter 5 - Critical overview of existing models

5.1 Introduction

The previous chapter presented the thematic findings of this study, identifying Institutional, Leadership, and Personal Factors as the primary factors of nurse turnover intention at KFAFH. This chapter builds on those findings by evaluating whether current theoretical models are sufficient to explain the patterns identified in the KSA context.

Four widely applied theoretical frameworks are considered: Social Exchange Theory, Herzberg's Two-Factor Theory, Price's Model, and the Job Demands-Resources Model. Each was selected because it captures a different explanatory dimension of occupational retention and turnover. However, as this chapter demonstrates, each framework also carries limitations that prevent it from fully accounting for the hierarchical and context-dependent dynamics identified in this study. Two additional models from the broader turnover literature are then evaluated and similarly found to be insufficient.

The chapter concludes by addressing these limitations directly. Drawing on the empirical findings presented in Chapter 4, a novel KSA-centric model of nurse turnover intention is developed, one that captures the structural, relational, and contextual dynamics that current frameworks are unable to account for.

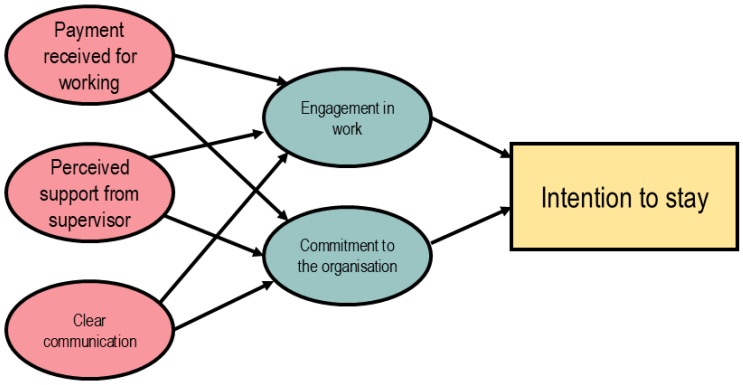
5.2 Social Exchange Theory

The first theory used to explore the problem of nurse turnover intention among nurses working in KSA is the Social Exchange Theory (Bierstedt, 1965). Social Exchange Theory

was chosen because it investigates the impact of exchanging resources, support, and recognition on organisational relationships. Social Exchange Theory emphasises that when employees perceive an imbalance in these exchanges, such as when they receive inadequate recognition or support, they may become dissatisfied and seek alternative opportunities, making it a potentially relevant framework for understanding how these factors may influence nurse turnover intention.

This theory was first described in “Exchange and Power in Social Life” by Peter M. Blau (Bierstedt, 1965). It essentially conceptualised interactions in human life as exchanges designed around social power (Bierstedt, 1965). Specifically, in terms of the workplace, Social Exchange Theory characterises the relationship among people from the perspective of “benefits” and “costs” (Ren & Ma, 2021). Figure 5.1 presents a generic diagram of how Social Exchange Theory could be applied in the setting of workplace turnover.

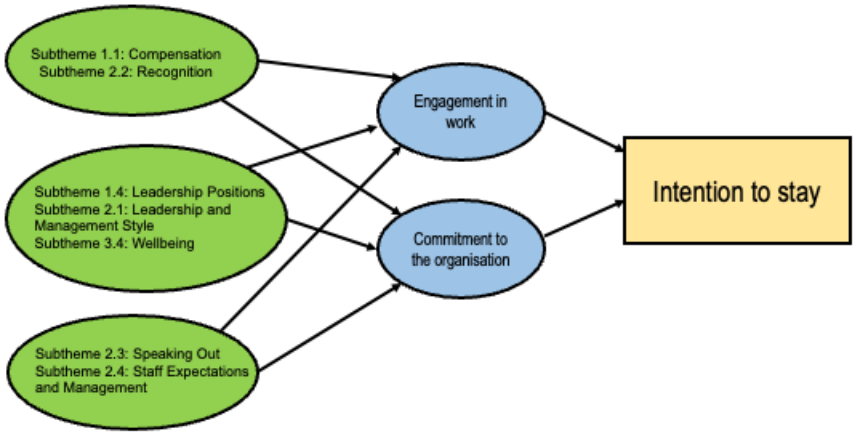
Figure 5.1. Social Exchange Theory in a Workplace Setting



As shown in Figure 5.1, Social Exchange Theory identifies theoretical relationships between costs and benefits in the workplace setting. The left side of the diagram depicts perceived benefits for the worker, which include being paid for doing work, having support from the supervisor, and experiencing clear communication at work. Because of these benefits, the worker agrees to the costs, which are engaging in work, and committing themselves to the organisation. If these benefits and costs are in balance, then theoretically, the worker has no intention to leave the workplace.

Reflecting the themes reported in the thematic findings, Figure 5.2 presents a specific version of Social Exchange Theory applied to turnover and turnover intention in nurses working in KSA.

Figure 5.2. Social Exchange Theory Applied to Nurses Working in KSA



As shown in Figure 5.2, although the costs remain the same as in the generic model, in the KSA model, the benefits are different. Recognition and compensation are particularly important for the KSA nurses as reported by both Saudi and non-Saudi nurses in the study. Also, relationships between coworkers were highlighted as very important in determining intention to stay or leave. Staff who responded positively to the leadership and management styles of their supervisors, felt they had a positive relationship with their supervisor, felt their supervisor had their wellbeing in mind, and had their expectations met by the leaders demonstrated a stronger commitment to staying in their positions. In addition, if they felt effective in managing staff and relationships, and if they felt appropriate adequate leadership positions were open and available to them. Finally, both staff and leaders felt that having teamwork, a culture that allows speaking out, and shared decision-making were benefits.

While Social Exchange Theory was useful in explaining several aspects of turnover and turnover intention among nurses working in KSA, it also has limitations in explaining all of the findings in this context. First, low salary was a main component of reasoning behind turnover and turnover intention. In Social Exchange Theory, inadequate compensation undermines the basis of exchange. While many benefits are represented in the KSA model, the findings suggest that these were not always sufficient to offset the impact of inadequate salary in this context. These benefits listed in Figure 5.2 increase engagement at work and commitment to the organisation as reported by those interviewed, these benefits cannot overcome the lack of exchange represented by the low salary, causing turnover intention and, thus turnover, to persist.

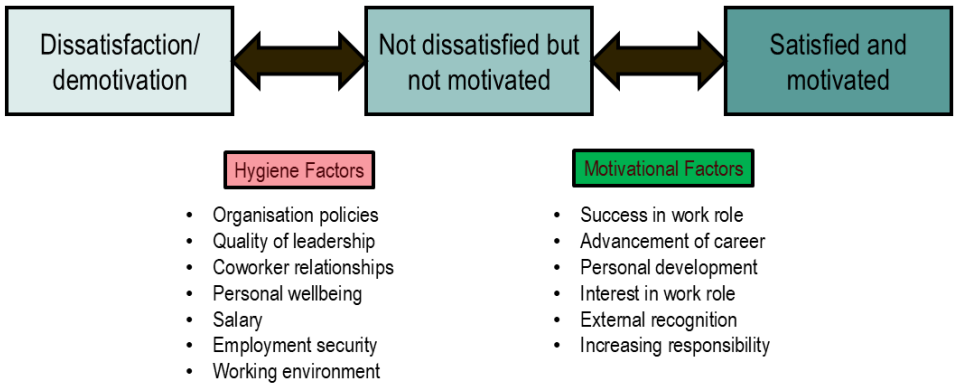
A further limitation is that Social Exchange Theory offers a more limited account for the complex interplay between different forces motivating nurses working in KSA toward turnover. Most prominently, it does not adequately take into account the institutional side of the exchange. While salary is indeed important, many other institutional factors impact non-Saudi nurses when they work as foreigners living in KSA. Because these institutional factors fall outside the primary focus of Social Exchange Theory, the theory provides only a partial explanation of turnover and turnover intention among nurses working in KSA.

5.3 Herzberg's Two-Factor Theory

While Social Exchange Theory rose to prominence in the 1960s, another theory was also gaining momentum to explain employee motivation in the workplace, namely Herzberg's Two-Factor Theory (Bierstedt, 1965; Dabscheck, 1994). The theory was originally based on a study of 203 accountants and engineers (Dabscheck, 1994). The theory is called "two-factor" because it sorts worker attitudes into two groups: "satisfiers" (which are motivational factors), and "dissatisfiers" (which are factors that demotivate workers, also originally called "hygiene") (Dabscheck, 1994). The idea is that only certain elements of the workplace could possibly serve as a hygiene element (Dabscheck, 1994; Rai et al., 2021). In their application of Herzberg's Two-Factor Theory in the nursing workplace, Rai and colleagues (2021) explain that the following factors could, if not optimal, potentially be demotivational hygiene factors: policy at the organisation, relationships among individuals in the workplace, level of job security, physical working conditions, adequacy of supervision, and salary. On the other hand, motivational factors can only serve as motivators (Dabscheck, 1994; Rai et al., 2021). In the nursing setting, Rai and colleagues (2021) suggest that motivational factors include having appropriate levels of authority and responsibility, receiving recognition for work, career advancement, opportunities to achieve, experiencing personal growth, and having interest in the job. Theoretically, workplace satisfaction could be improved by increasing the motivational factors that serve as satisfiers and ensuring the hygiene factors do not serve as dissatisfiers (Dabscheck, 1994).

Embedded within Herzberg's Two-Factor Theory is that workers are demotivated if there are hygiene issues in the workplace. Alrawahi and colleagues (2020) conducted a mixed methods study of medical laboratory professionals in Oman based on Herzberg's Two-factor Theory. They sorted the results into satisfiers and dissatisfiers, and noted that the primary dissatisfier was a lack of health and safety in the laboratory (Alrawahi et al., 2020). This underscores the importance of hygiene in the workplace setting, with hygiene extending beyond its most accessible meaning of cleanliness. The authors noted that lack of ability to gain professional status through recognition and appreciation was also a dissatisfier, and identified other dissatisfiers (Alrawahi et al., 2020). This may seem counterintuitive, as Rai and colleagues (2021) suggest that recognition can only serve as a motivator and not a hygiene element. Nevertheless, the authors concluded that the reason Herzberg's Two-Factor Theory was supported was that the primary dissatisfier was related to hygiene, which authors noted was consistent with other literature (Alrawahi et al., 2020). Figure 5.3 presents a generic depiction of Herzberg's Two-factor Theory as applied to a workplace.

Figure 5.3. Herzberg's Two-factor Theory in the Workplace



As depicted in Figure 5.3, the gradation across the top shows a continuum from dissatisfaction (associated with hygiene factors that could potentially serve as dissatisfiers) to satisfaction (associated with motivation). In nursing, hygiene factors could include organisational policies, leadership quality, coworker relationships, personal wellbeing, salary, employment security, and working environment (Dabscheck, 1994; Rai et al., 2021). On the other hand, as stated in the original model, motivational factors could include success in work role, career advancement, opportunities for personal development, interest in work being performed, external recognition, and increasing responsibility (Dabscheck, 1994; Rai et al., 2021).

Figure 5.4 presents Herzberg's Two-Factor Theory as applied specifically to turnover and turnover intention among nurses working in KSA.

Figure 5.4. Herzberg's Two-factor Theory Applied to Turnover and Turnover Intention Among Nurses Working in KSA

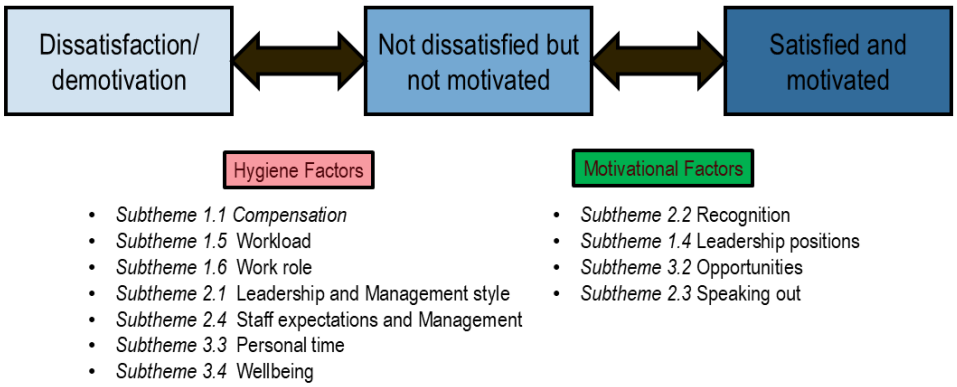


Figure 5.4 depicts specific items listed under Hygiene Factors and Motivational Factors. In terms of hygiene, issues with compensation, workload, work role, personal time, and wellbeing were primary dissatisfiers according to both staff and leaders. As captured by the model, when hygiene factors are serving as dissatisfiers, then it compromises the ability of motivational factors to motivate the worker (Dabscheck, 1994; Rai et al., 2021). Also, staff were concerned with leadership and management style, and whether their expectations were met. They also were concerned about teamwork and the interrelationships between members of the team.

On the other hand, many interviewees identified motivational factors, such as being supported by their supervisor in speaking out, and having shared decision-making with leadership. Many wanted more career development opportunities and recognition. Further, they expressed that openings for leadership opportunities would be a motivator. However, as per the model, when hygiene factors are present as demotivators, motivational factors cannot have a strong impact (Dabscheck, 1994; Rai et al., 2021).

While Herzberg's Two-Factor Theory was useful in explaining several aspects of turnover intention among nurses working in KSA, it has limitations in informing a solution in this context. Herzberg's Two-Factor Theory does not fully account for that lack of motivators actually may serve as hygiene factors (Dabscheck, 1994; Rai et al., 2021). Specifically, research has shown that when the motivational factors listed in Figure 5.4 are absent from the nursing workplace, such as recognition and opportunities for career advancement, the environment appears to contribute to burnout and turnover intention in the nursing workforce (Al Muharraq et al., 2022; Mahoney et al., 2020; Norful et al., 2023).

Herzberg's Two-Factor Theory rests on the assumption that hygiene factors can be mitigated independently of motivational factors. In reality, in the case of the nursing workplace, motivators may, in practice, overlap with or be influenced by hygiene factors. In general, the hygiene factors for nurses working in KSA are based largely on low salaries leading to staffing shortages and an excessive workload. Other issues, such as lack of personal time and wellbeing are caused by these primary issues. Because of resource

constraints, limited attention may be given to promoting motivational factors. If efforts are made to improve the hygiene factors, it may automatically improve the motivational factors. For example, creating leadership positions to alleviate staffing and workload issues would not only address hygiene but would also create motivations through availability of leadership positions and opportunities.

Because of the complexity of turnover and turnover intention among nurses working in KSA, Herzberg's Two-Factor Theory provides a useful framework but does not, on its own, provide sufficient guidance for developing a strategy. The theory does not take into account how the hygiene factors and motivational factors are related, and how they could be manipulated at the institutional level. Therefore, the Herzberg Two-Factor Theory provides only a partial explanation of turnover intention in this context.

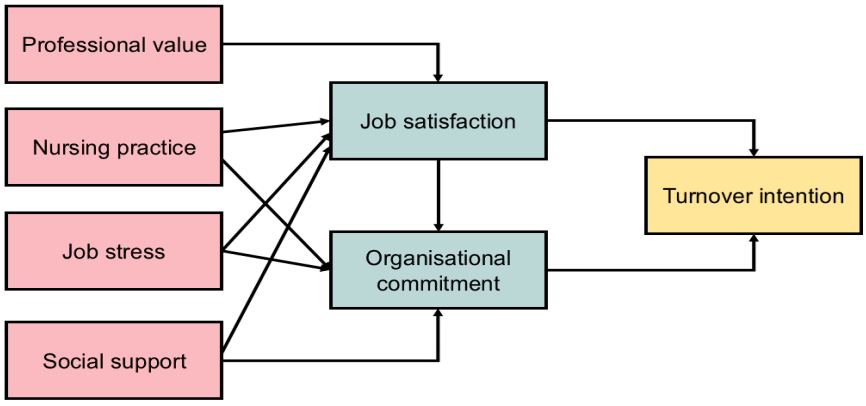
5.4 Price's Model

Both Social Exchange Theory and Herzberg's Two-Factor Theory were developed early in the evolution of turnover theory and are consequently relatively limited in their conceptualisation (Bierstedt, 1965; Dabscheck, 1994). In recognition of their limitations, Price developed a more complex theoretical framework to explain turnover (Gannon, 1978). Price's model is somewhat generic, with the assumption that it will need to be interpreted into specific workplace contexts (Gannon, 1978). Importantly, Price defined the concepts of "determinants" and "correlates" of turnover (Gannon, 1978). Determinants of turnover are factors in a workplace setting that actually cause turnover, while correlates

of turnover are factors that merely indicate that turnover is likely to occur, but are not a direct cause (Gannon, 1978). Of course, some determinants are stronger than others in causing turnover, so an entire model needs to be assembled to consider the interrelationships between factors (Gannon, 1978).

Specifically, Zhang and colleagues (2021) applied Price's Model to a study of nursing turnover intention in secondary hospitals in China. They produced a general model of nursing turnover reproduced in Figure 5.5.

Figure 5.5. Price's Model of Nursing Turnover



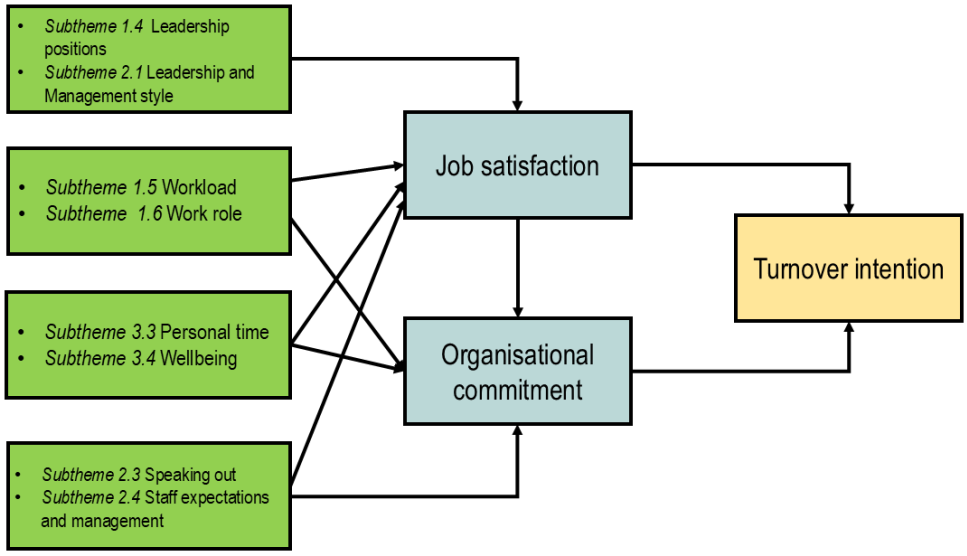
Note: Based on research by Zhang and colleagues (2021).

With respect to Figure 5.5, the authors noted that in Price's original model, factors influencing job satisfaction and organisational commitment were either individual (including personal aspects such as level of training and job involvement), structural (having to do with institutional influences like autonomy, job stress, and pay), or

environmental (including how individuals interrelate) (Zhang et al., 2021). This explains how the authors characterised the four determinants of turnover intention listed on the left side of Figure 5.5, which are professional value, nursing practice, job stress, and social support.

To apply Price's model to the issue of turnover and turnover intention in nurses working in KSA, Figure 5.5 was modified and is presented as Figure 5.6.

Figure 5.6. Price's Model of Nursing Turnover Applied to KSA



As shown in Figure 5.6, four boxes of determinants on the left side of the figure were identified through the research. As with the application of the model by Zhang and colleagues (2021), the first set of determinants relates to professional value, and includes the availability of leadership positions, supervisor management and leadership styles. The

second set of determinants covers the practice of nursing, and includes issues surrounding workload, and role being played at work. The third set of determinants relates to job stress, and include feeling the need for more personal time, as well as attention being paid to personal wellbeing. The final set of determinants concerns the ability to speak out about issues, levels of teamwork, and how well staff are managed.

In applying Price's model, having identified determinants, the next step is to understand which determinants have the greatest influence (Gannon, 1978; Zhang et al., 2021). Theoretically, if the determinants with the greatest impact are then adjusted, turnover intention would theoretically decrease. At first glance, Price's model appears efficient, in that once the main drivers are identified, they could theoretically be addressed, potentially reducing turnover intention. However, in the case of nurses working in KSA, because the determinants are highly interrelated, applying the model becomes more challenging. Many of the determinants listed in Figure 5.6 result from a few primary causes. Low salary and lack of positions (including leadership positions) are main determinants of turnover intention but also impact upon other determinants of turnover, such as staffing shortages, high workloads and lack of personal time.

This challenge of dealing with interrelated, hierarchical determinants is a downside to using Price's model. Zhang and colleagues (2021) resolved this through their research study design. The authors collected quantitative data from 594 nurses and used structural

equation modelling to attempt to understand the relationships between the different determinants using statistics (Zhang et al., 2021).

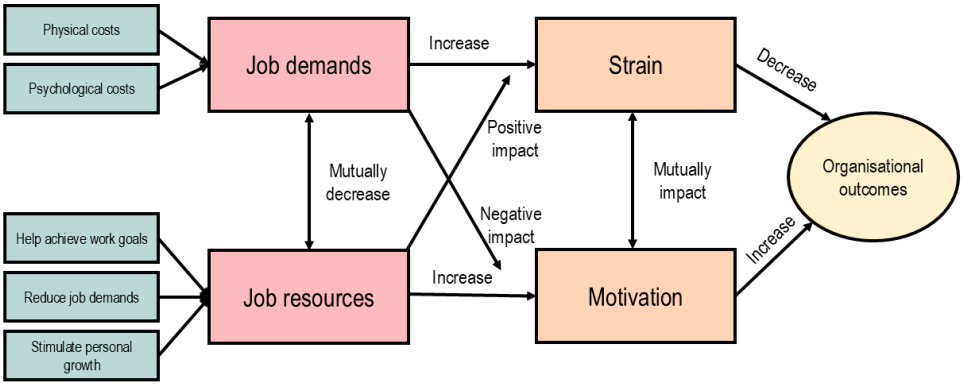
As this study is qualitative, statistical modelling of determinants was not appropriate. However, it was possible to view the themes presented in Figure 4.1 as determinants, and consider the relative importance of each theme, and how each relates to the other themes. While this type of inquiry would be necessary to develop an appropriate model to explain turnover and turnover intention in nurses working in KSA, it would be challenging to use Price's model as a framework because it does not explicitly account for these interrelationships or their hierarchical nature. Therefore, although Price's model can be applied to the challenge of turnover and turnover intention among nurses working in KSA, it provides only a partial framework for interpreting the qualitative findings because it does not explicitly acknowledge the interrelationships between, or the relative importance of, determinants. These features may limit the usefulness of Price's model in guiding policy development in this setting.

