

RESEARCH ARTICLE

Work-life balance of expatriate nurses working in acute care settings

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Abstract

Aim: To examine the quality of work life of acute care expatriate nurses in multiple regions of Saudi Arabia.

Methods: A country-wide cross-sectional survey was carried out between June–August 2020 using the Brooks' quality of nursing work-life questionnaire.

Results: The range of quality of nursing work-life scores (80 to 245) was moderate, with an overall mean score of 175.3 (\pm 23.1). Only 723 (42.4%) of the nurses experienced a high quality of nursing work life. Multivariable regression analysis showed that 21 to 40 years' age group, being a Filipino or Indian nurse and working in the northern region were the independent predictors of low quality work life.

Conclusion: Most expatriate nurses were not satisfied with their quality of work life. Hospital administrators should take initiatives to enhance the quality of expatriate nurses' work life towards improving their productivity and quality of patient care.

KEYWORDS

acute care, expatriate nurses, job satisfaction, nursing workforce, QNWL, Saudi Arabia, turnover, workforce issues

1 | INTRODUCTION

Quality of work life (QWL) is a worldwide, multidimensional fundamental phenomenon that explores the emotion of workers in consideration of their work and other aspects of their personal life (Leitão et al., 2019). The QWL encompasses several concepts like the job content, work environment, adequate wages and compensation, job description, prospects for career growth, workplace safety, job security, employee relations, involvement in decision-making, job-related stress and work-life balance (Pandey & Tripathi, 2018; Phillips, 2020; Sumartini et al., 2018). In a more specific nursing perspective, the Quality of Nursing Work life (QNWL), encompasses the different concepts that greatly influence the QWL of nurses and it is crucial to their productivity in

the field (Nayeri et al., 2011; Nowrouzi et al., 2016; Phillips, 2020; Sumartini et al., 2018). Modifications occurring in the QNWL may cause adverse outcomes in the personal life of the nurses and predispose them to offering poor nursing service, thereby being a threat to patient care and safety (Nayeri et al., 2011; Nowrouzi et al., 2016; Phillips, 2020; Sumartini et al., 2018). Several studies have revealed that the QNWL is related to nurses' satisfaction with their work and high QNWL would improve productivity, lower absenteeism, decrease professional draining, lower occupational stress, burnout and injuries and improve job pleasure (Biresawa et al., 2020; Lee et al., 2015; Nayeri et al., 2011; Nazari et al., 2019; Nowrouzi et al., 2016; Parveen et al., 2016; Phillips, 2020; Sumartini et al., 2018). However, low QNWL has been shown to be a statistically significant factor associated with

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nurses' intention to leave their units, organization and profession (Almalki et al., 2012; Lee et al., 2015; Parveen et al., 2016).

Regular assessment of the QWL can potentially give health systems with crucial information about the welfare of their employees, including satisfaction with their job, general well-being, balance between their work and family life (Almalki et al., 2012; Leitão et al., 2019; Nowrouzi et al., 2016; Parveen et al., 2016). Therefore, the adoption of strategies to increase the QWL of nursing professionals and other healthcare workers can have many advantages for the health system particularly, in reinforcing employee commitment to the system, enhancing quality of services delivered and improvement in the productivity of the health workers (Nayeri et al., 2011; Nazari et al., 2019; Parveen et al., 2016).

2 | BACKGROUND

Studies carried out in the Kingdom of Saudi Arabia (KSA) have shown that 52.4% to 54.7% of nurses, especially those working in the primary healthcare units were not satisfied with their QWL, and 40% to 94% of the nurses have intention to quit their jobs as result of this low QWL (Almalki et al., 2012a, 2012b; Parveen et al., 2016). Furthermore, other studies have evaluated factors associated with QNWL and revealed that gender, marital status, qualification and nationality were the common sociodemographic characteristics associated with QNWL scores (Alharbi et al., 2019; Almalki et al., 2012b; Kaddourah et al., 2018; Moradi et al., 2014). Other studies have revealed that type of hospital, duration of work experience, nursing position and work department are the work-related factors that are associated with QNWL scores (Biresawa et al., 2020; Hemanathan et al., 2017; Kelbiso et al., 2017; Suleiman et al., 2019).