5.5 Job Demands-Resources (JD-R) Model

A subsequent theoretical framework was proposed to explain organisational outcomes in relation to the balance between job demands and employee resources; this theory was named the Job Demands-Resources (JD-R) model (Bakker & Demerouti, 2007). Like Price's model, the JD-R model assumes specific risk factors are associated with particular jobs, but all these factors can be classified into either of two general categories: job

demands or job resources (Bakker & Demerouti, 2007). Job demands refer to all aspects of the job that require sustained effort and skills, both physical and psychological (Bakker & Demerouti, 2007). Job demands are associated with particular costs for the worker, such as facing pressure at work, or having a high workload (Bakker & Demerouti, 2007). Job resources refer to aspects of the job associated with either functionally achieving work goals, reducing job demands associated with worker costs, or stimulating personal growth (Bakker & Demerouti, 2007). A general model of the JD-R is presented in Figure 5.7.

Figure 5.7. General JD-R Model



In Figure 5.7, the two red boxes present the main components of the model, which are the job demands and job resources. The left side of the figure includes the general inputs for both components. Job demands represent the costs the worker experiences, and job resources include supports that help the worker meet the job demands. The figure shows how the model conceptualises the relationships between job demands and job resources, and how they impact worker strain and motivation to ultimately influence organisational outcomes.

As depicted in Figure 5.7, job demands and job resources are constantly in tension. Job demands increase worker strain, while job resources reduce strain by supporting motivation. Job resources have a positive impact on strain, and job demands have a negative impact on motivation. Ultimately, motivation needs to be high in order to support positive organisational outcomes, and strain should be low, so it does not negatively impact organisational outcomes. In general, the model indicates that it is important to strategically manipulate the job demands and job resources so as to produce the highest motivation and the lowest strain in promoting improved organisational outcomes.

How the model is actually applied depends upon the setting. Ramaci and colleagues (2024) used the JD-R model to study perceived organisational support (POS) in Italian oncology nurses. They focused mainly on job demands rather than job resources, and found that high job demands appeared to contribute to burnout, low self-esteem, and job dissatisfaction (Ramaci et al., 2024). These demands all negatively impacted POS, but because the authors did not consider job resources, the main conclusion from the results was the need to reduce job demands in order to increase POS (Ramaci et al., 2024).

As with the other theories, the JD-R can be applied to turnover intention in nurses working in KSA (see Figure 5.8).

Figure 5.8. JD-R Model for Turnover Intention for Nurses Working in KSA

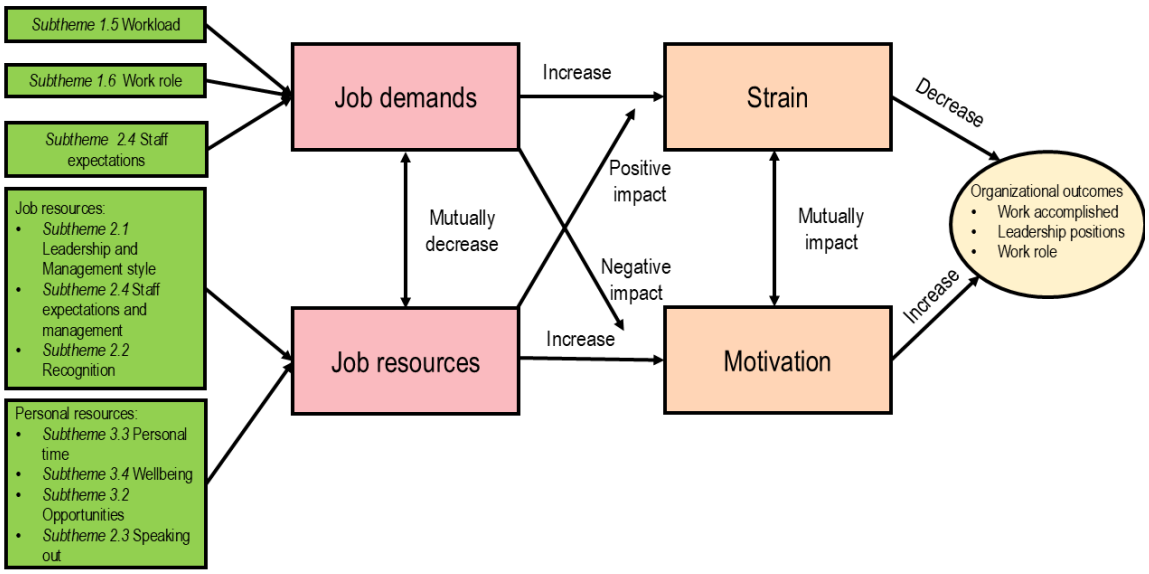


Figure 5.8 adapts the general JD-R model to turnover intention among nurses working in KSA. The job demands that exert cost on the worker include workload, work role, and staff expectations, which are listed on the left side of the figure. The job resources are divided into institutional as well as personal resources and are also listed on the left side of the figure. These influences proceed from left to right through the figure to the organisational outcomes, which are mainly work accomplished, the performance and success of those in leadership positions, and adequate performance of staff in their work roles.

The JD-R model is more complex than Herzberg's Two-Factor Theory but also has some limitations when applied to this context. Like Herzberg's Two-factor Theory, the components of turnover are conceptualised into two general categories. In Herzberg's Two-factor Theory, they are hygiene (which can potentially serve as dissatisfiers or demotivators) and satisfiers which can only serve as motivators (Alrawahi et al., 2020; Dabscheck, 1994; Rai et al., 2021), and in the JD-R, they are job demands and job resources (Bakker & Demerouti, 2007). Although the JD-R posits a more complex relationship between the two categories than is proposed in Herzberg's Two-factor Theory, ultimately, both theories lead to a strategy of increasing one category and decreasing another in order to positively impact turnover and turnover intention. In Herzberg's Two-factor Theory, decreasing hygiene issues and increasing satisfiers theoretically should lead to reduced turnover intention, and in the JD-R, increasing job resources and decreasing job demands theoretically should similarly lead to reduced turnover intention (Alrawahi et al., 2020; Bakker & Demerouti, 2007; Dabscheck, 1994).

Kaiser and colleagues (2020) applied the JD-R model to evaluate work-related outcomes among Norwegian healthcare workers. Although in general, the job demands and job resources were classified as in the original theory, authors found that lack of job resources showed up in their models as job demands - meaning that lack of resources decreases engagement (Kaiser et al., 2020). This issue of "lack of motivators" expressed by participants as "inadequately addressed hygiene factors" is likely the reason why Herzberg's Two-factor Theory failed to illuminate a potential strategy when applied

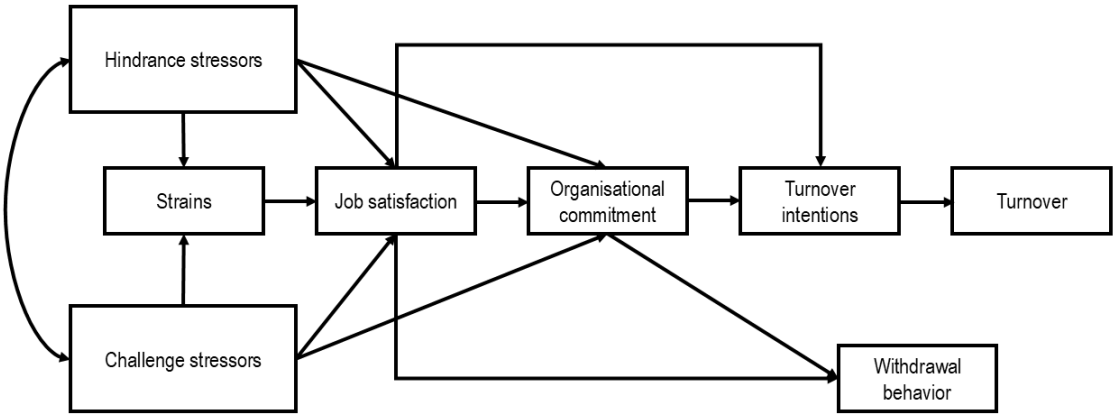
specifically to turnover intention among nurses working in KSA (Figure 5.4). The trade off between hygiene aspects of the job and satisfiers means that increasing satisfiers would automatically decrease many hygiene aspects, and vice versa. Similarly, the JD-R does not clearly yield a strategy to positively impact turnover intention in the nursing workforce, because lack of job resources may be experienced as increased job demands. If it were possible to reduce job demands independently of increasing job resources, such a strategy might already have been implemented. However, in reality, job demands and job resources are related, as demonstrated in relation to Norwegian healthcare professionals (Kaiser et al., 2020). Reduced job demands, including workload, are required in order to increase job resources such as personal time and wellbeing. Therefore, while it was possible to apply the JD-R model to turnover intention among nurses working in KSA, as with Herzberg's Two-Factor Theory, the model provides only partial guidance for addressing the issue in this context.

5.6 Evaluation of Additional Models from the Literature

Podsakoff and colleagues (2007) developed a generic model outside of nursing to explain turnover behaviour based upon a two-dimensional work stressor framework. The authors sought to explain inconsistencies in previous research with respect to relationships between different stressors (Podsakoff et al., 2007). They conducted a meta-analysis of 183 articles, and their resultant model was highly theoretical, focusing on the roles of challenge-related stressors and hindrance-related stressors (Podsakoff et al., 2007). They defined challenge-related stressors as stressors in the workplace that create a positive challenge and an

opportunity for professional development, while hindrance-related stressors were defined as stressors in the workplace that pose obstacles to personal and career growth (Podsakoff et al., 2007). Figure 5.9 provides a high-level summary of the model developed from the results of their analysis (Podsakoff et al., 2007).

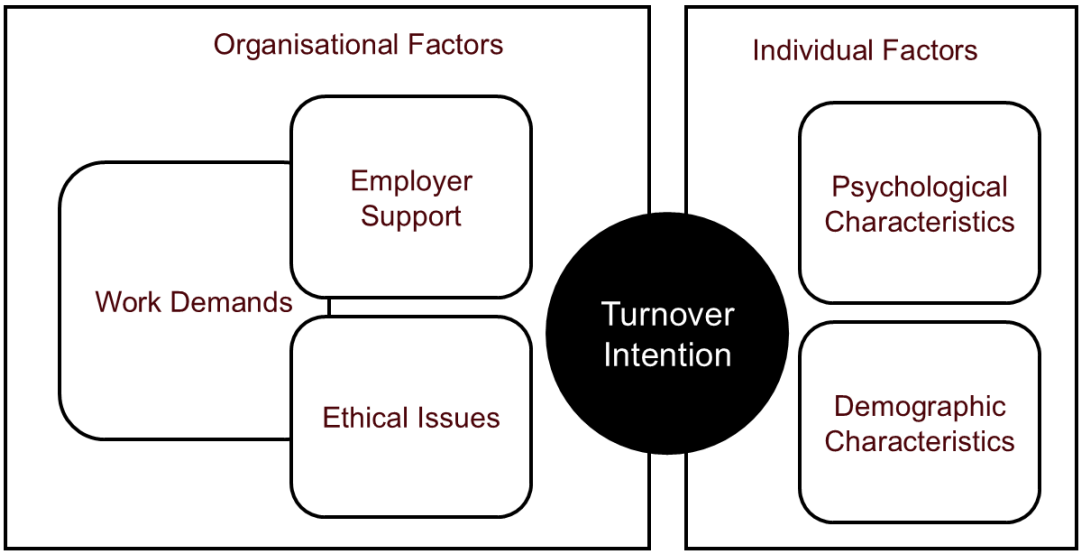
Figure 5.9. Conceptual Model About Challenge and Hindrance Stressor Relationships in Job Turnover. Adapted from Podsakoff and colleagues (2007)



As shown in Figure 5.9, both challenge and hindrance stressors impact strains, job satisfaction, and organisational commitment (Podsakoff et al., 2007). These impacts consequentially influence turnover intention and subsequent turnover, as well as withdrawal behaviour (Podsakoff et al., 2007).

More recently, Tolksdorf and colleagues (2022) completed a systematic review of turnover intention among nurses during the COVID-19 epidemic. Their synthesis included 19 articles on the topic from which they extracted themes (Tolksdorf et al., 2022). They assembled these themes into a model; a simplified version of this model is presented in Figure 5.10.

Figure 5.10. Simplified Model of Nurse Turnover Intention During the COVID-19 Epidemic. Adapted from Tolksdorf and colleagues (2022).



As shown in Figure 5.10, their model summarises the influences on turnover intention into organisational and individual factors. Among the organisational factors are work demands, employer support, and ethical issues. Among the individual factors are psychological and demographic characteristics (Tolksdorf et al., 2022).

These models provide only a partial explanation of turnover intention among nurses working in KSA for several reasons. First, the model by Podsakoff and colleagues (2007) which focuses on hindrance and challenge stressors, identifies stressors that do not align with those seen in the KSA context. Importantly, the different experiences of Saudi and non-Saudi nurses are not acknowledged in this model, while the current research shows that the difference in experiences of work between these two categories of workers in KSA is an important source of stressors (Podsakoff et al., 2007). For example, the pressures placed on less-experienced Saudi nurses to rise to leadership, as well as the stress that comes from occupational instability experienced by non-Saudi nurses are not explicitly captured in this model (Podsakoff et al., 2007).

Secondly, this model considered only three main sources of stressors: strains, job satisfaction, and organisational commitment (Podsakoff et al., 2007). The current research suggests that compensation was one of the most important stressors in the KSA nursing workplace and exerts an important influence on turnover intention. Several other factors identified in the current research are not explicitly captured in this model. This is likely due to the fact that the model was developed long before the development of complex and nuanced theories and research on the topic. Additionally, global occupational stressors were quite different in 2007 than at present, especially when considering the advancement of technology such as social media. Hence, applying an earlier and more general model to a current, context-specific issue may be limited in its usefulness.

With respect to the model to explain turnover intention among nurses working during COVID-19, again, the model primarily identifies work demands, employer support, ethical issues, and individual psychological and demographic characteristics (Tolksdorf et al., 2022). In the context of COVID-19, ethical issues indeed imposed much stress on the nursing workforce; however, the current research did not identify ethical issues in general among stressors in the Saudi nursing workforce (Tolksdorf et al., 2022). Further, the current research shows that the main demographic characteristics impacting the Saudi nursing workplace relate to Saudi and non-Saudi nationality, and this remains unacknowledged in this general model as presented (Tolksdorf et al., 2022). Also, the current study did not recognise a strong role for psychological characteristics in turnover intention among nurses working in KSA.

In summary, both models appear to have limited applicability when applied to turnover intention among contemporary nurses working in KSA. The 2007 model does not capture several important influences, even though subsequently found to be important in the nursing literature (Podsakoff et al., 2007). In contrast, the model explaining nursing turnover intention during the COVID-19 epidemic appears too specific to help explain turnover intention among contemporary nurses working outside of a pandemic (Tolksdorf et al., 2022).

5.7 Limitations of Existing Models for Explaining Nurse Turnover in KSA

This section justifies the need for a novel model to explain turnover intention among nurses working in KSA in order to meet the research aims and objectives. While the models

considered capture certain aspects of nurse turnover and turnover intention, particularly in relation to compensation, workload, and supervisor support, these contributions are partial. Rather than evaluating each model in isolation, this section synthesises the limitations across the considered models using data-driven reasoning and explains why these models offer only a partial explanation of the findings of this study.

Across the models considered, including Social Exchange Theory, Price's Model, and the JD-R Model, a key shared limitation is the reliance on broad conceptual categories such as "job satisfaction", "organisational commitment", or "engagement in work". As shown in Figures 5.1 and 5.5, these models reduce numerous workplace dynamics to these higher-level categories, despite the fact that such constructs did not arise as themes or subthemes in this analysis (see Figure 4.1). Instead, the findings of this study demonstrate that turnover intention among nurses working in KSA is shaped by specific and observable factors, including Recognition, Staff Expectations and Management, Leadership and Management Style, and Leadership Positions, as evidenced by verbatim extracts throughout Chapter 4. This reliance on broad conceptual categories also means that both Social Exchange Theory and Price's Model are limited in generating context-specific recommendations, as their frameworks are too broad to identify the precise points at which intervention would be most effective.

Social Exchange Theory remains useful for highlighting the role of recognition and support in shaping engagement, though it is further limited in that it assumes exchange operates on equal terms between worker and employer. The findings of this study suggest that non-

Saudi nurses experienced structurally unequal exchanges shaped by nationality rather than performance, with differential access to benefits and leadership opportunities. The theory also does not capture family separation as a driver of turnover intention, as this is a structural condition shaped by national policy rather than an organisational exchange. Finally, the theory does not explain why nurse leaders remained in acting roles despite clearly imbalanced exchanges, suggesting that professional obligation and limited alternatives shaped retention in ways that exchange logic cannot capture.

A further limitation shared across models such as Social Exchange Theory and Price's Model is their inability to account for the interrelationships between institutional, leadership, and personal-level factors. As described in Chapter 4 under Cross-Theme Synthesis, institutional decisions, such as compensation structures or the allocation of leadership positions, directly shape leadership practices and, in turn, influence personal experiences such as workload, personal time, and wellbeing. For example, lack of compensation at the institutional level complicates the ability of leaders to maintain staff relationships, as evidenced by verbatim extracts by Ahmed and Shatha. Similarly, the awarding of leadership positions primarily to Saudis creates diversity issues and impacts teamwork and leadership effectiveness, as evidenced by verbatim extracts under the Diversity Issues, Staff Expectations and Management, and Leadership and Management Style subthemes. These interconnected dynamics are not adequately represented in current models, which tend to treat factors as independent rather than structurally related.

Price's Model remains valuable for distinguishing determinants from correlates of turnover, though a further limitation is its assumption that determinants operate uniformly across all workers. The findings of this study suggest that determinants such as family-related pressures, lifestyle adjustment, and access to leadership opportunities shaped turnover intention differently for Saudi and non-Saudi nurses. Price's Model provides no mechanism for capturing these nationality-based variations, limiting its applicability in the multinational workforce context of KFAFH. It is also worth noting that Price's Model was originally developed to explain actual turnover rather than turnover intention. Since this study focuses on turnover intention as its primary outcome, applying Price's Model requires an additional inferential step that the model itself does not provide, further limiting its direct applicability to the aims of this research.

The JD-R Model usefully separates workplace conditions into demands and resources, though in this context these factors operate simultaneously and are structurally interdependent. As shown in Chapter 4, workload and staffing are not separate categories, but rather interconnected institutional conditions. Verbatim extracts from Maram, Kavita, Noura, Rachna, Reem, and Maria demonstrate that insufficient staffing increases workload, while increased staffing reduces workload. The JD-R Model does not capture conditions that fall outside the job demands/resources framework. Family separation among non-Saudi nurses is neither a job demand nor a job resource, but a structural condition shaped by national policy, which the model has no mechanism for capturing. The model also assumes that demands and resources operate uniformly across all workers. The findings

suggest that Saudi and non-Saudi nurses experienced different demands and had access to different resources, with non-Saudi nurses facing additional pressures related to lifestyle and career limitations, while Saudi nurses had preferential access to leadership positions. Therefore, the model provides no framework for capturing these nationality-based asymmetries.

The experience of nurse leaders in acting roles further exposes a gap in the model. These leaders carried full leadership demands without the corresponding resources of formal authority or recognition. Yet participants described remaining due to professional obligation rather than disengaging, suggesting that factors beyond the demands/resources balance shaped retention decisions in ways the model cannot explain.

Another shared limitation across models is the failure to account for key drivers identified in this study, particularly those related to leadership and workplace relationships. Models such as Social Exchange Theory do not fully account for the importance of teamwork, staff relationships, and leadership roles in shaping turnover intention and retention. This is evidenced by verbatim extracts from Tala, Reem, Aurora, Maria, Christina, Ahmed, Alma, Shatha, and Jasmin under the subthemes Recognition, Staff Expectations and Management, Leadership Positions, and Leadership and Management Style in Chapter 4. These factors were central to participants' experiences yet are either underdeveloped or absent in current models.

Herzberg's Two-Factor Theory remains useful for identifying broad categories of satisfaction and dissatisfaction, though it is further limited by the instability of its

underlying assumptions in this context. In the context of nurses working in KSA, factors such as Compensation and Workload function simultaneously as both hygiene factors and motivators. As evidenced by verbatim extracts from Christina, Shatha, Ahmed, Noura, Maria, Reem, and Rachna in Chapter 4, dissatisfaction with compensation and workload increases turnover intention, while improvements in these same factors increase retention. This indicates that motivators are effectively the inverse of hygiene factors in this context, which contradicts the structural separation assumed in Herzberg's model and limits its applicability. This overlap is particularly significant because it means the model offers no clear intervention point, since addressing a hygiene factor simultaneously changes the motivational landscape, making it difficult to apply Herzberg's framework in a targeted way in this context.

Herzberg's Two-Factor Theory also does not fully account for the fact that Saudi and non-Saudi nurses experienced fundamentally different drivers of dissatisfaction. Factors such as family separation and lifestyle adjustment, which were significant for non-Saudi nurses, do not fit within either hygiene or motivational categories as they are shaped by national policy rather than organisational practice, limiting the theory's applicability in a multinational workforce. Furthermore, the theory cannot explain the experience of nurse leaders who held full responsibility without formal recognition or authority. Under Herzberg's model, responsibility functions as a motivator, yet when present without recognition or formal appointment, its motivational potential is undermined, contradicting the model's core assumption.

The model by Podsakoff and colleagues (2007) is useful for capturing challenge and hindrance stressors broadly, though it is limited because it does not account for variation in stressors across different groups within the workforce. As demonstrated in Chapter 4, non-Saudi nurses experienced unique stressors related to separation from family, as evidenced by verbatim extracts from Mohammed and Shatha under the Families and Personal Time subthemes. At the same time, Saudi nurses and leaders experience challenges related to training and experience, as evidenced by Katie's verbatim extract under the Diversity Issues subtheme. Because the model does not differentiate stressors according to nationality and workforce structure, it does not fully explain turnover intention among nurses working in KSA.

A further limitation of Podsakoff's model is the limited consideration of leadership-level factors. Leadership emerged as one of the three core themes in this study, yet the model makes no provision for how leadership practices shape stressor experiences. This gap is particularly significant given the central role that Leadership and Management Style, Recognition, and Speaking Out played in shaping turnover intention at KFAFH.

The COVID-19 model by Tolksdorf and colleagues (2022) is useful for distinguishing organisational from individual factors, though it is limited in scope, as it focuses only on these without accounting for leadership-level drivers. However, as demonstrated in Chapter 4 through verbatim extracts from Christina, Ahmed, Alma, Shatha, Maria, Jasmin, Aurora, Katie, Omar, Rana, and Lama, leadership factors play a central role in shaping turnover intention.

Tolksdorf model (2022) also does not fully capture the experience of non-Saudi nurses, for whom family separation and lifestyle adjustment were significant drivers of turnover intention. These factors are shaped by national policy rather than COVID-19 conditions and fall outside the model's organisational and individual factor categories entirely.