Although several studies have investigated the QNWL among nurses working in KSA (Albougami et al., 2020; Alharbi et al., 2019; Almalki et al., 2012a, 2012b; Parveen et al., 2016), none have specifically investigated the level and determinants of QNWL among expatriate nurses. Data available from the Ministry of Health (MOH) in KSA indicate that about 60% of nurses are expatriate nurses, and about 5% of them are males (Ministry of Health, 2019). The majority of those expatriate nurses come from the Philippines, India and Malaysia to fill specialty care nursing positions in highly technical acute care settings (Alluhidan et al., 2020). Mostly contracted by the MOH, the contract benefits include the following free services; housing, food supply, transportation, health insurance and a returned air-flight ticket to the country of origin. Typically, expatriate nurses live in a free-of-charge shared housing, normally with other female nurses of the same nationality, arranged by their employers in close proximity of the hospital they work at. However, there might be some house regulations and movement restrictions in these housing compounds set by the hospital management, which differ from one workplace to another. That's why those married expatriate nurses may choose to live, with their families, elsewhere. Expatriate

nurses work 8-hr a day for five to six days a week, expected to perform shift work including night shifts. Previous studies have reported that expatriate nurses face a number of challenges with their work in particular the challenges of cultural competency (due to their religion, culture and language), nurse-patient communication barriers and workplace incivility (Alosaimi & Ahmad, 2016; Alshehry et al., 2019). Albougami et al. (2020) surveyed 318 staff nurses (57.5% expatriate) working in KSA to investigate the aspects affecting nurses' intention to leave. They found that some quality of life dimensions such as physical and psychological health could predict the nurses' turnover intention. In particular, high risk groups were identified as being single, a Filipino or Indian nationality, or having a low monthly wage.

Some reports highlight that a statistically significant proportion of expatriate nurses in KSA tend to have high job insecurity, unfavourable working conditions, low pay and low-social status, which led to alarming rates of turnover (Alluhidan et al., 2020; Falatah & Salem, 2018; Saquib et al., 2020). Furthermore, expatriate Filipino nurses revealed that poor salary/financial motivations, poor quality of life and poor work environments were their topmost reasons for quitting practice in Saudi hospitals (Aljohani & Alomari, 2018). These challenges underscore the need to regularly evaluate the QWL of expatriate nurses so that evidence-based strategies to enhance their work life and productivity could be developed.

3 | THE STUDY

3.1 | Aims

The purpose of this study is to examine the pattern and level of QNWL and its predictors among expatriate nurses in acute care settings in Saudi Arabia.

3.2 | Design

A descriptive country-wide cross-sectional online survey was carried out between June–August 2020 to achieve the study objectives. The study adheres to the STROBE reporting guidelines for cross-sectional studies.

3.3 | Study setting

This study covered the five main geographical regions of KSA by recruiting expatriate nurses from public (government) hospitals in the major cities of each region. The inclusion criteria were being an expatriate nurse and having one-year experience of working in an acute care setting, for example, the intensive care unit, paediatric intensive care unit, emergency department, coronary care unit, artificial kidney unit, neonatal intensive care unit, burn unit, operating room, labour room, stroke unit and day surgery unit. The reason for

including only the expatriate nurses working in acute care units is because these work units are highly specialized requiring special set of nursing skills and training. In addition, the experienced nurses in these units are in high demands due to shortage of their skillset making them prone to having a high workload and having high turnover rates (Aljohani & Alomari, 2018; Phillips, 2020).

3.4 | Respondents

A non-probability convenient sampling technique was used to recruit all consenting registered expat nurses working in acute care settings of large public hospitals in KSA. The eligible nurses were recruited via nursing management office of each hospital. An invitation email with electronic link to the survey was sent to the nursing management office in each region to distribute to the target population and recruit those who agree to participate. A complementary printable invitation poster with a quick response code linked to the survey was also sent to be placed at the nursing office and on each unit. A summary of the study aimed and objectives and what is required from nurses to participate were explained, and also a copy of a printable survey document was attached for those nurses who prefer to use a printable survey. A follow-up telephone call with the hospital nursing managers were initiated to send reminder email/messages to eligible nurses in their hospitals.

3.5 | Data collection

Data were mainly collected through an online survey using Qualtrics system and distributed to the respondents through the nursing management office of each selected hospital. An electronic link and the quick response code were sent to eligible nurses, and they were able to complete all items of the survey in 15 to 20 min. A check code was activated to prevent multiple responses by the same user. Expatriate nurses were also encouraged to pass the invitations for the survey via social media apps to other expatriate nurses working in other acute care settings in the same hospital to maximize responses. The usage and combination of these techniques to recruit the nurses have resulted in the large sample of expatriate nurses who responded and returned the survey.

3.6 | Ethical considerations

Research Ethics Committee approval for the study was obtained from the IRB of the primary investigator's institution, which is affiliated with the Ministry of Health (approval no 2020-8). All surveys contained a detailed explanation about the study aim, goals and expectations from the respondents. Participation was voluntary and no personal identifying data were collected.

3.7 | Data analysis

The data entry, cleaning and analysis were carried out using the Statistical Products and Services Solutions (SPSS) software for Windows, version 24.0 (IBM, NY, USA). The normality of distributions of QNWL scores were checked using the Shapiro-Wilk test which was normally distributed. Therefore, means \pm (standard deviation; SD) was used to report continuous variables. Also, frequencies and percentages were used to summarize categorical variables. Mean differences in QNWL scores between groups were compared using the *t*-test or Analysis of Variance (ANOVA). A multivariate logistic regression analysis was performed to determine the independent predictors for poor QNWL (defined as having a low or moderate QNWL) using the full model fit. The predictor variables included (e.g. age, gender, qualification, nationality, region of practice, nursing position nursing work experience and acute care unit of work); while the outcome variable was the occurrence of poor QNWL (Yes / No). All analysis was two-sided and a *p*-value < .05 was statistically significant for all tests.

3.8 | Validity and reliability

The instrument used was a pre-tested self-administered and standardized questionnaire, that is, Brook's quality of nursing work life (BQNWL) questionnaire (Brooks, 2001). A permission was granted from author of the tool for a reuse in this study. The BQNWL tool consist of a 42 scale items that assesses the QWL among nurses (Brooks & Anderson, 2005). Each of the scale items require a response based on a six-point Likert scale ranging from 1; strongly disagree to 6; strongly agree. Brooks and Anderson recommended that the ratings of the scale can be classified into two groups according to the respondent's level of agreement; that is, positive "agree" responses (4, 5, or 6) as "agree" and negative "disagree" responses (1, 2 or 3) as "disagree" (Brooks & Anderson, 2005). Individuals who disagrees with an item (i.e. chose 1 to 3 in the scale) were considered to be *dissatisfied* about the scale item while those who agreed (i.e. chose 4 to 6 in the scale) were considered to be *satisfied* with the item. The overall score of the BQNWL could be obtained by the addition of each of the scores of the 42 scale items. The scores therefore can range from 42 to 252—the greater the score, the better the QNWL. A score of (42–112) was considered low QNWL, while a score of (113–182) was considered moderate QNWL and a score of (183–252) was considered high QNWL.

In addition, four dimensions or sub-scales were created from the items of the tool. They are; work-life/home-life dimension (consisting of seven items with scores ranging from 7–42) which explores the interaction between the nurses' work and home life. The work-design dimension (10 items; scores range 10–60) describes the immediate work set-up of the nurses such as staffing, scheduling and practice autonomy. The work-context dimension (20 items; scores range 20–120) explores the resources for work and their interplay.

Finally, the work-world dimension (5 items; scores range 5–30) explores societal influences on work (Brooks & Anderson, 2005).

A previous study has indicated that the BQNLW questionnaire had a high internal consistency with a (Cronbach $\alpha = 0.89$) (Brooks, 2001). Also, another study reported that it has a high test-retest reliability when administered to 53 qualified nurses over a two-week interval between the testing and re-testing ($r = .90$, $p < .001$) (Brooks & Anderson, 2005). The reliability analysis of the BQNLW questionnaire in this study population showed a high internal consistency coefficient with a Cronbach's α of 0.904.