Finally, a further limitation shared across all considered models is the lack of guidance towards evidence-based retention strategies. While these models identify general relationships between variables, they do not provide a clear framework for intervention. This is particularly important given the second aim of this thesis, which is to develop evidence-based retention strategies for nurses working in KSA.

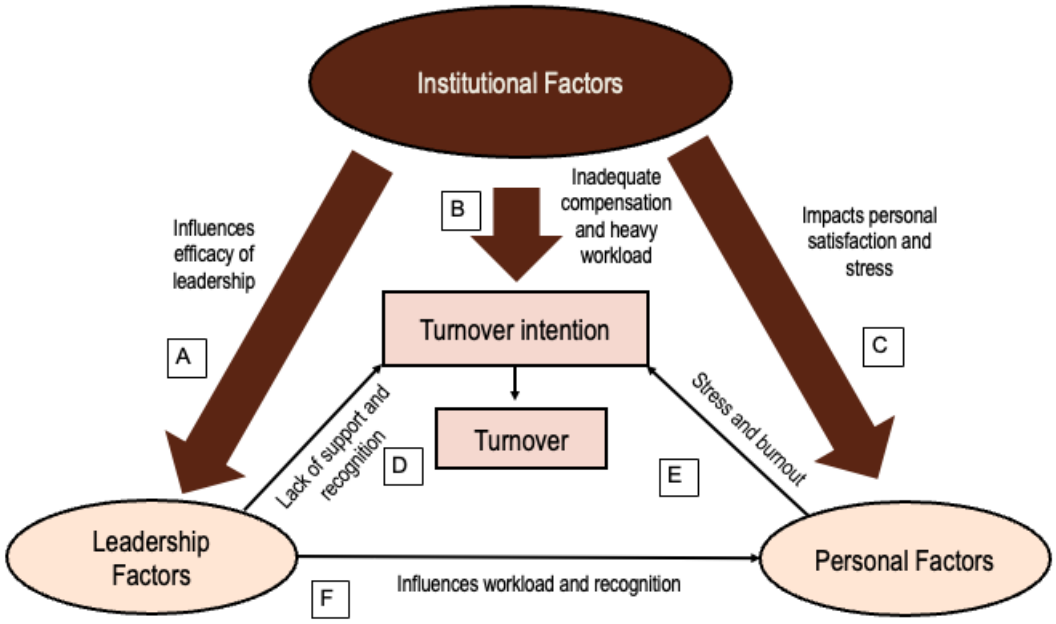
These limitations suggest that the current models provide only a partial explanation of turnover intention among nurses working in KSA and support the need for a novel, context-specific model that captures the structural, relational, and contextual dynamics identified in this study.

5.8 Novel Model for KSA

Across the models considered, several shared limitations were identified. Each of the models reviewed either treats factors of turnover intention as operating independently of one another or does not explicitly capture their interrelationships and hierarchical structure within the KSA context. None of the models reviewed provided a sufficiently clear and context-specific mechanism for capturing these conditions in a way that could generate actionable guidance. A novel, KSA-centric model was therefore required.

As revealed in the thematic findings, the main factors influencing turnover intention among nurses working in KSA were institutional. The hierarchical structure of the model is grounded in the cross-theme synthesis presented in Section 4.8, where the analytical relationships between Institutional, Leadership, and Personal Factors demonstrated that institutional conditions consistently set the parameters within which leadership was enacted, and personal experiences emerged. This hierarchical ordering therefore arose from the data itself rather than being imposed externally. Figure 5.11 provides a KSA-centric model for turnover and turnover intention in nurses working in KSA that overcomes the weaknesses in the models applied previously.

Figure 5.11. KSA-centric Model for Turnover and Turnover Intention in Nurses Working in KSA



Note: The A–F labels are visual reference markers indicating the position of subthemes within the model pathways and do not represent an additional analytical categorisation. Please refer to themes and subthemes described in Chapter 4. *A* refers to these subthemes under the theme Institutional Factors: Leadership Positions and Diversity Issues. *B* refers to the subthemes under the theme Institutional Factors: Compensation, Work Role, and Workload. *C* refers to the subtheme under the theme Institutional Factors: Families. *D* refers to the subthemes under the theme Leadership Factors: Recognition, Staff Expectations and Management. *E* refers to these subthemes under the theme Personal Factors: Lifestyle, Opportunities, Personal Time, and Wellbeing. *F* refers to these

subthemes under the theme Leadership Factors: Leadership and Management Style and Speaking Out.

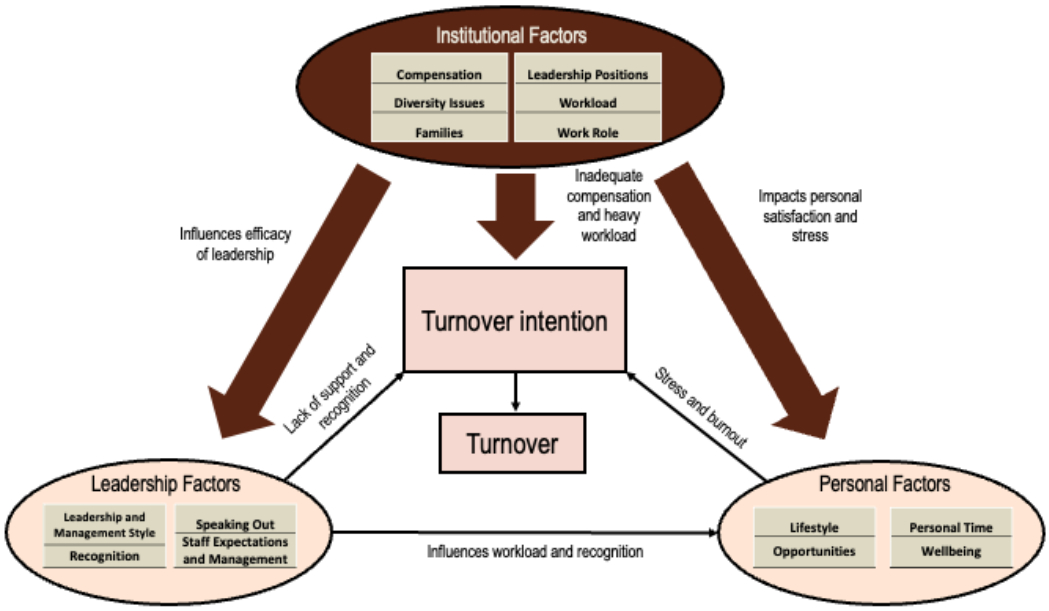
As shown in Figure 5.11, institutional factors play a major role in the KSA-centric model. The model illustrates a hierarchical mechanism in which institutional factors shape leadership conditions, which in turn influence personal wellbeing and stress, ultimately contributing to turnover intention. Institutional factors strongly and directly impact turnover intention through mechanisms such as inadequate compensation and excessive workload, as shown in the centre of the model. Institutional factors also impact both leadership and personal factors in ways that lead to increased turnover intention. Poor leadership at the institutional level negatively impacts leaders in all of their roles (including ward leadership), and can increase leadership-associated factors of turnover intention, such as lack of support and recognition for both nursing leaders and staff. Stress on nurse leadership can lead to increased workload and lack of recognition of staff, which impacts personal factors of turnover intention, as seen in the lower right area of the model. As shown on the right side of the model, institutional factors have a very strong influence on personal satisfaction and stress, which impacts personal factors of turnover intention. The personal factors are seen mainly as stress and burnout.

The model in Figure 5.11 addresses the need to recognise that the primary factors influencing turnover intention operate at the institutional level. The model makes it clear that intervening on leadership factors or personal factors alone are unlikely to be sufficient

at impacting turnover intention among KSA nurses. Solutions will have to be implemented that first and foremost address the institutional factors influencing turnover intention (indicated by arrows in Figure 5.11) to primarily target leadership quality, compensation, workload, and personal satisfaction, which can be improved as a direct result. Focusing the interventions along the institutional level will increase the likelihood of intervention success.

Figure 5.11 presents the overall structure and interaction between these themes. Figure 5.12 was included to show the subthemes under each main theme, to make it clear how the model was built from the findings.

Figure 5.12. Subthemes Integrated Within the Novel Model for Turnover and Turnover Intention in Nurses Working in KSA



5.9 Model Validation

This section compares the novel model against the considered models using the criteria of scope, hierarchy, cultural fit, and explanatory power. Rather than evaluating each model in isolation, this section evaluates the novel model against the shared limitations identified across the chosen models. These four criteria were selected to correspond to the limitations of the models evaluated in Section 5.7, allowing for a systematic and evidence-based evaluation of the novel model's contribution.

In terms of scope, models such as Social Exchange Theory, Price's Model, and the JD-R Model are limited in that they focus on a restricted set of factors or categorise workplace

dynamics into broad conceptual categories such as job satisfaction, organisational commitment, or job demands and job resources. Similarly, the Podsakoff Model and the COVID-19 Model are limited in scope in that they focus on hindrance and challenge stressors, and organisational and individual factors respectively, neither of which mapped onto the full complexity of themes and subthemes identified in this research. In contrast, the novel model structurally integrates the full diversity of themes and subthemes identified in this study, including Institutional, Leadership, and Personal Factors. In this way, it captures factors of turnover intention that were evidenced in Chapter 4 but not fully represented in alternative models, particularly those related to recognition, leadership roles, staff relationships, and workplace expectations.

With respect to hierarchy, familiar models, including Herzberg's Two-Factor Theory, Price's Model, and the COVID-19 model, tend to treat drivers of turnover intention as operating at a single level or as independent categories. Social Exchange Theory similarly presents costs and benefits as operating at the same level, without recognising that institutional-level factors act as primary drivers that shape the conditions under which leadership and personal-level factors operate. In contrast, the novel model illustrates that the primary factors originate at the institutional level and flow through leadership factors to influence personal-level outcomes. This hierarchical structuring reflects the relationships identified in Chapter 4 under Cross-Theme Synthesis, where institutional conditions shape leadership practices and, in turn, affect individual experiences such as workload, personal time, and wellbeing. The novel model therefore addresses the

previously identified limitation of current models in failing to represent the structural interdependence of these factors.

In terms of cultural fit, models such as the JD-R Model and the Podsakoff Model do not fully account for differences in experiences across workforce groups, particularly between Saudi and non-Saudi nurses or between staff and leadership. As demonstrated in Chapter 4, turnover intention is shaped by factors that vary according to nationality, experience, and role, including family separation, training disparities, and leadership expectations. Furthermore, Herzberg's Two-Factor Theory assumes a clear structural separation between hygiene factors and motivators, which does not hold in the KSA context, where the same factors simultaneously function as both. This reflects a context-specific dynamic that the theory was not designed to accommodate. For example, factors such as family separation, lifestyle adjustment, and differential access to leadership opportunities shaped turnover intention among non-Saudi nurses, while acting leadership roles created distinct pressures for nurse leaders. Contemporary models do not provide a clear framework for capturing these distinctions simultaneously. While the novel model was not designed to separate these groups, the distinctions identified in Chapter 4 informed the development of the recommendations presented in Chapter 6.

With respect to explanatory power, current models are limited in that they do not provide clear guidance for intervention. As discussed in Section 5.7, models such as Social Exchange Theory, Herzberg's Two-Factor Theory, and the JD-R Model identify general relationships between variables but do not indicate where intervention should take place.

The COVID-19 model further weakens explanatory power by omitting leadership-level drivers, meaning it does not fully capture one of the three core themes identified in this study and is therefore particularly limited in the KSA nursing context. The novel model addresses this limitation by demonstrating that meaningful intervention must begin at the institutional level in order to influence leadership practices and personal outcomes. By identifying the institutional level as the primary point of influence, the model provides a clearer framework for developing evidence-based retention strategies. Unlike alternative models, which identify relationships between variables without specifying where intervention should be directed, the novel model provides a directional framework that positions institutional factors as the primary lever for change, offering a practical basis for developing retention strategies in the KSA context.

Collectively, these comparisons demonstrate that the novel model addresses the key limitations identified across chosen models in terms of scope, hierarchy, cultural fit, and explanatory power. As a result, it provides a more comprehensive and contextually appropriate framework for explaining turnover intention among nurses working in KSA.

5.10 Applying the Novel Model to its Source Data

As the model was developed from the empirical findings, the relationships between levels are illustrated in Table 5.1. The table links illustrative subthemes to their corresponding model levels and shows the hierarchical and cross-level influences identified in the data.

Table 5.1. Structural Mapping of Subthemes to Model Levels and Hierarchical Relationships

Subtheme	Model Level	Influence on Other Levels	Verbatim Evidence	Demonstration of Hierarchy / Dependency
Leadership Positions	Institutional	Impacts leadership efficacy	*"If you are a leader, you need full authority for your job." [Omar, Saudi leader]*	Institutional Factors limit leadership autonomy, demonstrating Institutional → Leadership dependency
Compensation	Institutional	Contributes to loss of motivation and turnover intention	*"Benefits and salaries. If we are receiving an amount that we don't see as compensating enough for our kind of work, then we lose this kind of motivation to continue in our job." [Christina, non-Saudi staff]*	Institutional compensation structures appeared to undermine personal motivation and contribute to turnover intention, demonstrating Institutional → Personal dependency.
Workload	Institutional	Directly contributes to turnover intention	*"Sometimes we are [experiencing] more turnover because [there are] more patient [in] one day. The staff maybe they will receive two*	Institutional workload intensity contributed to turnover intention, demonstrating a direct pathway from Institutional

			three labour patient. It's difficult." [Kavita, non-Saudi staff]	Factors to turnover intention
Recognition	Leadership	Impacts nurses' satisfaction and turnover intention	*"Leaders that did not support staff also contribute to increased likelihood of turnover. Assurance, it's the only thing I need. I need them to recognise the work I do." [Tala, non-Saudi leader]*	Absence of recognition impacted nurses motivation and strengthened turnover intention, demonstrating Leadership → Personal dependency
Leadership and Management Style	Leadership	Impacts personal satisfaction and turnover intention	*"The leader, if she is not listening or he is not listening to the staff, like they have complaints or anything, if you don't want to listen, the staff will leave." [Tala, non-Saudi leader]*	Leadership behaviour appeared to influence personal factors, demonstrating Leadership → Personal dependency
Staff Expectations and Management	Leadership (constrained by institutional)	Interacts with personal stress and satisfaction	*"But if the teamwork fails, since we're doing procedural work, then we feel like we are in burnout and stress out, which make us think to move to different areas or even move to*	Demonstrates how leadership factors contributed to personal-level outcomes such as stress and burnout, which in turn contributed to turnover intention.

			other hospital." [Christina, non-Saudi staff]	
Wellbeing	Personal	Directly drives turnover intention	*"One of the greatest factors is the nurses burnout" [Christina, non-Saudi staff]*	Personal factors functioned as immediate antecedents to turnover intention

The data also suggested a sequence in which institutional constraints influence leadership practice, which in turn affects personal stress and burnout and contributes to turnover intention. Participants described structural conditions as shaping leadership practices and personal responses, which in turn influenced turnover intention. This sequential pattern supports the hierarchical structure of the novel model, in which institutional conditions are positioned as the primary factors, shaping both leadership practices and personal experiences. The model therefore reflects the analytical relationships identified in the data rather than imposing an external theoretical framework.

5.12 Validating the Novel Model against Current Literature

To further explore the validity of the model, data from two other studies were applied to the model: Alshareef (2019), which focuses on nursing turnover, and Shatnawi (2020), which examines workplace challenges and related factors among nurses to assess the alignment and explanatory relevance of the model.

Institutional Factors, such as heavy workload, inadequate staffing, and insufficient compensation, are evident in both studies. For instance, Alshareef (2019) found that institutional challenges were a major driver of turnover, particularly the heavy workload:

"Lack of staff, 12 hours duty, a low of days for vacation…… too much workload and not enough staff. We need more staff."

Similarly, Shatnawi (2020) identified heavy workload and a lack of institutional support as serious issues:

"We are not well staffed and sometimes you feel that you need to have some extra staff with the extra tasks we are having, and we tried to ask for overtime. But the management refuse."

These findings support the model's positioning of Institutional Factors at the top of the hierarchy, as structural factors that shape both leadership function and personal wellbeing.

As depicted in the model, Institutional Factors also influence Leadership Factors. Inadequate staffing and lack of support constrain the leaders' ability to manage effectively. Alshareef (2019) provides evidence to support this:

"Enhance nursing leadership and management skill, to improve job scope related to nursing proficiency, not only multitasking nursing when giving care to patients."

Likewise, Shatnawi (2020) revealed how lack of recognition and support from leadership increases nurses' dissatisfaction:

"I don't feel valued as I am not appreciated like other and if my demanding work has not been valued, it makes me feel down and this is accumulated as extra stress because lack of fairness."

Personal Factors, such as stress, burnout, and dissatisfaction, were evident in the findings of both studies. Alshareef (2019), highlighted that limited career advancement opportunities left nurses feeling unfulfilled:

"There is no fairness in promotion and many personal issues affecting on staff by the highest level of directors."

Moreover, Shatnawi (2020) emphasised how excessive workload contributed to burnout and stress among nurses, which in turn contributed to turnover:

"I feel stress and depress when I'm not finish my patient work due to extra task. Sometime they gave us extra number of patient and duty for that month."

Both studies highlight that Institutional Factors, such as insufficient staffing, and heavy workload, created an environment where leaders struggle to manage effectively, resulting in unclear work roles, lack of recognition, and unfair practices. These challenges increased

nurses stress, burnout, and dissatisfaction, which may ultimately result in turnover intention and, consequently, turnover.

The findings from Alshareef (2019) and Shatnawi (2020), align with the novel model, suggesting that the interconnected dynamics of Institutional, Leadership, and Personal Factors identified in the current study are reflected in the broader KSA nursing context. This alignment suggests the model may have relevance beyond the specific setting of KFAFH, though further research would be needed to confirm this.

5.13 Model Critique

The model was developed from the data collected in this study, along with theoretical insights and empirical findings of previous research, thereby building on and extending current knowledge on nurse turnover intention. However, as this model is novel, it has not yet been empirically tested in other settings nor been exposed to systematic consideration of strengths and limitations.

Nevertheless, the model demonstrates notable strengths, especially for the issue of turnover and turnover intention of nurses working in KSA. While the model acknowledges key drivers identified in both the literature and this study, such as inadequate compensation and heavy workload, it goes further by offering a context-specific understanding of how these factors operate within the KSA context. By focusing on the interconnected nature of Institutional, Leadership, and Personal Factors, the model introduces a hierarchical

structure that plays a crucial role in addressing the specific challenges facing KSA's healthcare sector. In the context of KSA, drivers such as low salaries, excessive workloads, and barriers to leadership development, exacerbated by Saudization policies, trigger a chain reaction that affects leadership dynamics and personal wellbeing. This focus on Institutional Factors ensures that the identified interventions target the root causes of turnover and turnover intention.

This is particularly important given the mixed Saudi and non-Saudi composition of KSA's nursing workforce, which faces distinct challenges such as inadequate compensation, workload distribution, and limited opportunities for career advancement. Targeting these Institutional Factors first supports improvements in leadership quality and personal satisfaction, with the potential to reduce turnover intention. Furthermore, the model takes into account the effect of lack of recognition for leaders as a driver of turnover intention. This factor is not adequately considered in prevalent theories. Because many of the nurses working in KSA could choose to work in another country, the model suggests that unaddressed Personal Factors driving turnover intention may contribute to a countrywide nurse shortage.

The model is most applicable to the KSA context, as specific issues with turnover intention having to do with leadership situations, personal attributes, and Institutional Factors are likely to differ from country to country. Ultimately, this model provides a clear framework for developing interventions tailored to the specific needs of nurses working in KSA.

5.14 Model Limitations

There are several limitations to this model. First, like all models developed from qualitative research, this model is sample-dependent, being based on interviews conducted with a subset of workers at KFAFH. If other workers who did not participate had been interviewed, different perspectives may have emerged, potentially influencing the model. However, the depth and coherence of the data provide confidence in the consistency of the findings. A limitation of this model is that it does not take into account the opinions of nurses who had already left KFAFH, as they could not be interviewed.

Second, this study was conducted at a single site (KFAFH), and therefore the findings may not be generalisable to other healthcare settings in KSA. While the model reflects patterns also identified in the QES, it has not yet been externally validated in other healthcare settings. In addition, the relative influence of Institutional, Leadership, and Personal Factors may differ across healthcare settings (e.g., private or outpatient settings), which may limit the model's transferability.

Although the model differs conceptually from models such as Price's Model, some overlap exists in recognising the role of organisational factors in turnover intention. However, unlike Price's Model, the current model does not rely on quantitative weighting of variables and instead reflects the hierarchical relationships identified through qualitative thematic analysis.

Finally, the novel model pertains specifically to the culture and settings in KSA. It should therefore be applied cautiously in healthcare settings outside of KSA.

5.15 Demonstration of Hierarchy

Figure 5.11 illustrates the hierarchical structure of the novel model. The brown, thick arrows indicate that Institutional Factors are at the top of the hierarchy. They impact Leadership Factors and Personal Factors, which are at the same (second) level of the hierarchy. This section provides evidence of this from verbatim extracts presented in Chapter 4.

5.15.1 Institutional Factors Impact Leadership Factors

These verbatim extracts demonstrate that Institutional Factors impact Leadership Factors:

"If you are a leader, you need full authority for your job." [Omar, Saudi leader]

"They don't say you're the leader but you do everything, and they don't acknowledge that. Yeah, or it's like my hands are tied most of the time. I don't have much authority to do and act." [Reem, Saudi leader]

These two verbatim extracts indicate that leaders are unable to effectively address staff turnover intention because of drivers originating at the institutional level, which may also lead leaders themselves to leave their positions. The verbatim extract from Omar explains that at the institutional level, leaders do not have the authority they need to perform their roles. This can lead to poor leadership performance, which may contribute to staff turnover

intention. It may also cause the leader themselves to leave. The verbatim extract by Reem describes how leadership's "hands are tied" by institutional constraints, preventing leaders from executing their duties in ways that would reduce staff turnover intention. This frustration can also lead to leadership turnover intention.

5.15.2 Institutional Factors Impact Personal Factors

These verbatim extracts demonstrate that Institutional Factors impact Personal Factors:

"Too much workload and no one [will] listen to us, to our concerns...when you have too much pressure and too much work, you feel unsafe to work in this place." [Rana, Saudi staff]

"One of the greatest factors is the nurses burnout due to a high volume of patients that we are receiving. For ward nurses, they are usually complaining on nurse patient ratio, if they're having too much patients to attend to especially in the ward." [Christina, non-Saudi staff]

Both verbatim extracts describe how the Institutional Factor of an excessively heavy workload directly impacts the Personal Factors of burnout and compromised wellbeing. Rana indicates that the institutional decision to allow the workload to be too heavy, despite staff complaints, leads staff to "feel unsafe" in the workplace, which is a Personal Factor contributing to turnover intention. Christina's verbatim extract describes the same situation, where the "high volume of patients" and nurse-to-patient ratio, which are institutional-level conditions, lead to burnout and reduced wellbeing at the personal level.

5.15.3 Leadership and Personal Factors operate at the Same Hierarchical Level

These verbatim extracts demonstrate that Leadership and Personal Factors operate at the same hierarchical level beneath Institutional Factors:

"Showing support to the staff when it comes to their leaves [requests] to their evaluation to their concerns at accommodation, etc. And the relationship with other colleagues, then yes, I think the relationship is a contributory factor for turnover." [Reem, Saudi leader]

"So with now the leadership that of the Saudis we bringing them. We have to give as much support as we can from what we know from experience from qualification of specially administration, because you will be moving now away from a floor .... that higher level it needs also a skill and knowledge of that." [Katie, non-Saudi leader]

These two verbatim extracts demonstrate that even where leaders attempt to alleviate Personal Factors influencing turnover intention, they are constrained by institutional conditions, which supporting the positioning of Leadership and Personal Factors at the same level of the hierarchy beneath Institutional Factors. In Reem's verbatim extract, leaders are institutionally constrained in approving leave and addressing concerns, which affects personal wellbeing and turnover intention. In Katie's verbatim extract, the institutional decision to appoint Saudi leaders who may lack experience compared to non-Saudi leaders creates both leadership-level and personal-level pressures contributing to turnover intention.

5.16 Chapter Summary

This chapter has demonstrated that current theoretical models of nurse turnover and turnover intention, while widely applied, are insufficient to explain the specific dynamics of turnover intention among nurses working in KSA. Six frameworks were evaluated and found to be limited in their reliance on broad categories, their treatment of factors as independent rather than hierarchically related, and their failure to account for the context-specific conditions identified in this study.

In response, a novel KSA-centric model was developed, grounded in the thematic findings presented in Chapter 4. The model proposes a hierarchical structure in which Institutional Factors operate as the primary level, shaping leadership conditions and personal experiences in an interconnected and hierarchical way. The model was applied to its source data, examined against two independent KSA studies, and critically evaluated in terms of its strengths and limitations.

The following chapter builds on this model by presenting the discussion, recommendations, and conclusions of the thesis, interpreting the findings in relation to related research and developing evidence-based retention strategies for nurses working in KSA.

Chapter 6 - Discussion, Recommendations and Conclusion

6.1 Introduction

The previous chapter evaluated theoretical models of nurse turnover and turnover intention and presented a novel KSA-centric model grounded in the empirical findings of this study. This chapter builds on that model by interpreting the findings in relation to the research and developing evidence-based recommendations for addressing nurse turnover intention at KFAFH.

The chapter begins with a summary of the thematic findings, followed by an interpretation of how institutional, leadership, and personal conditions interact to influence turnover intention within this setting. The findings are then examined in relation to the literature, across institutional, leadership, and personal levels. The chapter next integrates the findings of this study with those of the qualitative evidence synthesis presented in Chapter 2, identifying areas of alignment and divergence. To contextualise the KSA experience, the chapter then compares nurse turnover intention in KSA with that reported in the United Kingdom, United States, and Canada, drawing lessons for policy and practice.

The chapter then moves to recommendations. The impact of Saudi Vision 2030 on nurse turnover is discussed, followed by recommendations for national workforce policy, including Saudization reform. The chapter identifies a lack of structured professional development at KFAFH as a key driver of turnover intention across both Saudi and non-Saudi nurses and proposes a formal continuing professional development programme as a

targeted institutional intervention. Recommendations for policy, practice, and future research are then presented. The chapter concludes with a discussion of study strengths, limitations, methodological reflections, and the theoretical and practical contributions of this research.

6.2 Summary of Findings

The aim of this research was to investigate the factors contributing to nurse turnover intention and to develop evidence-based retention strategies for the nursing workforce within KSA healthcare settings. The analysis also explored how these factors were experienced differently according to nationality, distinguishing between Saudi and non-Saudi nurses, and how they differed between staff and nurse leaders.

The findings indicated that Institutional Factors were the primary and most fundamental driver of turnover intention, shaping the experiences of both Saudi and non-Saudi nurses, and of both staff and leaders. Saudi and non-Saudi nurses experienced these conditions in structurally distinct ways, while leadership functioned as an intermediate layer that either amplified or buffered the pressures originating at the institutional level.

Thematic analysis identified 14 subthemes organised under three main themes: Institutional, Leadership, and Personal Factors. Under the Institutional Factors, six subthemes were identified. One subtheme, Leadership Positions, illustrates differences between leaders and staff. Also under the Institutional Factors, three subthemes revealed distinctions between Saudis and non-Saudis, namely Diversity Issues, Families, and Workload.

Under Leadership Factors, four subthemes were identified. No distinctions were identified between Saudis and non-Saudis or between staff and leaders. Finally, four subthemes were represented under the Personal Factors theme. Two subthemes, Lifestyle and Opportunities, revealed distinctions between Saudi and non-Saudi nurses. No distinctions between staff and leaders were identified within the Personal Factors theme.

This led to the development of a context-specific model of nurse turnover intention for KSA, addressing the conditions shaping this phenomenon. The model provides a framework for understanding how Institutional, Leadership, and Personal Factors interact to influence turnover intention, offering insights for targeted interventions and policy recommendations aimed at reducing turnover intention and, consequently, actual turnover among Saudi and non-Saudi nurses.

6.3 Interpretation

The previous section summarises what was found in this study. The overall interpretation is that, in the KSA healthcare setting, institutional factors influencing turnover intention impact staff directly at a personal level, while they also impact leaders at a leadership level, and this in turn impacts how the leaders relate to staff. For example, two factors influencing turnover intention at the personal level are burnout and leaders declining requests for personal time off. The reason staff and leaders report burnout is understaffing, which leads to excessive workload. In addition, salaries are perceived as inadequate. These decisions are all made at the institutional level, not the leadership or personal level. Leaders are

consequently hesitant to approve personal time off because the workload is so high and the understaffing is so severe.

Other contributors to burnout at the personal level specifically include working under the leadership of poor leaders, who may exhibit inadequate management styles, be unsupportive of their staff, make their staff fear speaking out, and fail at facilitating teamwork. Although these factors contributing to personal burnout appear to originate at the leadership level, the presence of ineffective leadership may result from institutional decisions that place individuals in leadership roles without adequate preparation or support.

Altogether, this suggests that interventions at KFAFH to reduce turnover intention will not necessarily work if conducted at the personal level or the leadership level. For example, if a personal level intervention simply provided additional training and skill development to nurses or nurse leaders, it would likely not succeed at reducing turnover intention unless it was fully embraced at both the leadership and institutional levels as well (Albalawi et al., 2024; Alreshidi et al., 2021; Mlambo et al., 2021; Naholi et al., 2023; S. Price & Reichert, 2017). Further, simply providing professional development guidance at the leadership level would likely have limited impact on turnover intention, because this would not address the institutional-level factors of turnover intention, such as low staffing, low salary, and high workload (Alasiry & Alkhaldi, 2024; Gan & Voon, 2021; Suliman et al., 2020).

6.4 Consistency with Current Literature

In this section, the themes identified in this study are compared with current literature. The findings are consistent with previous research on turnover and turnover intention in KSA, while also identifying additional reasons for turnover intention that have not been addressed in earlier studies. Rather than treating consistency with the literature as confirmation alone, this section interprets how and why these patterns persist within the KSA healthcare context, and where the findings extend or challenge current explanations of nurse turnover intention.

6.4.1 Institutional-Level Themes Related to Turnover Intention

The themes identified at the institutional level in this study were consistent with those in the published literature. Studies have shown that Saudization is taking place, causing a preference for Saudi nurses, especially at the leadership level (Alluhidan et al., 2020; Alreshidi et al., 2021). There is a difference in how Saudi and non-Saudi nurses are treated, and non-Saudi nurses report that they are not recognised for their experience (Alreshidi et al., 2021). From an organisational justice perspective, this differential treatment undermines perceptions of fairness and reciprocity, which weakens commitment among non-Saudi nurses and increases their willingness to leave.

High workload was cited in this study as an institutional-level factor influencing turnover intention and reducing job satisfaction, and this has been found in other studies as well (Attar & Alsharqi, 2021; Falatah et al., 2021). When viewed through the Job Demands–

Resources framework, sustained workload pressure without compensatory resources shifts coping into strain, making turnover intention a rational response rather than an individual failure to adapt. Also, non-Saudi nurses often express an intention to leave because their families are not accommodated, and this was the main reason for turnover intention found in a study at another military hospital in KSA (Alonazi & Omar, 2013). Non-Saudi nurses also complain of lack of benefits, inadequate housing and hospital facilities, and poor pay, as identified in this study and in others (Al-Ahmadi, 2014; Alreshidi et al., 2021). Non-Saudi nurses have also cited lack of recreational activities as contributing to turnover intention in another study, as was also identified in this study (Alshareef et al., 2020).

This study revealed a novel institutional-level factor that appeared to contribute to turnover intention, in that the hospital assigned inappropriate work roles to nurses who had no experience in such a role, and this appeared to lead to dissatisfaction. No evidence of this issue was identified in the literature on other work sites in KSA. This suggests that role mismatch operated as a locally produced organisational practice rather than a sector-wide norm, highlighting how site-specific decision-making can intensify turnover intention even within a shared national policy environment.

6.4.2 Leadership-Level Themes Related to Turnover Intention

Leadership Factors found in this study were similar to those described in the wider literature. Lack of good leadership and recognition on the job that led to poor job satisfaction were among reasons for turnover intention (Al-Ahmadi, 2014). Poor leadership

styles were another cause for turnover intention as identified in this study and in others (Alshahrani & Baig, 2016; Al-Yami et al., 2018). Within high-pressure healthcare settings, leadership behaviour functioned as a key pathway through which institutional constraints shaped individual coping responses, meaning weak leadership amplifies the effects of workload, insecurity, and role ambiguity rather than operating as an isolated factor.

High moral distress was associated with turnover intention (Abumayyaleh et al., 2016). That finding relates to the issue in this study that participants cited about fear of speaking out, which would lead to moral distress (Abumayyaleh et al., 2016). This pattern reflects moral distress arising from constrained professional voice, where nurses recognise unsafe or unfair practices but lack the power to challenge them, leading to psychological strain that accelerates turnover intention. Also, quality of relationships between staff has been found to impact turnover intention, in that workplace bullying increased turnover intention, as was found in this study (Al Muharraq et al., 2022).

A unique contribution of this study is in integrating these different forces to describe an overall picture that serves to increase turnover intention among non-Saudi nurses. First, due to Saudization, few leadership positions were available to non-Saudis. Next, living conditions for non-Saudis are often perceived as less favourable in KSA compared to other countries, and the salary is relatively low. This appeared to lead to non-Saudis using KSA as a "training ground" early in their careers only to leave for better opportunities having gained a small amount of experience. This dynamic reflects a form of strategic workforce

mobility, where non-Saudi nurses assess the Saudi system as offering short-term skill accumulation but limited long-term returns, making exit a calculated career strategy rather than an impulsive decision.

This dynamic of limited opportunities for non-Saudis to advance due to Saudization policies, along with the inadequate living conditions and compensation they experience in KSA, leaves the healthcare system in a persistent cycle of training new staff due to persistently high rates of nurse turnover. This also means that the effort spent training these staff may not be subsequently recouped, as when nurses become experienced, they likely leave, and Saudi patients are less likely to benefit from experienced nursing care. This dynamic may represent a fundamental contributor to the nurse staffing shortages affecting the entire country.

6.4.3 Personal Themes Related to Turnover Intention

Lack of appealing employment opportunities in KSA compared to other countries was cited in both the literature and in this study as a reason for turnover intention (Al-Ahmadi, 2014). In this study, many nurses reported burnout and low quality of nurse work life (QNWL) as documented in previous studies (Albougami et al., 2020; Al-Mansour, 2021; Kaddourah et al., 2018; Soqair, 2021). Burnout therefore functioned not only as an emotional state but as a cognitive signal that continuing employment was unsustainable, linking personal exhaustion directly to turnover intention.

A finding from this study that has received limited direct attention in the current literature concerns the extent to which non-Saudi nurses are unable to plan for a long-term life in KSA due to policy-related constraints, including property ownership and other practical constraints related to residency status, family arrangements, and long-term stability. Although limited opportunities for experience and career development were factors influencing turnover intention among non-Saudis, the findings suggest that more than just employment issues were impacting non-Saudis. They could not envision a sustainable long-term future in KSA under current policies. From a psychological contract perspective, the absence of long-term security beyond the workplace disrupted expectations of mutual commitment, making sustained attachment to the organisation unlikely even when job conditions were tolerable.

An issue unique to this study was the complaint that when personal time off was requested, it was not always granted. Although previous studies in KSA have generally discussed work–life balance and managerial support, the specific issue of approved personal leave being rescinded has not been explicitly highlighted as a driver of burnout or turnover intention.

6.5 Integration with QES

This section integrates the findings of this study with the findings of the QES reported in Chapter 2, which had five main themes: Relationships with Supervisors/Leads, Workplace Equity, Work Assignments/Workload, Quality of Life, and Saudi Society (Almubark et al.,

2025). The first primary theme identified in the QES as a driver of turnover and turnover intention among nurses working in KSA was Relationships with Supervisors/Leads, which included the subtheme of Leadership Interactions and Management Support. Unlike in the QES, this study found that there were leadership factors encouraging retention, such as leaders working with staff in shared decision-making, leaders providing recognition to staff, leaders meeting staff expectations and standing up for staff, and leaders facilitating teamwork. However, it seemed that only certain units operated with leaders behaving this way, as factors increasing turnover intention at the leadership level reflected factors found in the QES, such as leaders making staff uncomfortable speaking out, leaders having poor relationships with staff, and leaders having poor leadership and management styles. In contrast to the QES, where leadership themes focused predominantly on leadership failures as drivers of turnover, in this study, at KFAFH, there appeared to be some leaders who through their interactions and relationships with staff actually encouraged retention. This finding suggested the presence of variation in leadership practices within the same organisational setting, where some leaders demonstrated behaviours that supported retention, while others contributed to turnover intention. These examples of positive leadership practice, which deviated from the dominant patterns identified in the QES, indicate that not all leadership within KSA healthcare settings was experienced negatively. Identifying and examining these ‘good leaders’ in more detail may provide valuable insights into effective leadership behaviours that could be replicated to improve retention. Future research could therefore focus on systematically identifying such leaders and examining the specific practices that distinguish them from others.

A similar difference between the findings of this study and the QES can be seen when considering the overarching theme of Workplace Equity as a driver of turnover and turnover intention found in the QES (Almubark et al., 2025). In the QES, lack of staff involvement in decision-making was found to be a driver of turnover, while in the current study, leaders were found to involve staff in decision-making, and therefore this was not a driver of turnover intention in this study. Also, Social Support, identified as a subtheme of Workplace Equity in the QES, was not directly mirrored in the current study, because some participants perceived that they received support in the form of recognition from leaders and the facilitation of teamwork by leaders, while others cited that poor leadership complicated staff relationships and teamwork, showing a lack of social support. There were other subthemes of the Workplace Equity theme in the QES that were not reflected in the same form in the findings from this study, including Perception of the Nursing Profession, Professional Disrespect, and Concepts of Seniority (except in contexts where Saudis in general were seen as senior to non-Saudis across organisational levels, and were provided with more opportunities for leadership). This may indicate more favourable conditions compared to those described in the QES with respect to Workplace Equity.

However, some of the subthemes found in the QES under the Workplace Equity theme were also echoed in the current findings under other themes (Almubark et al., 2025). Salary was specifically mentioned in this study as a primary driver of turnover intention, especially among non-Saudis, although at KFAFH, some participants reported that non-Saudi salaries were increased, but these increases were not provided to Saudi workers. This

led to a perception of injustice by Saudis that was found in this study but not present in the QES. The subtheme of Opportunities for Educational/Career Development under the Workplace Equity theme was reflected in the findings of this study, specifically in the observations of participants that non-Saudis did not have fair opportunities to rise to leadership positions or to plan a long-term career in KSA due to KSA policies that make it difficult for non-Saudis to live long-term in KSA. The subtheme of Personnel Policies under the Workplace Equity theme identified in the QES was reflected in the current study through participants reporting poor benefits and lack of approval for personal time off.

In the QES, the theme of Work Assignments/ Workload as a driver of turnover and turnover intention was directly reflected in the current study under the theme of Institutional Factors and the subtheme of Workload (Almubark et al., 2025). However, three of the four subthemes of the Work Assignments/ Workload theme found in the QES, specifically Night and Weekend Shifts, Emotions Caused by Work, and Language of Communication at Work, were not identified in the current findings. Participants in the current study did not report issues related to night or weekend shifts, and complications caused by language of communication at work, suggesting that in this way, KFAFH's working environment may be more favourable than that of other healthcare settings in KSA. However, the subtheme from the QES of Job Satisfaction was echoed in the current study under the theme Personal Factors, specifically in the subthemes of Lifestyle and Wellbeing.

In the QES, the theme of Quality of Life included the subthemes of Living Accommodations, Recreational Activities, and Work Transportation (Almubark et al.,

2025). Only the issue of Recreational Activities was identified in the current study, but did not rise to the level of constituting a theme. Non-Saudis expressed that increasing recreational activities would increase retention, as reflected under the subtheme Compensation under the theme Institutional Factors. Also, the fifth theme cited in the QES which was Saudi Society, with the single subtheme of Islamic/Saudi Norms and Policies, was not identified at all as a driver of turnover intention in the current study.

The differences found between the findings of the current study and the findings of the QES are likely due to two main factors: specific differences between the KFAFH setting and the settings in which the studies incorporated into the QES took place, and the impact of Vision 2030 reforms which are reflected in the current study (Almubark et al., 2025; Alsufyani et al., 2020; Kingdom of Saudi Arabia, 2017). In terms of attributes of KFAFH which appeared to be different than the settings reflected in the QES, it appeared that while some leaders contributed to staff turnover intention, others were actually very supportive of staff and behaved in ways that encouraged retention. The current study showed that staff were involved in decision-making, and many received recognition and social support from their managers, and this was not found in the QES. Many of the subthemes under the Workplace Equity theme in the QES were not evidenced in the current study, which showed that many leaders at KFAFH were perceived as doing well with meeting staff expectations for supporting them and teamwork. Also, in the current study, KFAFH employees did not complain about night or weekend shifts, and issues of language of communication at work.

Secondly, the improvements associated with the implementation of Saudi Vision 2030 were apparent when comparing the findings of this study to the QES findings (Almubark et al., 2025; Alsufyani et al., 2020; Kingdom of Saudi Arabia, 2017). Under Vision 2030, the nursing profession has been elevated in stature, which is likely why in this study, there were no reports of the perception of the nursing profession driving turnover intention (Alsufyani et al., 2020; Kingdom of Saudi Arabia, 2017). Also, the requirement of using English as the language of communication at work in healthcare settings has been strengthened through the implementation of Vision 2030, so language of communication at work as a driver of turnover intention has been reduced (Alsufyani et al., 2020; Kingdom of Saudi Arabia, 2017). Under Vision 2030, women in KSA are now allowed to drive, and this has alleviated work transportation issues as drivers of turnover intention that were cited in the QES findings (Almubark et al., 2025; Alsufyani et al., 2020; Kingdom of Saudi Arabia, 2017). Perhaps the most obvious finding from the current study compared to the QES was reduced turnover intention due to issues with having to align with Saudi society, and follow Islamic and Saudi norms and policies, which particularly impacted non-Saudis (Almubark et al., 2025; Alsufyani et al., 2020; Kingdom of Saudi Arabia, 2017). Under Vision 2030, in the healthcare workplace, these norms were relaxed and internationalised, with the intention of aligning Saudi workplaces to international standards (Almubark et al., 2025; Alsufyani et al., 2020; Kingdom of Saudi Arabia, 2017). Although the findings from the current study demonstrate that further work needs to be done to reduce turnover intention and, consequently, actual turnover among nurses working in KSA, the findings

suggest a potential positive impact of Vision 2030 reforms when comparing findings of the QES to the findings of the current study.

6.6 Comparing KSA with Other Countries

As described in the introduction, nurse turnover and turnover intention are a serious problem globally and impact many countries (Adams et al., 2021; Ohue et al., 2021). Ohue and colleagues (2021) surveyed nurses in Canada, Japan, Malaysia, Thailand, and the US, and found the highest level of burnout exhaustion in Japan, and the highest level of cynicism and intention to leave the job in Malaysia (Ohue et al., 2021). To contextualise the findings of this study, this section compares the challenge of nurse turnover intention in KSA with the experience in the UK, the US, and Canada. The purpose of this comparison is not only to identify shared drivers of turnover intention across countries, but to examine how other countries have responded to this challenge, and to consider what lessons KSA may draw from these approaches.

6.6.1 United Kingdom

As acknowledged in the introduction, many of the causes of nurse turnover and turnover intention are seen as global obstacles, such as burnout and low pay (Adams et al., 2021). Therefore, it can be difficult to differentiate the specific characteristics of the issue of nurse turnover and turnover intention in any specific country, including the UK (Adams et al., 2021). One approach is to examine studies of nurses in the UK that specifically address turnover intention (Cull et al., 2020; Theodosius et al., 2021). A study of midwives in the UK found that they felt immense work pressure, and this was caused by a heavy workload

and poor staffing (Cull et al., 2020). Working relationships were seen as protective against this stress if the relationships were positive (Cull et al., 2020). Ultimately, the midwives took great pleasure in their work, but wanted to be treated as individuals, and have shared decision-making with respect to their shift pattern and area of work role (Cull et al., 2020). A study of 118 registered nurses in the UK found that the high work demands necessary to be patient-focused and exhibit collegial emotional labour led to burnout and turnover intention (Theodosius et al., 2021).

Adams and colleagues (2021) conducted a systematic review of turnover and turnover intention in mental health nurses (MHN) worldwide in order to compare their findings with the UK. Their review included 23 studies which they summarised in a table to allow comparisons between countries, and among these, six were set in the UK (Adams et al., 2021). The factors affecting turnover intention identified from the studies in the UK settings included many of the themes found in the current study, including level of job preparation, job satisfaction, poor leadership, burnout, working relationships, staffing levels, and salary (Adams et al., 2021). However, UK MHNs pointed to some drivers of turnover intention not emphasised in the themes arising from this study, such as desire for consolidation of skills, too much paperwork, reflection on practice, and poor physical working conditions (Adams et al., 2021).

The UK has implemented different strategies to address nurse turnover and turnover intention (Henshall et al., 2021; McNiven et al., 2021). One policy strategy was to promote and encourage nurses to work in academic roles, but this was found to only succeed in

certain areas, and there were still shortages of these types of nurses in other areas (Henshall et al., 2021). Another study found that research nurses, midwives, and allied health professionals experienced significant challenges in their professional roles in establishing a professional identity (McNiven et al., 2021). The authors found that the way nurses were treated in the UK exacerbated the complication of their role identity, leading to unnecessary stress (McNiven et al., 2021). Also from a policy standpoint, the UK seeks to expand the diversity of its nursing workforce, because workforce diversity leads to improved patient outcomes (Qureshi et al., 2020). Therefore, efforts were made to increase nurses from Black and Asian minority ethnic (BAME) groups (Qureshi et al., 2020). However, a qualitative study of British South Asian male nurses found that they experienced poor pay, negative working conditions, and were victims of negative community views and the lack of knowledge and awareness of the nursing profession (Qureshi et al., 2020).