4 | RESULTS

4.1 | Sociodemographic characteristics

In total, 2,433 nurses received the invitations to fill the survey. A total of 1,704 (70%) expatriate nurses completed and returned the survey; 724 (42.5%) and 681 (40.0%) belong to the 21 to 30 years and 31 to 40 years age group, respectively. Most of the nurses 1,678 (98.5%) were females and 1,464 (85.9%) had a Bachelor's degree. All the geographical regions of KSA were represented in the study: 713 (41.8%) of the respondents were working in the Central region. Most of the respondents 993 (58.3%) were Indians and 641(37.6%) were Filipinos. Sudanese 23 (1.3%), Egyptian 19 (1.1%), Indonesian 7 (0.4%), Pakistani 6 (0.4%), South African 5 (0.3%) and Jordanian 4 (0.2%) nurses accounted for most of the nurses classified as "other" nationalities. Overall, 1,095 (64.3%) of the surveyed nurses have worked in their current unit for over three years, and 1,333 (78.2%) of them are working as staff nurses. Also, the survey showed that 402 (23.6%) and 385 (22.6%) of the nurses are working in intensive care units and emergency departments, respectively.

4.2 | Level and pattern of QNLW

The total QNLW scores of the nurses ranged from 80 to 245 with an overall mean score of 175.3 (± 23.1). This indicate that the study respondents had a moderate QNLW (Appendix S1). However, when the data were disaggregated according to the recommended cut-off of the QNLW scores, only 16 (0.9%) of the respondents had a low level of QWL, 965 (56.6%) had a moderate level of QWL and 723 (42.4%) experienced a high level of QWL.

4.3 | Work-life-home-life dimension

The range of scores obtained for this dimension was 7 to 38 with a mean of 27.7 (± 4.5). The majority of the nurses 973 (57.1%) had moderate level of QWL in the work-life-home-life subscale; and only 39.7% had high QWL in this subscale. Most of the respondents reported that having to deal with rotating schedules negatively

affected their lives 1,172 (68.9%), they lack energy after work 789 (46.3%), there are inadequate policies for family-leave time 677 (39.7%) and over a quarter of the nurses reported inability to balance between family needs and work life 432 (25.4%). Table 1 summarizes the description of the QNLW dimensions and scale items among the expatriate nurses.

4.4 | Work-design dimension

The range of scores obtained for this dimension was 16 to 60 with a mean of 41.2 (± 5.4). The majority of the nurses 1,207 (70.8%) had moderate level of QWL in the work-design subscale; and only 28.2% had high QWL in this subscale. Over half of the nurses reported that the number of Registered Nurses in their work setting were inadequate 960 (56.3%), over a third of the nurses reported that they do not receive adequate assistance from unlicensed support staff members 615 (36.1%) and 535 (31.4%) indicated that even if available, they do not get quality support from unlicensed support staff members (Table 1). Furthermore, over a quarter of the nurses 431 (25.3%) reported lacking autonomy to make patient-care decisions.

4.5 | Work-context dimension

The range of scores obtained for this dimension was 30 to 119 with a mean of 87.0 (± 13.5). Majority of the nurses 1,341 (78.7%) had high level of QWL in the work-context subscale; and 358 (21.0%) had moderate QWL in this subscale. Logistic, security and supervision issues were of concern in this domain. Almost half of the respondents 808 (47.4%) reported inadequacy in patient-care resources. Some of the respondents reported that the security departments in their facilities do not give a secure environment 535 (31.4%), and 512 (30.0%) reported feeling unsafe from personal harm in their hospital setting. Also, 500 (29.3%) of the respondents reported lack of respect for nursing by the upper level management of their facilities (Table 1). However, the study revealed that the nurses had substantial satisfaction with issues related to their co-workers and physicians. Overall, 1,639 (96.2%) reported that friendships with their co-workers was important to them, and 1,623 (95.2%) reported that there is adequate communication between nurses and physicians at their workplace.