In summary, like many countries, the UK faces challenges with nurse turnover intention driven by factors common to other healthcare systems (Adams et al., 2021). A distinguishing feature of the UK context is that the policy approaches to solving the problems focus on career development strategies, and are implemented as countrywide programmes (Henshall et al., 2021; McNiven et al., 2021; Qureshi et al., 2020). UK approaches tend to focus on nurses expressing intention to move between organisations, but they do not clearly address the proportion of nurses who leave the profession altogether, which has not been widely quantified in these studies (Theodosius et al., 2021). Although these programmes have admittedly encountered obstacles to success, this approach

represents one that has not been adopted by KSA as a strategy to reduce turnover intention and, consequently, actual turnover in nurses working in KSA.

6.6.2 United States

Compared to the UK, a considerably larger body of research exists in the US (Adams et al., 2021; Bae, 2023; Iheduru-Anderson, 2020; Jones et al., 2024; Kelly et al., 2021; Mahoney et al., 2020; Norful et al., 2023). The results of these studies are difficult to synthesise due to the diversity of settings in which they were conducted (Adams et al., 2021; Mahoney et al., 2020; Norful et al., 2023). Norful and colleagues (2023) studied emergency nurses in the US and compared reasons they gave for turnover to reasons given by nurses working in other settings. They found that emergency nurses cited the following main reasons for turnover at a significantly higher rate than other nurses: staffing insufficiency, increased physical demands, dissatisfaction with patient population, opportunities for higher pay elsewhere, seeking career advancement/promotion, long commuting distances, and needing to relocate (Norful et al., 2023). The authors recommended that interventions and future research should focus on finding ways to modify these drivers of turnover intention so as to reduce turnover rates (Norful et al., 2023).

Mahoney and colleagues (2020) studied turnover, burnout, and job satisfaction in Certified Registered Nurse Anesthetists (CRNAs) in the US, and found that certain characteristics of the job, demographic profiles of the nurses, and personality traits were associated with job satisfaction and burnout, which were in turn associated with turnover intention

(Mahoney et al., 2020). The authors recommended that nursing leaders revise the structure of CRNA jobs so that they feature greater skill variety and afford the worker greater autonomy (Mahoney et al., 2020). They hypothesised that making these changes would result in better job satisfaction and lower burnout, leading to lower turnover intention (Mahoney et al., 2020).

In the systematic review of reasons for turnover in MHN, nine studies from the US were included (Adams et al., 2021). Aside from the reasons for turnover identified in other studies of nurses in the US mentioned earlier, the review highlighted a few reasons not covered in those studies, including: stigma, rewarding nature of the job, personal qualities, time to spend with patients, ability to practice safely, justice in the workplace, better handling of disciplinary action, fear of losing nursing skills, need for a nurse residency program, improved role and identity orientation, and career pride (Adams et al., 2021).

National surveys and multi-institutional studies of nurses in the US also provide insight into the challenge of nurse turnover and turnover intention in the US (Bae, 2023; Jones et al., 2024). One survey of over 40,000 US registered nurses (RNs) found that 17% reported job turnover, and that the factors leading to turnover included education, employment settings, and years of nursing (Jones et al., 2024). Bae (2023) investigated how nursing work schedules in the US may lead to turnover in a national sample of US nurses. The author found that working long hours and working overtime were strongly associated with turnover (Bae, 2023). In another study of over 1,000 direct care nurses from three different US hospitals, 54% suffered from burnout, which was found to be a significant contributor

of turnover (Kelly et al., 2021). Authors recommended annual measurement of burnout, as well as increased support for employee wellbeing, and improvement in the work environment (Kelly et al., 2021). Racial stratification in the US has been shown to discourage racially minoritised nurses from developing careers in nursing, thus contributing to turnover (Iheduru-Anderson, 2021).

While it is difficult to summarise the literature on the specific challenges of nurse turnover and turnover intention in the US, one key difference is that the US response tends to differ from the UK response. In the UK, efforts to address turnover have been implemented in policy at the highest levels, even if these programmes have not been universally successful (Henshall et al., 2021; McNiven et al., 2021; Qureshi et al., 2020). In contrast, the US literature recommends solutions to turnover and turnover intention in nurses to take place at a more local level, in terms of institutional policy (Bae, 2023; Kelly et al., 2021; Mahoney et al., 2020; Norful et al., 2023). Examples of these solutions include modifying work schedules to be more amenable, decreasing job demands, changing the features of the jobs to make them more engaging, implementing improved governance in the workplace regarding staff relationships and civility issues, and revising the workplace setting so as to discourage burnout (Adams et al., 2021; Bae, 2023; Iheduru-Anderson, 2021; Kelly et al., 2021; Mahoney et al., 2020; Norful et al., 2023).

A consistent theme emerging from the US literature on nursing turnover and turnover intention is that there is an acknowledgment that improved local governance is needed. The current study in KSA also points to the need for improved local governance; however, this

point has not been emphasised in the KSA literature on nursing turnover and turnover intention. While the US literature acknowledges this need, the fact that solutions have not been widely implemented may indicate limitations in local institutional leadership and governance. Like the US literature, the findings of this study suggest that weaknesses in institutional governance and leadership practice are primary drivers of turnover intention at KFAFH, although whether this applies to other KSA healthcare settings remains to be tested.

6.6.3 Canada

Although from a population standpoint, Canada is a smaller country than the UK or the US, many articles exist in the nursing literature regarding turnover and turnover intention in Canada (Adams et al., 2021; Boamah et al., 2023; Campbell et al., 2020; Fournier et al., 2022; Nowrouzi-Kia & Fox, 2020). A national survey in Canada including 645 nursing faculty found that a supportive workplace culture reduced turnover intention, while work-life imbalance increased it (Boamah et al., 2023). The authors recommended modifying workplace factors and policies, and implementing interventions aimed at retention (Boamah et al., 2023). A survey in Ontario of over 1,000 registered nurses found that work environment variables explained 45.5% of the variance in the intent to leave scores of the nurses (Nowrouzi-Kia & Fox, 2020). Job satisfaction and resource availability were also related to intent to leave scores (Nowrouzi-Kia & Fox, 2020). To address turnover intention, the authors recommended that employers and health policy makers develop a

broader strategy to improve nursing work environments, and this effort could be led by occupational health nurses (Nowrouzi-Kia & Fox, 2020).

Other studies of turnover of nurses in Canada were conducted in specific settings (Campbell et al., 2020). One qualitative study focused on 28 public health nurses who practiced in the Nurse-Family Partnership programme as part of the British Columbia Healthy Connections Project (Campbell et al., 2020). The main reasons nurses gave for remaining in the programme included the opportunity for professional development and education, strong teamwork connections, and working at the full scope of their nursing practice (Campbell et al., 2020). Reasons for turnover were primarily personal and could not be influenced at the institutional level, like family or health needs, and relocation (Campbell et al., 2020). Another qualitative study of 20 nurse practitioners in primary healthcare (NP-PHCs) in Northern Ontario found that reasons for retention included adequate salary and pension, good benefits, and good relationships with management (Fournier et al., 2022). Distance from home and the different practice sites led to turnover, and inadequate salary led to seeking additional part-time employment (Fournier et al., 2022). In the systematic review about MHN and turnover, one study from Canada was included, and the main factor associated with turnover in that study was moral distress (Adams et al., 2021).

Synthesising the literature on nurse turnover intention in Canada remains challenging, because many of the drivers have already been identified as main drivers of turnover globally. One notable observation is that, like the UK, Canadian health leaders may take a

health policy approach to solving this issue, as recommended by the authors of the Ontario study of registered nurses (Nowrouzi-Kia & Fox, 2020). Also, like the US, Canadian health leaders may also approach the problem through local governance, as recommended by the authors of the nursing faculty study described (Boamah et al., 2023). The local studies of nurses in the Nurse-Family Partnership and the Northern Ontario NP-PHCs suggested that adjusting local governance policies may positively influence nurse turnover (Campbell et al., 2020; Fournier et al., 2022). These findings suggest potential approaches for KSA healthcare leaders, because national policy approaches to address turnover and turnover intention have not been tried extensively in KSA, and local healthcare governance in KSA remains underdeveloped in this area. They also indicate that if KSA healthcare leaders can take these approaches, they may be able to meaningfully address the issue of turnover and turnover intention in nurses in KSA.

6.6.4 Comparison with KSA

Considerable similarity was identified between the drivers of turnover intention among nurses in KSA and those reported in the UK, the US, and Canada (Adams et al., 2021; Ohue et al., 2021). Several attributes of the KSA healthcare system make it unique compared to the healthcare systems of Western countries, including the strong practical, occupational, and theoretical divisions between Saudis and non-Saudis, and the top-down influence of a non-Western government (Almalki et al., 2011).

Nevertheless, in comparing the UK, US, and Canada to KSA in terms of nurse turnover and turnover intention, two notable observations can be made about differences in how

these countries approach solutions compared to KSA. In addressing turnover intention, a country may opt to make changes at the national level through policy initiatives, such as increasing the recruitment of BAME nurses in the UK (Qureshi et al., 2020). Another option for the country is to encourage changes in governance at local healthcare institutions. The articles reviewed focusing on US nurses provided recommendations on the types of local governance required, including specific recommendations for emergency nursing as well as CRNAs (Mahoney et al., 2020; Norful et al., 2023). Notably, although workforce reforms have been introduced under Vision 2030, the literature reviewed did not identify nationwide initiatives specifically designed to address nurse turnover and turnover intention in nurses working in KSA, and limited guidance or encouragement has been given to local authorities to improve governance to address turnover intention. In this way, a review of the actions in the UK, US, and Canada to address this issue can be illuminating and offer guidance to KSA.

Articles reviewed about the issue in the UK largely propose or reflect the implementation of top-down policy solutions (Henshall et al., 2021; McNiven et al., 2021; Qureshi et al., 2020). Because the UK's healthcare system is centralised, these policies can be rolled out countrywide, and broadly implemented (Henshall et al., 2021; McNiven et al., 2021; Qureshi et al., 2020). Interestingly, the policy solutions implemented in the UK focused on improving the career experience for the nurse, thus encouraging nurses to stay in their positions (Henshall et al., 2021; McNiven et al., 2021; Qureshi et al., 2020). By contrast, solutions emphasised in the US focused on interventions at the level of local governance,

reflecting the non-centralised structure of the US healthcare system (Adams et al., 2021; Bae, 2023; Iheduru-Anderson, 2020; Jones et al., 2024; Kelly et al., 2021; Mahoney et al., 2020; Norful et al., 2023). While the capacity of local institutions to implement these interventions may vary, research results provided guidance on practical and evidence-based solutions, such as adjusting work schedules, and giving workers greater autonomy (Bae, 2023; Mahoney et al., 2020). Canada implements solutions at both the national and local levels (Campbell et al., 2020; Fournier et al., 2022). Addressing these issues at a local level requires strong leadership, and the lack of strong leadership may contribute to the weakness of local governance in the first place.

Therefore, in comparing the challenge of turnover intention in nurses working in KSA with those working in the UK, US, and Canada, while all countries experience many of the same drivers of turnover and turnover intention, it is important to observe that the Western countries have responded differently than KSA. Although many independent research groups in KSA have assembled a body of knowledge on the issue, there appears to have been limited organised governmental intervention specifically targeting nurse turnover intention. By contrast, the UK, US, and Canada have leveraged research results to implement changes. Both the UK and Canada have used the results of research to implement policy changes at the national level, and all the countries have used the results to guide implementation of improved local governance to address the issue. The result of this comparison highlights the potential for KSA to adopt similar approaches by leveraging

the results of research in order to address the issue of turnover intention in nurses working in KSA.

6.7 Critical Analysis

This section critically examines how the findings relate to current theoretical and empirical literature. Areas of alignment with previous studies are interpreted to understand their theoretical implications, while areas of divergence are analysed to consider contextual factors specific to the KSA healthcare system. In addition, novel insights from the current study are highlighted to demonstrate how the findings extend knowledge on nurse turnover intention. A particularly significant observation from this study is that chronic understaffing created pressure on those who remained in the system, leading to high workload and burnout, which in turn contributed to turnover intention. In effect, the chronic understaffing became self-perpetuating. Although efforts were made to recruit new staff, nurses were reported to leave shortly after being hired, creating a persistent cycle of recruitment and turnover at KFAFH. This circular effect of understaffing contributing to ongoing turnover appears to require priority attention. The mechanisms through which this cycle might be disrupted remain unclear. Salary has been identified as an important factor influencing turnover and turnover intention among nurses (Albougami et al., 2020; Alshareef et al., 2020; Wu et al., 2024). One possible approach would be to offer retention incentives, including significantly enhanced salary packages, to experienced nurses willing to remain at KFAFH during a period of active recruitment.

The findings from the current study align with the literature with respect to Saudization, where Saudi nurses are prioritised for leadership roles, and where they may be less trained and less experienced than non-Saudi nurses (Alluhidan et al., 2020; Alreshidi et al., 2021). What this suggests is that the findings in the current study about the tension created by populating leadership positions with Saudis at KFAFH may also impact other healthcare institutions in KSA. It also suggests that this issue may be linked to broader workforce nationalisation policies rather than being confined to a single institution, and it may therefore be difficult to address solely at the institutional level. If similar dynamics exist elsewhere, it may be challenging for organisations to balance national workforce priorities with expectations regarding leadership training and experience. In such contexts, institutions may face difficulties ensuring that leadership positions are perceived as equitable between Saudi and non-Saudi nurses in terms of preparation and professional development. Nevertheless, this situation could be addressed sensitively by providing the Saudis hired at KFAFH at all levels with more institutional support in the form of expanded experience and training (King et al., 2021; Manley et al., 2018; Naholi et al., 2023).

High workload was found to drive job dissatisfaction and turnover intention in this study, which is consistent with other studies (Attar & Alsharqi, 2021; Falatah et al., 2021). This suggests that reducing the workload could increase job satisfaction and make turnover intention less likely. Reducing the workload would require additional staffing, which incurs added cost. Also in this study, it was found that lack of benefits, poor work environment, and low pay were drivers of turnover intention, especially among non-Saudis, and this was

consistent with the literature (Al-Ahmadi, 2014; Alreshidi et al., 2021). Improving benefits, the work environment, and salary levels also incurs additional cost. This suggests a need for greater funding overall for healthcare institutions in KSA. One caveat to this interpretation is that administrators at a higher level were not included in this research, together with a lack of studies about higher level healthcare administration in KSA in the literature.

This study and another study both found that non-Saudi nurses working in KSA often express intention to leave their positions because they cannot bring their families with them to live in KSA (Alonazi & Omar, 2013). Also, it was cited in this study that requests for personal time were generally not approved for both Saudi and non-Saudi nurses due to understaffing and high workload. Specifically, it was cited that non-Saudi nurses were especially impacted by this, because they may need personal time to travel home to address problems with their families. Further, this study reported that non-Saudi nurses may come to work in KSA for a short period of time to acquire some experience, then immediately look for a new position in another country that is more accommodating of them. Non-Saudi nurses expressed preference for working in other countries, and consistent with the literature, this was because workplaces in other countries are less conducive to burnout and low QNWL (Al-Ahmadi, 2014; Albougami et al., 2020; Al-Mansour, 2021; Kaddourah et al., 2018; Soqair, 2021). This situation presents significant challenges for healthcare administrators in KSA, because when a non-Saudi worker leaves, administrators may lose a well-trained, well-integrated worker and will likely need to recruit a new one who

requires the same type of training. Further, as stated earlier, non-Saudis cannot fully participate in society in KSA (for example, although their children may enrol in public schools, teaching is primarily conducted in Arabic, meaning many expatriate families rely on private English-language schools, and non-Saudis are also unable to own land in KSA) which means that many cannot plan for a long-term career in KSA. These findings indicate that turnover intention among non-Saudi nurses is shaped not only by workplace conditions, but by structural constraints linked to residency, family separation, and limited long-term integration into society. As a result, turnover intention among non-Saudi nurses is often embedded within short-term employment strategies rather than long-term career planning within KSA. These KSA-level factors suggest that broader policy considerations, such as facilitating family presence and greater societal integration for non-Saudi nurses, may play a role in improving retention.

This study found that poor leadership and management styles of leaders contributed to turnover intention, which is consistent with the literature (Al-Ahmadi, 2014; Alrwili, 2022; Alshahrani & Baig, 2016; Al-Yami et al., 2018). One attribute of poor leadership and management skills that was found in this study and echoed in previous studies was leaders creating moral distress among staff by making them fear speaking out, and rather than leaders facilitating teamwork, allowing nurses to be victims of workplace bullying (Abumayyaleh et al., 2016; Al Muharraq et al., 2022). These poor leadership and management behaviours by leaders could be due to their lack of training and experience, and this could be improved by providing leaders more support, on-the-job training and

mentoring, and other types of leadership education (Alasiry & Alkhaldi, 2024; Gan & Voon, 2021; Suliman et al., 2020; Yun & Yu, 2021).

6.8 Model for Turnover and Turnover Intention in Nurses Working in KSA

The novel model developed in this study presents turnover intention as shaped through a hierarchical relationship between Institutional, Leadership, and Personal Factors. The discussion in this chapter reinforces this structure and shows that turnover intention among nurses working in KSA is not driven by isolated factors, but by interconnected conditions across these levels. Institutional Factors, particularly workload, staffing shortages, salary, and leadership structures, shape both leadership practices and personal experiences, which in turn influence turnover intention.

This interpretation is consistent with research from KSA. Previous studies have identified workload, inadequate staffing, and insufficient compensation as key contributors to turnover intention (Alreshidi et al., 2021; Falatah & Salem, 2018). These findings support the model's position that Institutional Factors act as primary influences. In addition, Falatah and Salem (2018) identified both workload and leadership as important contributors, supporting the view that institutional conditions also shape the leadership environment within which nurses operate.

The discussion also supports the role of Leadership Factors as a link between institutional conditions and personal outcomes. Poor leadership, lack of support, and lack of recognition were described as contributing to dissatisfaction, stress, and turnover intention. This is

consistent with Alrwili (2022), who found that ineffective leadership and limited support were associated with lower job satisfaction, while effective leadership improved staff experiences (Alrwili, 2022). This is consistent with the model's position that leadership operates as an intermediate level through which institutional pressures are experienced in daily practice.

Personal Factors, particularly stress, burnout, and dissatisfaction, were also consistently identified as immediate influences on turnover intention. Heavy workload, inadequate staffing, and lack of support were described as increasing emotional strain and reducing nurses' willingness to remain in post. Findings from Alshareef (2019) and Shatnawi (2020) similarly show that these conditions contribute to stress and dissatisfaction, supporting the inclusion of personal-level outcomes within the model (Alshareef, 2019; Shatnawi, 2020).

At the same time, the discussion shows that the importance of these factors is shaped by the KSA context. In other healthcare systems, factors such as autonomy, work-life balance, and professional development may play a stronger role (Adams et al., 2021). However, in KSA, the findings of this study show that institutional conditions, including workforce structure, Saudization policies, and the position of non-Saudi nurses, play a more dominant role in shaping turnover intention. This highlights the need for a context-specific model that reflects these conditions.

Overall, the findings and their interpretation reinforce the novel model as a framework for understanding turnover intention among nurses working in KSA. The model reflects the

empirical findings, aligns with current research, and demonstrates that meaningful intervention must focus on institutional conditions in order to influence leadership practices and personal outcomes. Addressing these conditions in practice, however, requires engagement with the national policy context within which the hospital operates, most significantly Saudi Vision 2030.

6.9 Recommendations for Saudi Vision 2030 and Saudization Policy

Based on the findings of this study, a special residency status could be introduced under Vision 2030 for non-Saudis and their families to live in KSA and enjoy rights with respect to housing, education, and business opportunities. The findings of this study identified family separation and limited lifestyle options as significant drivers of turnover intention among non-Saudi nurses. Addressing these structural barriers through policy reform, such as developing a special residency status under Vision 2030, may directly reduce these personal-level drivers of turnover intention. This special status would provide more equitable access to public services, including healthcare and education, and improve access to international schools for their children, which may increase the likelihood of long-term retention.

Although such a status is expected to improve the quality of life for non-Saudis, their professional advancement opportunities continue to be influenced by the Saudization policy. According to this policy, priority in employment and advancement is given to Saudi nationals, which limits opportunities for non-Saudis to progress into senior or leadership

positions (Albejaidi & Nair, 2021; Alluhidan et al., 2020). The findings identified that Saudization practices contributed to diversity issues at the institutional level, creating tension between Saudi and non-Saudi nurses and limiting career progression for non-Saudis. The findings also indicated limited access to leadership positions as a key institutional driver of turnover intention. The Saudization percentage varies by sector and is determined by the Ministry of Human Resources and Social Development (MHRSD) through sector-specific policies (Alnowibet et al., 2021). In line with this policy, certain leadership positions could be designated as accessible to non-Saudis, which may create more equitable opportunities for non-Saudi nurses to advance professionally. Allowing selected leadership roles to be accessible to non-Saudi nurses may help address this barrier and improve retention.

6.10 Lack of Professional Development at KFAFH

The findings of this study identified professional development as a critical gap across both Saudi and non-Saudi nurses, operating at both the institutional and leadership levels. Saudi nurses were advanced into leadership roles without sufficient preparation, while non-Saudi nurses described blocked career progression and limited opportunities for formal advancement. These patterns were identified under the subthemes of Leadership Positions, Diversity Issues, and Opportunities in Chapter 4. From the perspective of Saudi nurses, leadership opportunities were available, as they were preferentially selected for leadership roles. However, because these Saudi nurses were perceived as less trained and less experienced than non-Saudi nurses, they struggled in these leadership positions, partly due

to limitations in Saudi nursing education (AL-Dossary, 2018; Alluhidan et al., 2020; Almansour, 2017; Alsadaan et al., 2021). Both Saudi and non-Saudi leaders and staff described how non-Saudi nurses who were perceived as more experienced would attempt to support Saudi colleagues, especially those in leadership positions in order to maintain operational effectiveness and ensure necessary teamwork took place in the healthcare setting. This appeared to create considerable strain across both groups.

Further, even Saudis complained of acting in leadership positions but not getting the credit, with the title still being applied to the previous employee in the position who had since left. Other complaints included having nurses not be able to work in their specialty setting. Both non-Saudis and Saudis cited the lack of career development opportunities in the KSA healthcare system, but the non-Saudis emphasised the challenges logistically of having a long-term profession in KSA.

The data suggested that professional dissatisfaction arose from limited career development opportunities. The findings indicated not only limited development opportunities, but a structurally misaligned system of progression. Saudi nurses were being advanced into leadership roles without sufficient preparation, while non-Saudi nurses were informally compensating for this gap by providing on-the-job training without recognition or progression. At the same time, both groups described the absence of clear, structured career pathways, which weakened motivation to remain in the organisation. These conditions suggest that the issue was not only limited access to development, but the absence of a formalised system that links training, recognition, and progression. A structured continuing

professional development (CPD) programme therefore represents a targeted intervention, as it would introduce formal training pathways, reduce reliance on informal skill transfer, and align professional development with transparent career progression.

As a result, many participants expressed uncertainty about their long-term future at KFAFH. The demand for further education among nurses underscores the necessity of a CPD programme. Implementing a structured CPD programme would directly address this issue by providing clear pathways for skill development and career progression, which may reduce turnover intention.

6.10.1 Review of the CPD Literature

This section draws on the empirical findings of this study and evidence from the CPD literature to inform the development of a proposed CPD programme. This recommendation was based on the following studies: a CPD programme implemented in KSA by Naholi et al. (2023), a meta-synthesis of older studies of CPD by Mlambo and colleagues (2021), a study of CPD experiences by nurses in Canada by Price and Reichert (2017), a list of evidence-based recommendations to optimise a CPD programme by King and colleagues (2021), and a systematic review of retention strategies for nurses by De Vries et al. (2023).

In Naholi et al. (2023), which took place at King Abdullah Medical Complex (KAMCJ) in Jeddah, the retention strategy put in place included opportunities for professional development, work environment improvements, and the development of pathways for promotion. The programme set up work schedules to monitor nurse-to-patient ratio (Naholi et al., 2023). As part of this, they provided flexibility in work schedules with respect to

time-off requests and family leave (Naholi et al., 2023). They included housing allowances for married couples and updated the food menu to include Filipino and Indian food (Naholi et al., 2023). They improved housing environments by providing updated washing machines and prayer rooms (Naholi et al., 2023). They implemented several career development initiatives, including a Saudi Career Development Programme for Saudi nurses, mentorship programmes for promotion, and preceptorship training for senior staff (Naholi et al., 2023). They also provided cross-training across different departments (Naholi et al., 2023). They implemented a motivational programme giving recognition and awards (Naholi et al., 2023). The implementation of the programme decreased nurse turnover rate from 19.7% in 2019 to 8.9% in 2020 (Naholi et al., 2023).

Mlambo and colleagues (2021) conducted a meta-synthesis including 25 qualitative studies of CPD programmes for nurses. The review identified eleven countries in which participation in CPD programmes is mandatory (Mlambo et al., 2021). They found that successful CPD programmes shared several attributes (Mlambo et al., 2021). Successful CPD programmes provided nurses flexible time to engage in CPD activities without it negatively impacting the workload on other nurses (Mlambo et al., 2021). Successful CPD programmes also allowed the nurse to pursue additional learning in topics and areas of interest to them and aligned with their career goals (Mlambo et al., 2021). They found that nurses felt more supported in their CPD if the programme was arranged locally by their institution (Mlambo et al., 2021). Another finding was that the CPD programme was more effective if nurses were given financial support to participate in it, and were provided with

on-site mentors (Mlambo et al., 2021). They found that nurses valued receiving on-the-job training from other nurses, and that nurses were more likely to choose job positions that offered participation in a CPD programme (Mlambo et al., 2021). Another finding was that nurses who participated in a CPD programme were more motivated and engaged in their work (Mlambo et al., 2021).

Price and Reichert (2017) conducted a focus group study of nurses in Canada about their experiences with CPD. They conducted 18 focus groups involving a total of 185 nurses (Price & Reichert, 2017). All nurses participating were active in the Canadian Federation of Nurses Unions (CFNU) (Price & Reichert, 2017). They found that nursing students and new graduates greatly valued participating in orientation programmes when starting a new position (Price & Reichert, 2017). Nursing students and new graduates also expressed that they felt unprepared for their new positions, and felt they needed to undergo CPD in order to fulfil the demands of their new positions (Price & Reichert, 2017). Early-career nurses expressed that they also valued orientation, but also preferred positions where CPD was emphasised, and valued learning on-the-job from other nurses in different positions (Price & Reichert, 2017). Nurses identified that formal continuing education was necessary in order to keep their licenses and certifications updated (Price & Reichert, 2017). Mid- to late-career nurses indicated they valued mentoring new graduates as well as receiving mentorship, wanted recognitions, and desired formal pathways to promotion to leadership positions (Price & Reichert, 2017).

King and colleagues (2021) reviewed 37 papers from five different countries in the literature and assembled a list of evidence-based attributes of successful CPD programmes in nursing. They found five themes that describe successful CPD programmes: Self-motivation, relevance to practice, workplace learning, strong leadership, and positive culture (King et al., 2021). With respect to self-motivation, they found that nurses who were motivated to participate in CPD because they desired to provide optimal care, had a willingness to learn, saw relevance to clinical practice, and saw the benefit of learning activities were more likely to be satisfied by their CPD experiences (King et al., 2021). In terms of relevance to practice, nurses were more motivated toward CPD if they saw that the CPD programme provided skills and training that were directly relevant to their practice (King et al., 2021). CPD programmes were seen as relevant to practice if they were aligned with organisational priorities and focused on the needs of the patients experiencing care (King et al., 2021). CPD programmes that provided training in the care context (as opposed to outside of the healthcare setting) were seen to be more relevant to practice (King et al., 2021).

Learning taking place in the workplace setting, as part of a CPD programme, was seen to be relevant to practice increasing the nurse's sense of belonging and engagement in the activity (King et al., 2021). Using a preceptorship model was seen as valuable to workplace learning (King et al., 2021). Team-based learning, interdisciplinary learning, and cross-training in the workplace was valued as part of CPD (King et al., 2021). With respect to strong leadership, the review found that organisational support for the CPD was necessary

for it to succeed with nurses (King et al., 2021). Strong leadership in the CPD context was demonstrated through role modelling, mentorship programmes, participatory management, and involving staff in decision-making (King et al., 2021).

Finally, the review found that a positive workplace culture was necessary to optimise a CPD programme (King et al., 2021). A positive workplace culture for CPD refers to a culture that fosters relationships, knowledge creation, and transformation of practice (King et al., 2021). It also promotes academic development, adaptability to workplace learning through new practices (such as use of novel technology), and inter-professional knowledge sharing (King et al., 2021).

De Vries et al. (2023) conducted a systematic review of retention strategies in nursing. They found that high job demands led to burnout, which also led to turnover (de Vries et al., 2023). They also found that higher salaries, a flexible working schedule, and opportunity to participate in career development increased retention (de Vries et al., 2023). Their review found that poor working conditions including inadequate staffing led to turnover, while providing a positive environment and social support at work, and the ability to deal with family issues increased retention (de Vries et al., 2023). Nurturing professional relationships between nurses at work and fostering teamwork also increased retention (de Vries et al., 2023). What De Vries et al. (2023) termed "good organisational culture" also increased retention; being considered an environment where leadership is strong and leaders provided support to staff. A good organisational culture was also defined as not including discrimination or bullying (de Vries et al., 2023). Importantly, De Vries et al.

(2023) found that retention was multifactorial, meaning that many elements must be put in place together to achieve retention.

Taken together, these studies indicate that effective CPD programmes are not limited to training alone, but integrate career progression, workplace support, and organisational culture. This aligns with the findings of the current study, where the absence of structured development, recognition, and progression contributed to turnover intention.

6.10.2 Importance of Continuing Professional Development

The importance of continuing professional development (CPD) for nurses is widely recognised in the literature (Mlambo et al., 2021). CPD supports skill development, improves clinical competencies, and contributes to greater job satisfaction, which in turn can reduce turnover intention (Mlambo et al., 2021; Price & Reichert, 2017). Without CPD, nurses lack structured opportunities for development and career progression and consequently lack opportunities for continued education and career growth (Alreshidi et al., 2021; Mlambo et al., 2021). This absence of structured development opportunities may reduce nurses' motivation to remain in their current positions long-term (Alreshidi et al., 2021; Mlambo et al., 2021). These findings align closely with the patterns identified in this study, where lack of structured professional development, limited career progression, and insufficient leadership preparation were key drivers of turnover intention.

Evidence from KSA demonstrates the value of a CPD programme in supporting nurse retention in KSA. At King Abdullah Medical Complex in Jeddah (KAMCJ), a retention strategy was implemented to include professional development opportunities,

improvements in the work environment, and clear pathways for promotion (Naholi et al., 2023). After introducing these changes, the hospital reported a decrease in its nurse turnover rate from 19.7% in 2019 to 8.9% in 2020 (Naholi et al., 2023). However, this was the only study of implementation of a CPD programme in KSA to address nursing turnover, suggesting that a gap in the literature exists regarding CPD implementation for nurse retention in KSA. This example demonstrates that structured professional development programmes can yield measurable improvements in nurse retention, providing a strong evidence base for implementing a similar approach at KFAFH.

King and colleagues (2021) reviewed the literature to identify factors that optimise the impact of continuing professional development (CPD) in nursing. They noted that CPD is mandatory for nurses to continue with their careers, with country-level policies requiring demonstration of regular engagement in CPD (King et al., 2021). They identified five factors, four of which were directly related to the workplace: self-motivation, relevance to clinical practice, preference for workplace learning, strong enabling leadership, and a positive workplace culture (King et al., 2021). Aside from self-motivation, the other factors were directly related to the nurse's workplace experience (King et al., 2021). Motivation to engage in CPD was higher if the activity was directly relevant to clinical practice, and learning that took place outside the workplace was seen as less relevant and applicable (King et al., 2021). Further, nurses were more motivated to engage in CPD if leadership at work strongly supported this activity and enabled the nurses to fully engage in it (King et

al., 2021). Finally, a positive workplace culture that fosters respectful relationships was found to be a motivating factor for engaging in CPD (King et al., 2021).

As discussed in Section 6.9, Vision 2030 places a strong emphasis on developing the healthcare workforce and creating opportunities for career advancement (Kingdom of Saudi Arabia, 2017). Integrating a CPD programme into the healthcare system would enable Saudi nurses to transition into leadership roles, potentially equipping them with the expertise needed to succeed in these positions and contribute effectively to the advancement of the healthcare sector. At the same time, this approach allows experienced non-Saudi professionals to share their knowledge, recognising their expertise and potentially ensuring they continue to play a valuable role in the workforce.

6.10.3 Using a CPD Programme to Increase Nurse Retention

The findings of this study identified limited professional development opportunities as a significant driver of turnover intention at KFAFH, affecting both Saudi and non-Saudi nurses in different ways. Saudi nurses were advanced into leadership roles without adequate preparation, while non-Saudi nurses described blocked career progression and lack of recognition for their expertise. A structured CPD programme is proposed as a way to address these conditions by providing formal training pathways and transparent career progression for both groups. While financial rewards can provide immediate motivation, they do not contribute to long-term career progression. Additionally, improving working conditions without a structured CPD would still leave nurses without clear leadership

pathways, leading to continued dissatisfaction. CPD ensures that professional growth is embedded within the system, aligning with both workforce needs and Vision 2030.

De Vries and colleagues (2023) studied factors that impact retention of nurses and physicians in hospitals. The primary determinants they found for job retention among nurses and physicians were job satisfaction, career development, and work-life balance (de Vries et al., 2023). All three of these could be improved at KFAFH for Saudis and non-Saudis, and for staff and leadership by addressing all three through a structured CPD programme, as will be described here.

As stated in their review, De Vries and colleagues (2023) identified that one of the primary determinants of retention of healthcare clinicians is job satisfaction which, in turn, is made up of multiple components. Many of these components were mentioned by interviewees, including issues with emotional demands, compassion fatigue and workload, as well as feeling undervalued while having working values and an altruistic desire (de Vries et al., 2023). These elements were already present in the KFAFH setting, but were being challenged by the intersection of the diversity and leadership issues that put less-trained Saudis in leadership positions, which appeared to add stress to otherwise healthy working relationships.

Another primary determinant of retention, work-life balance (De Vries et al, 2023), is specifically challenged for non-Saudis. Even if non-Saudis work the same number of hours as Saudis, their workload is more demanding, largely because insufficiently prepared Saudi

colleagues are unable to fulfil the work assigned to them. In addition, non-Saudis face challenges to having their family living with them, which adds stress. Even if families are permitted, they face logistical challenges to living in KSA society. This contributes negatively to non-Saudi work-life balance and appeared to contribute to turnover intention.

A third and final primary determinant of retention is career development (De Vries et al, 2023). Nurses who participated in career development programmes reported lower levels of stress, higher job satisfaction, and were better equipped to handle new challenges (Mlambo et al., 2021; Price & Reichert, 2017). This is further supported by Alreshidi and colleagues (2021), who identified professional growth and career development as the most effective incentives for encouraging nurse retention (Alreshidi et al., 2021).

Therefore, offering a formalised CPD programme at KFAFH is proposed as a context-specific intervention that may address not only the career development determinant, but also the job satisfaction determinant, as well as the work-life balance determinant for non-Saudis. The CPD could be designed in a way that improves the opportunities for both Saudis and non-Saudis to progress into leadership positions as a result of completing training and having learning experiences within the CPD programme. It also can be designed so that non-Saudis can share their expertise and mentor the Saudis, and both the non-Saudis and the Saudis would be recognised for this as part of the programme. Using the CPD programme to address the pressures arising from insufficiently prepared Saudi

leaders may improve job satisfaction, as many of the complaints of the interviewees related to this issue.

Next, the CPD programme would be designed differently for Saudis and non-Saudis, because these two groups have differing needs for CPD. Saudis require the ability to gain more training and experience, and may benefit from the mentorship of more highly trained and experienced non-Saudis. Non-Saudis would be encouraged to contribute to the training of Saudis as part of their CPD programme. Further, leadership positions would be designated separately for Saudi and non-Saudi nurses, and training for these positions would take place in the appropriate leadership programme. This would allow both Saudis and non-Saudis access to leadership positions, and the ability to train into them. One of the barriers to professional development at KFAFH is managerial control over training decisions. To maximise the impact of the CPD programme, clear policies are required to ensure equitable access and managerial support. In the proposed CPD programme, nurses would have the choice to select CPD courses that align with their career goals, with reduced reliance on approval from hospital administrators. This ensures that professional development is driven by individual growth rather than institutional restrictions. To enhance flexibility and accessibility, the programme could follow an open enrolment model, enabling nurses to join at any stage in their careers. Participation in mentorship activities by non-Saudi professionals would be voluntary, allowing them to contribute their expertise without the expectation of additional obligations. By participating in the training and development of Saudi nurses, non-Saudi professionals would be offered additional

privileges as recognition for their contribution to workforce development. Development opportunities might include access to courses at KSA universities to further their knowledge. Additionally, they would be supported financially and professionally to attend educational and networking conferences. This may increase the likelihood of non-Saudis being retained at KFAFH.

Overall, the empirical findings and supporting literature suggest that a structured CPD programme may address key institutional, leadership, and personal drivers of turnover intention at KFAFH. The following section therefore presents a data-driven, context-specific CPD programme to address these challenges.

6.11 Recommendations for Policy

6.11.1 Proposed CPD programme

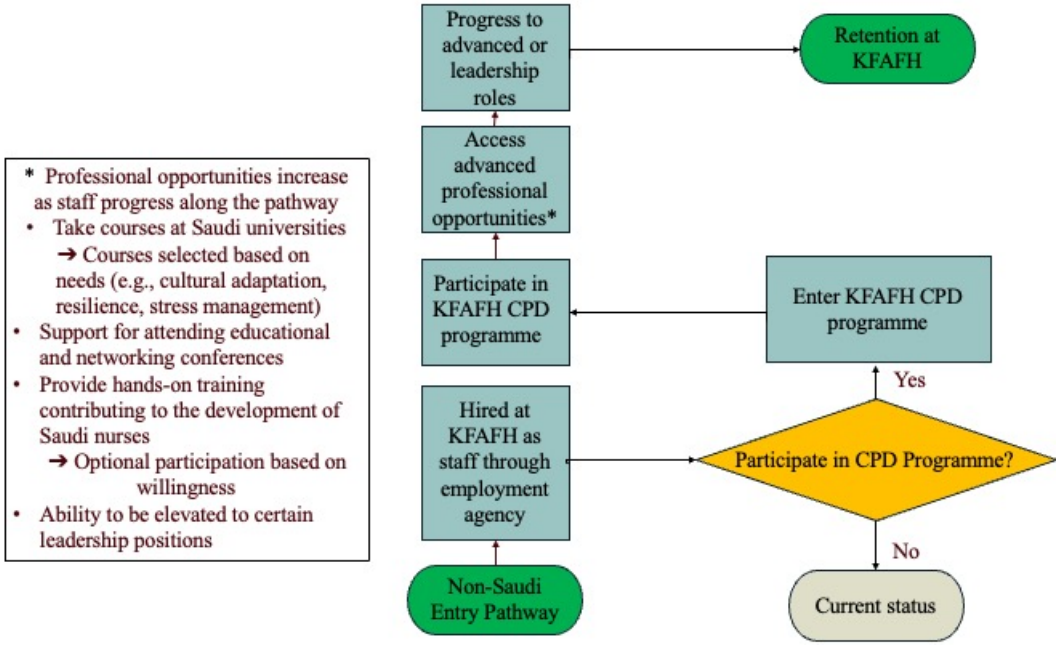
The recommendations presented in this section are grounded in the empirical findings of Chapter 4 and the model developed in Chapter 5, and are designed to address the Institutional, Leadership, and Personal Factors of turnover intention identified in this study. The proposed CPD programme intervenes at the institutional level. By addressing institutional factors first, the programme creates conditions that may support improved leadership practices and personal wellbeing, reflecting the model's positioning of institutional factors as the primary lever for change. To address the important issues cited by staff and leadership, and by Saudis and non-Saudis at KFAFH, a specialised formal CPD programme is proposed, with potential for implementation at the national level, and

managed through local governance. This recommendation draws on international approaches, including national policy approaches in the UK and local governance approaches in the UK, US, and Canada (Adams et al., 2021; Bae, 2023; Boamah et al., 2023; Henshall et al., 2021; McNiven et al., 2021; Nowrouzi-Kia & Fox, 2020; Qureshi et al., 2020). The implementation of such a programme requires organisational support, resource allocation, and alignment with national workforce policies.

The programme would have two distinct operating pathways, one for Saudis, and one for non-Saudis. While the programme focuses on CPD, it would be open to all nurses, with particular encouragement for those aspiring to leadership positions. Certain modules, such as ethical leadership, strategic decision-making, and change management would be included in the training based on the specific needs of each group and open to all participants, regardless of their nationality, while some modules would be designed exclusively for Saudi nurses, and others would be specifically created to meet the needs of non-Saudi nurses. To reduce dependency on informal support from non-Saudi staff, training for Saudis would include a leadership and management module, as well as mentorship and coaching. For non-Saudi nurses, the training would focus on cultural adaptation to help them adjust to Saudi culture and overcome language barriers. Additionally, resilience and stress management training would support them in developing coping strategies and stress management techniques.

Figure 6.1 presents the non-Saudi CPD programme pathway, and Figure 6.2 presents the Saudi CPD programme pathway.

Figure 6.1. Proposed Non-Saudi Continuing Professional Development Programme Pathway



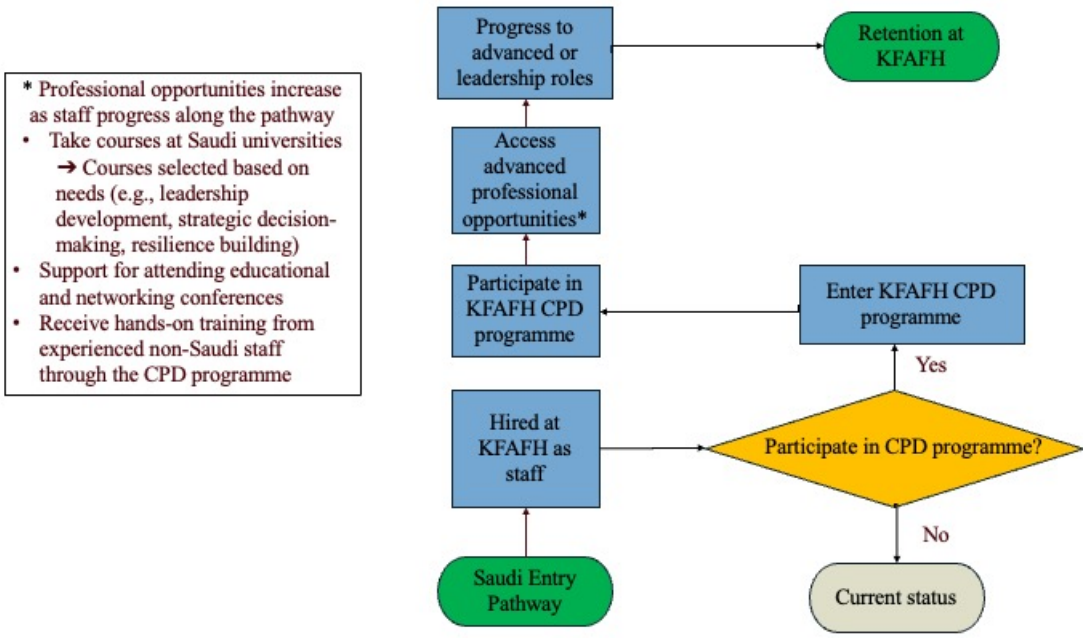
As shown in Figure 6.1, the CPD pathway would be offered to non-Saudi nurses as they are hired at KFAFH through an employment agency as staff. At that time, they can choose to retain their current status, or else enter into the CPD programme. If they enter the CPD programme, they are eligible to access advanced professional opportunities as they proceed through the programme. As shown in Figure 6.1, these include opportunities to take courses at KSA universities to further their knowledge. Additionally, they would be provided with

financial and professional support for attending educational and networking conferences. Non-Saudi staff who enter the CPD pathway will be given opportunities to train less experienced Saudis as part of the programme, and will be recognised for delivering this training. Even for experienced non-Saudi nurses, taking part in the CPD programme provides them with advanced expertise, strengthening their competitiveness for leadership roles.

As further shown in Figure 6.1, this approach ensures continuous engagement of non-Saudi nurses within the CPD programme and would support improvements in job satisfaction and work-life balance, as well as provide structured progression to advanced and leadership roles, which would contribute to retention.

As mentioned earlier, Figure 6.2 depicts the proposal for the Saudi CPD programme.

Figure 6.2. Proposed Saudi Continuing Professional Development Programme Pathway



Saudi nurses hired at KFAFH would be given the choice of participating in the CPD programme or not. As with non-Saudi participants in their CPD programme, Saudi nurses would be offered access to courses at Saudi universities, and would receive support for attending educational and networking conferences. As part of the Saudi CPD programme, nurses would receive training from experienced non-Saudis nurses in the non-Saudi CPD programme. Additionally, certain leadership positions at KFAFH would be designated for Saudi CPD programme participants, supporting alignment with Saudization objectives. To maximise the impact of the CPD programme, it is important to establish well-defined policies that support equity, encouragement, and managerial engagement. Through the

CPD programme, Saudi nurses progressing into leadership positions would be better prepared through structured training and experience. This supports improvements in job satisfaction and work-life balance among Saudi nurses, as well as provide structured progression to advanced and leadership roles, which may contribute to retention.

Separate pathways are necessary, in recognition that Saudis and non-Saudis face different institutional and policy challenges. For Saudis, CPD must align with national workforce goals under Saudization policy and Vision 2030, ensuring that they are prepared for leadership roles. For non-Saudis, CPD provides recognition and support that helps them navigate cultural and institutional barriers, while also opening structured opportunities for progression to advanced and leadership roles through the programme. A single programme does not adequately meet these distinct needs, whereas separate pathways ensure that CPD is relevant, equitable, and capable of addressing the specific drivers of turnover intention for each group.

Further justification for the need for a structured and modular CPD programme as proposed here draws on similar efforts within the Saudi healthcare context. The only intervention identified in the literature was carried out at KAMCJ in Jeddah, where improvements were made in professional development opportunities, the work environment, and pathways for advancement (Naholi et al., 2023). This intervention was linked to a clear reduction in turnover, showing that even general professional development initiatives can positively influence retention.

Beyond this, evidence from the wider CPD literature highlights the importance of programme design and organisational support. Manley et al. (2018) found that workplace-embedded and practitioner-driven CPD was most effective when supported by a positive workplace culture and organisational alignment. In contrast, ad hoc approaches to CPD were seen as inconsistent and limited in their ability to deliver sustained professional growth (Manley et al., 2018). Therefore, the proposed CPD programme builds on current evidence while introducing a formalised, modular, and leadership-focused structure tailored to the KSA context.

The proposed CPD programme draws on the themes identified in Chapter 4, including Institutional, Leadership, and Personal Factors, and reflects key areas related to Compensation, Diversity Issues, Leadership Positions, Leadership and Management Style, Recognition, Staff Expectations and Management, as well as Lifestyle and Opportunities.

6.11.2 Alignment with Existing Literature

This section connects the CPD programme proposed to the literature reviewed earlier. Consistent with Naholi et al. (2023), the proposed CPD programme would provide promotion and development opportunities for both Saudis and non-Saudis, including support for additional education, cross-training, and mentorship by preceptors at KFAFH. As emphasised in Mlambo and colleagues (2021), the proposed CPD programme would require support from leadership and organisational structures, including providing protected time for nurses to engage in CPD activities. As recommended by Mlambo and

colleagues (2021), the programme would be locally arranged by KFAFH, involve on-the-job training with on-site mentors, and be geared toward the specialties of participating nurses.

In addition, the proposed CPD programme reflects the findings by Price and Reichert (2017) by offering on-the-job training as well as formal continuing education. It also includes mentorship and formal pathways to promotion to leadership positions. In terms of the findings by King and colleagues (2021), because career development would primarily take place within the workplace setting, training would be provided in the care context and would be directly relevant to the nurses practices. Because the CPD programme would be implemented with strong leadership support from the KFAFH administration, it would be aligned with organisational priorities, and aimed at supporting the needs of KFAFH patients, as recommended by King and colleagues (2021). Building on the findings of King and colleagues (2021), the recommended CPD programme could include a preceptorship model, team-based learning, interdisciplinary learning from other nurses and nurse leaders at KFAFH, and cross-training in the workplace setting. The proposed CPD programme would include role modelling, mentorship, participatory management, and involving staff in decision-making, as recommended by King and colleagues (2021).

Finally, with reference to findings from retention strategies (De Vries et al 2023), Implementing the CPD programme at KFAFH supports improvements in the workplace environment by strengthening the skills of both leaders and staff. Through the CPD programme, professional relationships among leadership and staff may be strengthened

through on-the-job training and mentorship, potentially resulting in improved teamwork and reduced discrimination and bullying (de Vries et al., 2023). As recommended by De Vries et al. (2023), the CPD programme would be multi-factorial, meaning it would involve many different elements aiming to positively influence the work experience of both Saudi and non-Saudi nurses, potentially improving retention.

It was notable that none of the identified reviewed studies from the CPD literature used theoretical frameworks to guide the development of CPD programmes (de Vries et al., 2023; King et al., 2021; Mlambo et al., 2021; Naholi et al., 2023; Price & Reichert, 2017). This reflects a gap in the evidence supporting the use of formal frameworks in CPD programme development (Thennakoon et al., 2025). For example, the Medical Research Council (MRC) framework was developed not to guide the creation of CPD programmes in nursing, but instead to provide a guide to developing and evaluating health interventions for patients (Wallner et al., 2023). Further, the current CPD literature reviewed emphasised taking into account the opinions and experiences of nurses in the healthcare setting in which the CPD programme will be implemented, leading to a data-driven (rather than theory-driven) selection of CPD components, which may be seen as less aligned with the use of predefined frameworks (de Vries et al., 2023; King et al., 2021; Mlambo et al., 2021; Naholi et al., 2023; Price & Reichert, 2017).

6.11.3 Feasibility

These recommendations, including granting special status to non-Saudi nurses and providing separate CPD pathways for Saudi and non-Saudi nurses, may be considered feasible within the broader framework of Vision 2030 (Alsufyani et al., 2020; Kingdom of Saudi Arabia, 2017). Feasibility is considered here across three dimensions: economic, legal, and cultural. In general, implementing a change in policy is challenging and requires leadership buy-in and resource allocation, which represent key implementation challenges.

The economic feasibility, including costs and resources required to implement these policies, was not assessed in this study and therefore remains unclear. However, funding has been allocated by the Saudi government to achieve Vision 2030 goals, suggesting that economic feasibility may be achievable for these recommendations (Alsufyani et al., 2020; Kingdom of Saudi Arabia, 2017).

The legal feasibility similarly falls outside the scope of this study. However, as regulations are developed at the level of the Saudi Ministry of Health, it is reasonable to suggest that adjustments to accommodate these recommendations could fall within current regulatory authority.

Finally, the cultural feasibility (meaning the acceptability to stakeholders) of implementing these policy recommendations was likewise not formally assessed in this study. However, evidence from the current research suggests that providing Saudi leaders and staff with support to improve their training and experience would be acceptable to Saudi stakeholders. Evidence from the current research also suggests that providing non-Saudi

staff opportunities for career growth and long-term career development while living in KSA would be viewed positively by non-Saudi nurses. This is reflected in the subthemes 'Opportunities' (Personal Factors), which highlighted the importance of career development in shaping turnover intention.

6.12 Recommendations for Research

Although the implementation of a CPD programme is an evidence-based recommendation, there is limited empirical evidence on the impact of CPD programmes on nurse turnover intention (de Vries et al., 2023; King et al., 2021). Further research is therefore needed in this area, particularly within real healthcare settings where such programmes are implemented.

If KFAFH or other healthcare settings in KSA implement a CPD programme such as the one recommended here, this should be followed by research evaluating the effectiveness of its implementation. It is important for leaders implementing the CPD programme to gather feedback from participants and assess which features of the programme are effective and which require further development. Participant satisfaction is likely to play an important role in determining whether the programme contributes to reducing turnover intention.

Future research should also examine the extent to which CPD programmes influence key outcomes such as job satisfaction, career development, and work-life balance, which were identified in this study as contributing to turnover intention. Longitudinal research designs would be particularly valuable in assessing whether participation in CPD leads to sustained

reductions in turnover intention over time. Both qualitative and quantitative data would be gathered to provide a comprehensive evaluation of CPD implementation in healthcare settings in KSA, enabling a more robust understanding of its impact on nurse retention and turnover intention.

These research recommendations draw on the empirical findings presented in Chapter 4. In particular, the subtheme Opportunities (Personal Factors) highlights the importance of career development and progression, while the subtheme Diversity Issues (Institutional Factors) reflects tensions between Saudi and non-Saudi nurses, including perceptions of differences in training and experience. Together, these findings suggest that structured professional development and clearer career pathways may address key factors influencing turnover intention, supporting the need for further research on CPD implementation.

6.12.1 Feasibility

The feasibility of conducting research on the implementation of a CPD programme at KFAFH or other healthcare settings in KSA remains uncertain, as this was not directly assessed in the current study. However, several dimensions of feasibility can be considered based on the context of this research.

At a broader level, there may be disincentives to conducting research on nurse turnover intention, as it may be perceived by some stakeholders as exposing systemic weaknesses within the healthcare system. This may limit the extent to which such research is prioritised or supported, even where implementation feasibility exists.

From an economic perspective, if a CPD programme were implemented at the institutional level, evaluation activities could be incorporated into the overall implementation process. This suggests that research feasibility may be enhanced where evaluation is embedded within programme delivery.

In terms of political feasibility, the implementation of a CPD programme would likely be led by organisational leadership. As a result, research evaluating its effectiveness may be supported as part of accountability and performance improvement processes.

Cultural feasibility is supported by the findings of the current study. Participants were willing to share their experiences of turnover intention, indicating openness to engagement in research. This suggests that stakeholders may be willing to participate in future implementation-related research, particularly where it is positioned as contributing to workforce improvement rather than critique.

6.13 Recommendations for Practice

Figure 6.3 illustrates how the CPD programme could be implemented at KFAFH to address the factors influencing nurse turnover intention.

Figure 6.3. Proposed Implementation of Continuing Professional Development Programme to Address Nurse Turnover Intention at KFAFH

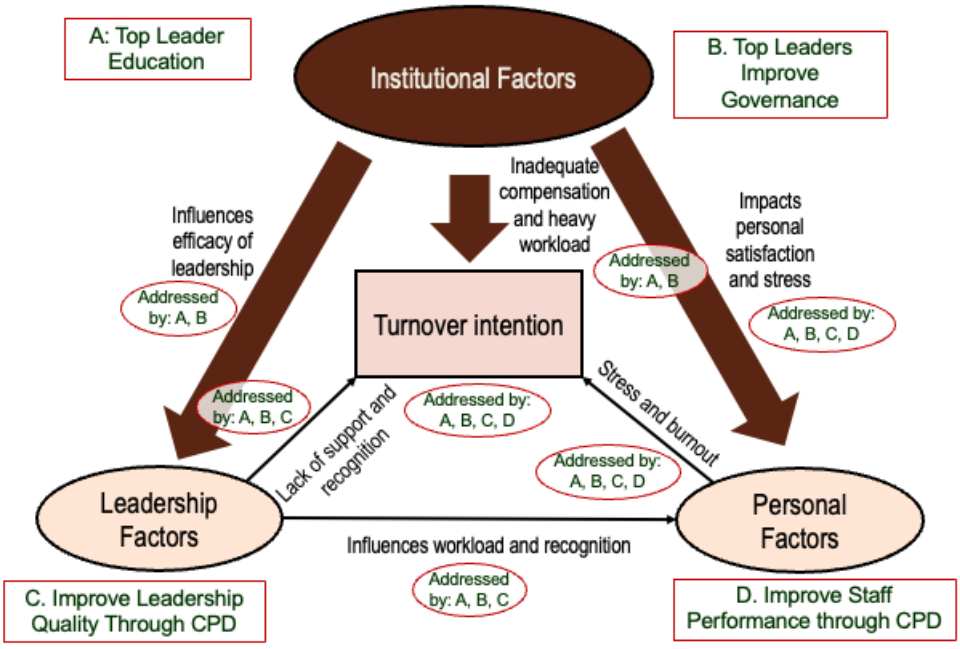


Figure 6.3 is labelled with the four phases of implementation, labelled A, B, C, and D to indicate their sequence.

6.13.1 Implementation Roadmap

Phase A involves top leader education. In this phase, senior leadership at KFAFH would work with CPD programme leaders to design the programme, including the development of structured pathways for leadership progression and continuing education. This phase may also require adjustments to human resources and organisational policies.

Phase B focuses on strengthening governance. During this phase, agreements would be established with relevant partners, and policies required for CPD implementation would be finalised.

Phases A and B focus on institutional-level change. Institutional factors represent the primary level influencing turnover intention, and these phases therefore aim to establish the structural conditions necessary for effective CPD implementation. This phased approach reflects the hierarchical structure of the KSA-centric model, where institutional changes precede leadership and personal-level improvements.

Phase C involves implementing the CPD programme at the leadership level. This stage is prioritised due to the smaller number of leaders and their wider organisational influence. Participation in CPD may strengthen leadership capability, improve management practices, and enhance recognition and support. These changes may positively influence staff experiences, including workload management and recognition, thereby addressing leadership-level factors of turnover intention.

Phase D involves implementing the CPD programme for staff. By this stage, institutional and leadership conditions may already be improved through earlier phases. Staff participation in CPD may contribute to improved job satisfaction, reduced stress and burnout, and enhanced career development. These outcomes directly relate to the personal and institutional factors of turnover intention identified in this study.

Across all four phases, the combined impact of institutional reform, leadership development, and staff engagement is likely to reduce the factors contributing to turnover intention at KFAFH.

These recommendations draw on the themes identified in Chapter 4, particularly Institutional, Leadership, and Personal Factors shaping turnover intention. They relate to Institutional Factors such as Diversity Issues and Leadership Positions, Leadership Factors including Leadership and Management Style, Recognition, Speaking Out, and Staff Expectations and Management, as well as Personal Factors related to Lifestyle and Opportunities.

Together, these findings highlight that nurse turnover intention at KFAFH is shaped by interconnected Institutional, Leadership, and Personal Factors. The proposed CPD programme is therefore designed to address these factors across all three levels through a phased implementation approach, ensuring that the intervention aligns with the empirical findings of this study.

6.13.2 Feasibility

The feasibility of implementing the CPD programme remains uncertain, as it was not directly assessed in this study. However, it can be considered across political, economic, legal, and cultural dimensions within the KSA context.

From a political perspective, the proposed CPD programme aligns with the workforce development priorities outlined in Saudi Vision 2030 (Alsufyani et al., 2020; Kingdom of Saudi Arabia, 2017). This alignment suggests that implementation may be supported at the policy level, although practical challenges related to organisational change and resource allocation remain.

In economic terms, while implementation costs were not evaluated, persistent nurse turnover and turnover intention place a burden on healthcare systems. As a result, a CPD programme may be viewed as a justifiable investment if it contributes to improved retention.

Legal feasibility is also likely to be manageable within the current regulatory framework. Workforce policies in KSA are subject to ongoing development, particularly in alignment with Vision 2030, indicating that regulatory adjustments could be made to support such a programme if required.

Cultural feasibility is supported by the findings of this study. Participants across both staff and leadership levels highlighted the importance of career development, leadership preparation, and long-term stability. This suggests that there may be openness among

stakeholders to initiatives that support professional development as a strategy to address turnover intention.

6.13.3 Success Criteria

In discussing success criteria, it is important to acknowledge that frameworks are generally not used in the development of CPD programmes, which may be due to the notable gap in evidence supporting the use of career development frameworks when creating a CPD programme for nurses (de Vries et al., 2023; King et al., 2021; Mlambo et al., 2021; Naholi et al., 2023; Price & Reichert, 2017; Thennakoon et al., 2025). While frameworks exist to guide the development and evaluation of interventions aimed at improving patient care, these are distinct from those required for employee-focused CPD programmes (Wallner et al., 2023). The absence of CPD programme frameworks consequently contributes to a lack of CPD evaluation frameworks (de Vries et al., 2023; King et al., 2021; Mlambo et al., 2021; Naholi et al., 2023; Price & Reichert, 2017). As a result, each CPD programme would be evaluated based on guidance from individual studies in the literature (de Vries et al., 2023; King et al., 2021; Mlambo et al., 2021; Naholi et al., 2023; Price & Reichert, 2017).

To determine whether the CPD programme contributed to reducing turnover intention and actual turnover, after one year of full implementation KFAFH could compare internal turnover metrics with those from the year prior to implementation. This would represent one indicator of progress.

Success may be indicated by measurable reductions in turnover intention and actual turnover rates, alongside improvements in staff-reported experiences, assessed through

surveys examining leadership and management style, recognition, speaking out, staff relationships, teamwork, opportunities for advancement, and quality of working life.

While these indicators provide a basis for evaluating short-term impact, the extent to which improvements can be sustained over time would require further longitudinal evaluation.

6.14 Reflexivity

Reflexivity has been discussed in detail in Chapter 3 and is briefly revisited here in relation to the discussion and recommendations. As a Saudi female non-nurse researcher with no prior relationship with KFAFH, the researcher's positionality may have influenced how participants expressed their experiences, particularly given the shared nationality with Saudi participants. This may have facilitated openness in discussing leadership and organisational challenges, while also requiring careful attention to avoid over-identification with these perspectives.

The researcher's commitment to improving the quality of nursing care in KSA shaped the interpretation of findings and motivated the development of practical recommendations, including the CPD programme proposed in this chapter. At the same time, this required ongoing reflexive awareness to ensure that recommendations were derived from the data rather than from pre-existing assumptions or expectations.

Throughout, the researcher remained grounded in the data, ensuring that personal values did not override analytical rigour. The recommendations presented in this chapter were

therefore developed through careful integration of empirical findings and supporting literature, maintaining alignment with the study's analytical framework.

6.15 Study Strengths and Limitations

The main strength of this study is that its qualitative design allowed in-depth exploration of themes related to nurse turnover in KSA that have not been previously explored. It enabled examination of differences between Saudi and non-Saudi nurses in factors influencing turnover intention and allowed comparison of issues between nurse leaders and staff that contribute to turnover intention. Another strength is the site-specific focus on KFAFH, which allows the findings to be directly applicable to that setting. KFAFH could implement these recommendations, which may support improvements in nurse retention.

This study, however, has several limitations. The study was conducted at KFAFH only, which limits the transferability of the findings to other healthcare settings. Additionally, direct benchmarking of turnover rates at KFAFH against national or sector-specific figures was not possible. The findings are based on participants who agreed to take part in the study and therefore do not capture the perspectives of staff nurses and nurse leaders from nationalities or demographic groups not represented in the sample. Fewer Saudi nurses participated compared with non-Saudi nurses, which may have influenced the balance of perspectives represented.

A further limitation is that data from nurses who had already left KFAFH could not be included because they were not available for interview. Although interviews were intended to be conducted in English, two interviews included some Arabic words that required

translation by the researcher, which may introduce translation bias. In addition, the novel model developed in this study has not yet been externally validated in other healthcare settings. Finally, actual turnover metrics were not available for analysis. As a qualitative study, the research focused on exploring experiences and perceptions related to turnover intention rather than measuring turnover rates.

6.16 Methodological Reflection

This section provides a critical reflection on what worked well in the study, what did not, and what could have been approached differently. Initially, remote data collection was planned; however, this approach proved challenging. Data collection was much improved when the researcher was on site. Being on site provided greater insight into the KFAFH environment from personal experience and allowed the nursing workforce to feel more comfortable with the researcher, thus improving the quality of their participation in the research.

As the researcher was not affiliated with KFAFH, participants appeared more comfortable sharing their opinions and experiences. Also, because the researcher was not a nurse, the participants did not fear the researcher sharing information with any nurse colleagues she may have. Because the researcher was seen as an outside professional, the participants were more comfortable sharing information about their experiences working as nurses at KFAFH.

Another methodological reflection relates to the use of peer debriefing, as described in Chapter 3. Regular discussions with the supervisory team provided opportunities to review

interpretations and developing findings. This process encouraged the researcher to consider alternative explanations and engage more critically with the data and interpretations, which supported the rigour of the thematic analysis.

6.17 Implications

This section outlines implications of the findings of this research on theory, practice, policy, and research.

6.17.1 Theory

While not aspiring to be theory-driven research, the findings of this research may contribute to theoretical understanding of turnover and turnover intention in nursing by revealing the limitations of current theoretical models, which may reflect the challenges of applying Western models within under-resourced settings. The attributes of lack of adequate salary and chronic staffing issues at KFAFH made it challenging to apply frameworks that rely heavily on job resources within such settings. This motivated the development of the proposed novel model, thereby indicating how strongly the turnover intention problem was driven by institutional-level decisions and attributes. This phenomenon was not clearly identified in the studies included in the QES, so this finding may influence future theories about nurse turnover in under-resourced settings.

6.17.2 Practice

Given that this study was conducted at KFAFH, the findings apply primarily to this setting. It is conceivable that if nursing leaders or administrators at healthcare settings in KSA read

this thesis seeking a strategy to deal with nurse turnover, they may consider implementing the CPD programme recommended. Institutionally, it is anticipated that leaders at KFAFH may consider the findings of this research and the potential value of implementing the proposed CPD programme as a practice change.

6.17.3 Policy

The policy implications of this research relate primarily to the KFAFH context, because the study took place within a specific healthcare setting. At KFAFH, the findings suggest that policies supporting structured professional development may help to address nurse turnover intention. If the CPD programme is successful, administrative leaders may implement policy changes that positively impact Saudi and non-Saudi nurses.

6.17.4 Research

This research may also inform future research on nurse turnover. Researchers who learn about the findings from this research may consider examining institutional-level factors in their research, as well as implementing and evaluating a CPD programme in nursing settings as a strategy to address turnover intention and increase retention. Future research could explore whether the novel model developed in this study applies to other nursing settings beyond KFAFH, particularly within the Gulf Cooperation Council (GCC) countries where similar workforce structures and reliance on expatriate nurses exist. It may also be explored in other international contexts; however, this would depend on key parameters of comparability, including workforce composition, employment structures, and organisational and policy environments.

6.18 Future Research

This section builds on the earlier recommendations for future research. As discussed in the earlier review of the CPD literature, little evidence exists for CPD programmes actually reducing nurse turnover (de Vries et al., 2023; King et al., 2021). Therefore, future research could examine the impact of implementing a CPD programme on nurse turnover and retention. One potential research question is: "What is the impact on nurse turnover and retention of implementing a CPD programme?" The method used could be an implementation research approach (Damschroder et al., 2022).

Also, this research found that existing theories and frameworks were limited in their applicability in the KFAFH setting. Therefore, future research (especially in KSA healthcare settings) could examine the applicability of the novel model developed in this study. A specific question that could be asked is, "Does this novel model apply to a particular nursing environment experiencing turnover?" A case study or other qualitative methodology could be used to examine this question.

Future research on nursing turnover in under-resourced settings could also examine institutional-level factors, a consideration that was not clearly identified in the studies reviewed in the QES. A specific question that could be asked is, "Are institutional factors contributing to nurse turnover?" These institutional factors could be systematically identified and examined, and a survey-based approach could be used to collect data from staff nurses, nurse leaders, and administrators to examine this question.

6.19 Contributions to the Literature

This study makes methodological, empirical, and theoretical contributions to the literature on nurse turnover intention.

From a methodological standpoint, this study applies qualitative interviews and reflexive thematic analysis to examine nurse turnover intention within a complex healthcare setting in KSA. Additionally, the two-phase research design, combining a qualitative evidence synthesis in Phase 1 with primary qualitative research in Phase 2, represents a methodological contribution by demonstrating how QES findings can be used to inform and strengthen primary qualitative research design.

As an empirical contribution, this research identified themes and subthemes not clearly identified in the QES, including institutional-level factors influencing turnover intention and factors associated with leadership composition, where leadership positions were largely occupied by Saudi staff who were sometimes perceived as less experienced than non-Saudi staff. A further empirical contribution is the identification of differential experiences of Saudis and non-Saudis, as well as differences between staff and leadership, in shaping turnover intention. These distinctions had not been clearly identified in the studies included in the QES.

From a theoretical standpoint, the main contribution of this research is the development of a novel model explaining nurse turnover and turnover intention within the KSA healthcare context. This model highlights the hierarchical relationship between Institutional,

Leadership, and Personal Factors and provides a structured framework for further testing and refinement within future research.

6.20 Novel Contribution of Knowledge

This thesis makes several contributions to knowledge in relation to nurse turnover and turnover intention in the Kingdom of Saudi Arabia (KSA). First, it presents the first qualitative evidence synthesis (QES) conducted specifically on nurse turnover and turnover intention within the KSA healthcare context, addressing a clear gap in the existing literature. The QES further identified that previous studies have not differentiated between Saudi and non-Saudi nurses, or between nurse leaders and staff nurses. By examining these groups separately, this study enables a more nuanced understanding of turnover-related experiences.

The qualitative findings demonstrate that the experiences of Saudi and non-Saudi nurses, as well as those of staff nurses and leaders, differ in substantive ways that have not been adequately addressed in the literature. In addition, this study identifies subthemes that have not been clearly examined in the KSA context, including leadership positions and diversity issues, and highlights the role of Saudization as a contributing factor to turnover intention by demonstrating the mechanisms through which it operates.

Building on these findings, the thesis presents a novel model for understanding nurse turnover and turnover intention at King Fahad Armed Forces Hospital (KFAFH), conceptualising Institutional, Leadership, and Personal Factors within a hierarchical

structure. This model extends current research by demonstrating how these factors operate in relation to one another within the KSA context.

The study also develops context-specific, evidence-based recommendations tailored to KFAFH. These include proposals such as establishing a special status under Vision 2030 for non-Saudi nurses and their families, and implementing separate Continuing Professional Development (CPD) pathways for Saudi and non-Saudi nurses.

6.21 Conclusion

This research investigated the factors contributing to nurse turnover intention and developed evidence-based retention strategies for the nursing workforce in KSA healthcare settings. The findings demonstrate that reasons for turnover intention differ between Saudi and non-Saudi nurses. Non-Saudi nurses faced additional structural barriers arising from their residency status and family separation, making turnover intention more pronounced among this group. Both Saudis and non-Saudis expressed barriers to engaging in a long-term career and progressing to leadership roles at KFAFH. Differences were also identified between staff nurses and nurse leaders, particularly in relation to leadership experiences. Nurse leaders felt undervalued and unsupported by higher-level management, reflecting broader issues within the institutional leadership structure, including the frequent use of acting roles rather than formally recognised leadership positions.

A further contribution of this research was the development of a novel KSA-centric model of nurse turnover intention. This model proposes a hierarchical structure in which Institutional Factors operate as the primary level, shaping leadership conditions and

personal experiences. The model addresses a gap in the literature by capturing the structurally hierarchical conditions that shape nurse turnover intention within the KSA context, which are not fully represented in contemporary theoretical models.

Overall, this thesis proposes evidence-based recommendations to address nurse turnover intention at KFAFH, consistent with both the literature and KSA's countrywide strategic plan Vision 2030. These include affording special status under Vision 2030 for non-Saudi nurses and their families with rights to housing, education, and business opportunities. To address professional development needs alongside these structural reforms, a formalised CPD programme is proposed for implementation at KFAFH, with distinct pathways for Saudi and non-Saudi nurses in recognition of differences in their needs. Through these CPD programmes, KFAFH would provide structured training aligned with identified development gaps and formally recognise both staff and leaders for their accomplishments. While the effectiveness of this intervention requires further evaluation, it may contribute to reducing turnover intention and improving retention of both Saudi and non-Saudi staff and nurse leaders, thereby supporting the sustainability of KFAFH's nursing workforce and contributing to the broader goals of Vision 2030.

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Appendices

A	Instructions for CASP Tool
B	The assessments in the Methodological Limitations
C	Results of the GRADE-CERQual
D	Nurse Leader Recruitment Survey
E	Nurse Staff Recruitment Survey
F	Nurse Leader Questionnaire
G	Nurse Staff Questionnaire
H	Nurse Leader Interview Questions
J	Nurse Staff Interview Questions
K	Approval from KFAFH's ethical board
L	Approval from UREC

Appendix A: Instructions for CASP Tool

Instructions for Nurse Turnover Modified CASP Tool

Overview

This method was adapted from several sources. First, the original article on the CASP was reviewed, along with evidence from the literature related to Cochrane reviews and qualitative research

Next, how the CASP tool was adapted to use in a particular study was reviewed (Karimi-Shahanjarini et al., 2019).

The tool is designed so that the reviewer is asked to rate and then classify each article for inclusion against seven (7) items that are supposed to be completely addressed in each article in order for it to have a high methodological appraisal. The classification scale is this:

Item Status
Item presents no methodological limitations
Item presents minor methodological limitations
Item presents moderate methodological limitations
Item presents major methodological limitations

The following instructions will provide guidance on classifying each item. The first individual will classify all of the articles of inclusion for all seven (7) items on an Excel spreadsheet. She will then provide this Excel sheet to the two other raters. Those will either agree or disagree with each classification. If there are any disagreements, they will be discussed, and the group will arrive at a consensus classification.

After all items are rated, the reviewers will look across the profile of all included studies and provide an overall evaluation of their methodological limitations.

Item 1. Was the context described?

In this case, "context" refers to both the background of the issue of nurse turnover and related issues (burnout, job satisfaction, etc.) as well as the actual context of the data collection (e.g., hospital or clinic, ICU or other department, etc.).

Table A1. Appraisal criteria for assessing whether the study context was described

Circumstance	Classification
Item is missing. The article is missing both an explanation of the background of the issue, as well as a description of the setting in which the research took place.	Item presents major methodological limitations
Item is poorly addressed. Either the background or the description of the setting is present, but not both.	Item presents moderate methodological limitations

Circumstance	Classification
Item is addressed. Both the background of the issue and the setting are described, but not completely.	Item presents minor methodological limitations
Item is completely addressed. Both the background of the issue and the setting are completely described.	Item presents no methodological limitations

Item 2. Was the sampling strategy appropriate and described?

Some of the articles will be mixed methods, but this review is only focusing on the qualitative data. Therefore, only the qualitative sampling strategy (and not the quantitative one included) will be appraised here.

Here is guidance on classifying the article as to whether or not the qualitative sampling strategy was appropriate and described.

Table A2. Appraisal criteria for assessing whether the qualitative sampling strategy was appropriate and described

Circumstance	Classification
Item is missing. There is no discussion of how the sample was obtained.	Item presents major methodological limitations

Circumstance	Classification
Item is poorly addressed. Sampling strategy is mentioned, but no description of how the sampling was done is included.	Item presents moderate methodological limitations
Item is addressed. Sampling strategy is described, but not completely.	Item presents minor methodological limitations
Item is completely addressed. Sampling strategy completely described.	Item presents no methodological limitations

Item 3. Was the data collection strategy appropriate and described?

Again, this review includes mixed-methods studies with a focus on the qualitative component of the study. Therefore, this item should only appraise the qualitative data collection strategy.

This table focuses on classifying whether or not the qualitative data collection strategy was appropriate and described.

Table A3. Appraisal criteria for assessing whether the qualitative data collection strategy was appropriate and described

Circumstance	Classification
Item is missing. There is no discussion about how qualitative data were collected.	Item presents major methodological limitations
Item is poorly addressed. It is apparent that qualitative data were collected, but it is not clear exactly how.	Item presents moderate methodological limitations
Item is addressed. How the qualitative data was collected is described, but not completely.	Item presents minor methodological limitations
Item is completely addressed. How the qualitative data was collected is completely described.	Item presents no methodological limitations

Item 4. Was the data analysis appropriate and described?

Again, this review includes mixed-methods studies, but the focus is only on the qualitative portion of the study. Therefore, this part should only appraise the qualitative data analysis strategy.

This table presents guidance on classifying whether or not the qualitative data analysis strategy was appropriate and described.

Table A4. Appraisal criteria for assessing whether the qualitative data analysis strategy was appropriate and described

Circumstance	Classification
Item is missing. There is no discussion about how qualitative data were analysed.	Item presents major methodological limitations
Item is poorly addressed. It is apparent that qualitative data were analysed and findings revealed, but it is not clear exactly how.	Item presents moderate methodological limitations
Item is addressed. How the qualitative data was analysed is described, but not completely.	Item presents minor methodological limitations
Item is completely addressed. How the qualitative data was analysed is completely described.	Item presents no methodological limitations

Item 5. Were the findings supported by evidence?

Again, in mixed-methods studies, this will only pertain to the qualitative findings and evidence, not quantitative.

How well the qualitative findings are supported by the evidence depends upon what evidence is actually presented, and which findings are actually presented. If evidence is presented without findings, or findings are presented without evidence, then the item may be classified as "unclear". If both findings and evidence are presented, and the findings

appear supported by the evidence, then how well this is expressed will be the difference between a classification of “unclear” and “completely”.

Table A5. Appraisal criteria for assessing whether the qualitative findings were supported by evidence

Circumstance	Classification
Item is missing. Both findings and evidence are either extremely poorly addressed or missing.	Item presents major methodological limitations
Item is poorly addressed. Findings and evidence are present, but it is unclear how they are connected.	Item presents moderate methodological limitations
Item is addressed. Findings and evidence are presented, and the findings appear to support the evidence, but complete information is not presented.	Item presents minor methodological limitations
Item is completely addressed. Complete information about how the findings are supported by the evidence is presented.	Item presents no methodological limitations

Item 6. Is there evidence of researcher reflexivity?

Researcher reflexivity refers to considering the views and perspectives of the researchers, and reflecting on how this could have led to bias in the analysis and reporting of results (Karimi-Shahanjarini et al., 2019; Long et al., 2020). This item is only applicable to

qualitative studies, so in mixed-methods studies included, only the qualitative portion will be evaluated for researcher reflexivity.

Table A6. Appraisal criteria for assessing whether researcher reflexivity was demonstrated

Circumstance	Classification
Item is missing. There is no mention of researcher reflexivity.	Item presents major methodological limitations
Item is poorly addressed. Researcher reflexivity in mentioned, but not described.	Item presents moderate methodological limitations
Item is addressed. Researcher reflexivity is described, but not completely.	Item presents minor methodological limitations
Item is completely addressed. Research reflexivity in completely described.	Item presents no methodological limitations

Item 7. Have ethical issues been taken into consideration?

There are slightly different ethical issues with quantitative vs. qualitative research. This appraisal will only apply to the qualitative portion of included mixed-methods studies.

Ethical issues that could be taken into consideration include but are not limited to: Ethical board approval; informed consent; levels of confidentiality and privacy with respect to data

collection, storage, and analysis; and suppressing private information or aggregating it for publication.

Table A7. Appraisal criteria for assessing whether ethical issues were considered in the qualitative component of the study

Circumstance	Classification
Item is missing. There is no mention of any ethical issues being taken into consideration.	Item presents major methodological limitations
Item is poorly addressed. Article mentions ethics (e.g., ethical board approval), but there is no description of ethical issues being taken into consideration.	Item presents moderate methodological limitations
Item is addressed. Discussion of ethical issues being taken into consideration is present, but not complete.	Item presents minor methodological limitations
Item is completely addressed. Complete discussion of ethical issues is present.	Item presents no methodological limitations

Appendix B: The assessments in the Methodological Limitations

Methodological Limitations

✓	None
Minor	Minor
?	Moderate
×	Major

Study ID	Year	Was the context described?	Was the sampling strategy appropriate and described?	Was the data collection strategy appropriate and described?	Was the data analysis appropriate and described?	Were the findings supported by evidence?	Is there evidence of researcher reflexivity?	Have ethical issues been taken into consideration?	Overall assessment of methodological limitations
Alotaibi	2016	?	×	✓	?	✓	×	✓	Moderate
Almansour	2017	✓	?	✓	✓	✓	×	✓	Minor
Aljohani	2018	?	×	×	?	×	×	?	Major

Saleh	2018	✓	×	✓	✓	?	×	?	Moderate
Alshareef	2019	✓	×	×	×	✓	×	✓	Major
Shatnawi	2020	✓	✓	✓	✓	✓	✓	✓	None
Al-Nusair	2022	?	✓	✓	?	×	×	?	Major

Appendix C: GRADE-CERQual Results

Summary of review finding	Studies contributing to the review finding	Methodological limitations	Coherence	Adequacy	Relevance	GRADE-CERQual assessment of confidence in the evidence	Explanation of GRADE-CERQual assessment
Leadership Crisis: Due to the economic and policy environment, workers at all levels in the healthcare system in Saudi lack leadership and management skills. This includes staff nurses, head nurses, nurse managers, physicians, higher level managers, and members of the administration, and is true of both Saudis and non-Saudis	1-7	Moderate (Three were theses so were not peer-reviewed, but these had more findings from the qualitative portion of mixed-methods studies. The four journal articles did not present extensive or well-analysed qualitative findings. Therefore, the findings are heavily based on the three theses	Minor Concerns (Authors of all studies did not prepare their qualitative findings using a clear, actionable approach. This led to an overabundance of thinly-supported themes, but overall, these are coherent with our findings.)	No or minor concerns about adequacy	This finding is highly relevant. Most articles showed that there was a leadership crisis, but did not identify it or point it out.	High confidence	Data from 9 articles about 7 studies with moderate limitations and minor concerns about coherence and adequacy

Summary of review finding	Studies contributing to the review finding	Methodological limitations	Coherence	Adequacy	Relevance	GRADE-CERQual assessment of confidence in the evidence	Explanation of GRADE-CERQual assessment
		compared to the four journal articles.)					

Summary of review finding	Studies contributing to the review finding	Methodological limitations	Coherence	Adequacy	Relevance	GRADE-CERQual assessment of confidence in the evidence	Explanation of GRADE-CERQual assessment
Complex Webs of Discrimination: Unequal treatment of workers happens at all levels for complex reasons having to do with favouritism, nepotism, stereotypes, racial and ethnic discrimination (especially Saudi vs. non-Saudi), sexism, favouritism toward certain professions, and other features depending upon the local context and the makeup of the employees in it.	1-7	Moderate (Not all articles studied both Saudi and non-Saudi nurses, or nurses at different levels of leadership. Although discrimination is rampant, how it plays out depends upon the local context.)	Minor Concerns (findings from all the articles included are represented in this theme, because they all reported at least one type of discrimination. This suggests that the finding of a high prevalence of discrimination in workplace contexts in general is coherent.)	No or minor concerns about adequacy	This finding is highly relevant. Most articles showed that there was at least one type of discrimination, but did not assign overall discrimination as a theme or finding.	High confidence	Data from 9 articles about 7 studies with moderate limitations and minor concerns about coherence and adequacy

Summary of review finding	Studies contributing to the review finding	Methodological limitations	Coherence	Adequacy	Relevance	GRADE-CERQual assessment of confidence in the evidence	Explanation of GRADE-CERQual assessment
Saudi Societal Factors Place Pressure on Saudis and Non-Saudis: Saudis feel societal pressure to adhere to Saudi and Islamic norms, but the workplace environment makes this difficult. Non-Saudis feel oppressed by Saudi norms, such as having to wear and abaya, and having lack of recreation in Saudi.	1 and 4-6	Moderate (Not all articles studied both Saudi and non-Saudi nurses. Analyses often did not acknowledge cultural, societal, Islamic or other influences.)	Minor Concerns (When articles brought up cultural, societal, or Islamic influences, they generally showed how these added pressure to the workplace environment, regardless of who was in it.)	No or minor concerns about adequacy	This finding is connected with the first two findings, and will have a strong influence over any solutions proposed. Therefore, this finding is highly relevant.	High confidence	Data from 4 studies with moderate limitations and minor concerns about coherence and adequacy

Appendix D: Nurse Leader Recruitment Survey

[EMAIL WORDING]

Dear KFAFH Nurse Leader,

My name is Sarh Almubark, and I'm a doctoral student at University of Sheffield. I am conducting research at King Fahad Armed Forces Hospital (KFAFH) on ways to reduce nurse turnover and improve nurse retention. I will be collecting data from November 2023 to January 2024.

In the research I am conducting, I will record interviews with nurse leaders and staff nurses at KFAFH. I will ask about the reasons for nurse turnover and factors that contribute to nurses leaving KFAFH.

If you think you might be interested in participating in my research, please click on this link [XXXX] to provide your contact information, and I will contact you to answer any questions.

[SURVEY]

Name: ___

E-mail for contact: _____

Phone for contact: _____

WhatsApp for contact: _____

What is your title?: _____

In what unit or department do you work?: _____

What year did you first work for KFAFH?: _____

Thank you! I will contact you. I look forward to speaking with you.

Appendix E: Nurse Staff Recruitment Survey

[EMAIL WORDING]

Dear KFAFH Staff Nurse,

My name is Sarh Almubark, and I'm a doctoral student at University of Sheffield. I am conducting research at King Fahad Armed Forces Hospital (KFAFH) on ways to reduce nurse turnover and improve nurse retention. I will be collecting data from November 2023 to January 2024.

In the research I am conducting, I will record interviews with nurse leaders and staff nurses at KFAFH. I will ask about the reasons for nurse turnover and factors that contribute to nurses leaving KFAFH.

If you think you might be interested in participating in my research, please click on this link [XXXX] to provide your contact information, and I will contact you to answer any questions.

[SURVEY]

Name: ___

E-mail for contact: _____

Phone for contact: _____

WhatsApp for contact: _____

What is your title?: _____

In what unit or department do you work?: _____

What year did you first work for KFAFH?: _____

Thank you! I will contact you. I look forward to speaking with you.

Appendix F: Nurse Leader Questionnaire

What is your gender? Circle the correct response.

1. Male

2. Female

9. Do not want to say

What is your country of origin? _____

What is your title at work? _____

In which department or unit do you work? _____

What is your highest educational degree? _____

In what year did you receive this degree? _____

How many years have you worked at KFAFH (in any role)? If you have taken time away from KFAFH, count up the total amount of time you have actually worked at KFAFH. Please circle the number next estimate.

1 Less than one year

2 One to two years

3 Three to five years

4 Six to ten years

5 More than ten years

9 Don’t know/do not want to say

How many years have you served in a manager role at KFAFH?

1 Less than one year

2 One to two years

3 Three to five years

4 Six to ten years

5 More than ten years

9 Don’t know/do not want to say

Appendix G: Nurse Staff Questionnaire

What is your gender? Circle the correct response.

1. Male

2. Female

9. Do not want to say

What is your country of origin? _____

What is your title at work? _____

In which department or unit do you work? _____

What is your highest educational degree? _____

In what year did you receive this degree? _____

How many years have you worked at KFAFH (in any role)? If you have taken time away from KFAFH, count up the total amount of time you have actually worked at KFAFH. Please circle the number nearest to your estimate.

1 Less than one year

2 One to two years

3 Three to five years

4 Six to ten years

5 More than ten years

9 Don’t know/do not want to say

Appendix H: Interview Questions for Nurse Leadership

First, I will ask you a few questions about turnover among staff nurses at KFAFH. Later, I will ask you questions about turnover among nurse leadership at KFAFH.

Staff Turnover

1. What are the reasons for turnover in staff nurses at KFAFH, in your opinion? (Probe)

2. If any, how do you think relationships between Saudi and non-Saudi staff play a role in turnover in staff nurses, if any? (Probe)

3. If any, how do you think relationships between leadership and staff nurses play a role in turnover of staff nurses, if any? (Probe)

4. What do you think KFAFH leadership should do to address turnover among nursing staff? (Probe)

Now, let's change to a new topic, which is turnover among nurse leadership at KFAFH.

Leadership Turnover

4. In your opinion, that are the reasons for turnover in nurse leadership at KFAFH? (Probe)

5. If any, how do you think relationships between Saudi and non-Saudi employees in general play a role in turnover in of nurse leadership? (Probe)

6. What do you think KFAFH leadership should do to address turnover among nursing leadership? (Probe)

7. Before we end, is there anything more you want to tell me about nurse turnover at KFAFH?

Appendix J: Interview Questions for Nurse Staff

1. What are the reasons for turnover in staff nurses at KFAFH, in your opinion? (Probe)

2. If any, how do you think relationships between Saudi and non-Saudi employees play a role in turnover in staff nurses? (Probe)

3. If any how do you think relationships between leadership and staff nurses play a role in turnover of staff nurses? (Probe)

4. What do you think KFAFH leadership should do to address turnover among nursing staff? (Probe)

5. Before we end, is there anything more you want to tell me about nurse turnover at KFAFH? (Probe)

Appendix K: Approval from KFAFH's ethical board

Notification Approval of a Proposal

Date: 20/Sep/ 2023	**Department**: Nursing	**Ref:** REC 618
Researcher Name: Sarh Almubark	**Email**	[redacted]
Address: King Fahd Armed Forces Hospital / Jeddah	**Mobile:**	[redacted]
Supervisors or Co-authors Contact info	Emily Wood: [redacted] Andrew Booth	

Dear Sarh Almubark

The Research Ethics Committee of Armed Forces Hospitals-Jeddah, has reviewed your research project application Number (2023-66), entitled (**Study of Turnover, Ethnicity and Leadership Among Nurses at a Public Hospital in the Kingdom of Saudi Arabia)** And is pleased to inform you that, this project has been approved under the normal procedure.

The project complies with all the requirements and policies established by the REC.

- *Unless renewed, approval lapses **Nine Months** after approval date, you are requested to observer the following for undertaking the project:*
  1. *At designated intervals until the project is completed, a Project Status Report must be submitted to the REC office.*
  2. *Any significant change in the experimental procedure as described should be reviewed by this Committee prior to altering the project.*
  3. *Notify REC about any new investigators not named in original application.*
  4. *Any injury to a subject because of the research procedure must be reported to the Committee immediately.*
  5. *When signed consent documents are required, the primary investigator must retain the signed consent documents for at least three years past completion of the research activity. If you use a signed consent form, provide a copy of the consent form to subjects at the time of consent.*
  6. *If this is a funded project, keep a copy of this approval letter with your proposal/grant file.*
  7. *In publication process, name of the hospital must be mentioned in the affiliation.*
  8. *After publication, a cop of the published article to the sent to Research Department/Research Committee.*
- Please inform REC when this project is terminated.
- You must also provide REC with a **periodic or maximum an annual** status report to maintain REC approval.
- If your project receives funding which requests an annual update approval, you must request this from REC **one month** prior to the annual update.

Thanks for your cooperation. If you have any questions, please contact me.

Sincerely,

[redacted]

Signature:

[redacted]

Appendix L: Approval from UREC