4.6 | Work-world dimension

The range of scores obtained for this dimension was 6 to 30 with a mean of 19.4 (± 3.6). Over half of the respondents 942 (55.3%) had moderate level of QWL in the work-world subscale; and 701 (41.1%) had high QWL in this subscale. Almost two-thirds of the nurses 1,121 (65.8%) reported that their income is inadequate for the job given considering the current market climate and 406 (23.8%) of them believed that their employments are secured (Table 1). However, 1,561

TABLE 1 Description of the quality of nursing work-life scale items (N = 1,704)

Quality of work-life scale items ($\alpha = 0.904$)	Dissatisfied		Satisfied	
	N	%	N	%
<i>Work/home life dimension items</i>				
5. I am able to balance work with my family needs.	432	25.4	1,272	74.6
10. It is important for a hospital to offer employees on-site childcare services.	181	10.6	1,523	89.4
12. I have energy left after work.	789	46.3	915	53.7
20. Rotating schedules negatively affect my life.	1,172	68.9	530	31.1
25. My organization's policy for family-leave time is adequate.	677	39.7	1,027	60.3
27. It is important for a hospital to offer employees on-site day care for older parents.	215	12.6	1,489	87.4
36. It is important for a hospital to offer employees on-site ill child care services.	128	7.5	1,576	92.5
<i>Work-design dimension items</i>				
1. I receive a sufficient amount of assistance from unlicensed support personnel (the dietary aides, housekeeping, patient care technicians, and nursing assistants).	615	36.1	1,089	63.9
2. I am satisfied with my job.	239	14.0	1,465	86.0
3. My workload is too heavy.	352	20.7	1,352	79.3
6. I have the autonomy to make patient care decisions.	431	25.3	1,273	74.7
11. I perform many non-nursing tasks.	320	18.8	1,384	81.2
16. I experience many interruptions in my daily work routine.	388	22.8	1,316	77.2
17. I have enough time to do my job well.	372	21.8	1,332	78.2
18. There are enough RNs in my work setting.	960	56.3	744	43.7
23. I am able to give good quality patient care.	81	4.8	1,623	95.2
42. I receive quality assistance from unlicensed support personnel (the dietary aides, housekeeping, patient care technicians, and nursing assistants).	535	31.4	1,561	91.6
<i>Work-context dimension items</i>				
7. I am able to communicate well with my nurse manager/supervisor.	283	16.6	1,421	83.4
8. I have adequate patient care supplies and equipment.	808	47.4	896	52.6
9. My nurse manager/supervisor gives adequate supervision.	338	19.8	1,366	80.2
13. Friendships with my co-workers are important to me.	65	3.8	1,639	96.2
14. My work setting gives career advancement opportunities.	384	22.5	1,320	77.5
15. There is teamwork in my work setting.	198	11.6	1,506	88.4
19. I feel a sense of belonging in my workplace.	306	18.0	1,398	82.0
21. I am able to communicate with the other therapists (physical, respiratory, etc.).	214	12.6	1,490	87.4
22. I receive feedback on my performance from my nurse manager/supervisor.	381	22.4	1,323	77.6
26. I am able to participate in decisions made by my nurse manager/supervisor.	466	27.3	1,238	72.7
28. I feel respected by physicians in my work setting.	306	18.0	1,398	82.0
29. It is important to have a designated, private break area for the nursing staff.	86	5.0	1,618	95.0
30. It is important to me to have nursing degree-granting programs available at my hospital.	122	7.2	1,582	92.8

(Continues)

TABLE 1 (Continued)

Quality of work-life scale items ($\alpha = 0.904$)	Dissatisfied		Satisfied	
	N	%	N	%
31. I receive support to attend in service and continuing education programs.	222	13.0	1,482	87.0
32. I communicate well with the physicians in my work setting.	81	4.8	1,623	95.2
33. I am recognized for my accomplishments by my nurse manager/supervisor	396	23.2	1,308	76.8
34. Nursing policies and procedures facilitate my work.	191	11.2	1,513	88.8
35. The security department gives a secure environment.	535	31.4	1,169	68.6
38. I feel safe from personal harm (physical, emotional, or verbal) at work.	512	30.0	1,192	70.0
40. Upper-level management has respect for nursing.	500	29.3	1,204	70.7
<i>Work-world dimension items</i>				
4. In general, society has an accurate image of nurses.	550	32.3	1,154	67.7
24. My salary is adequate for my job given the current job market conditions.	1,121	65.8	583	34.2
37. I would be able to find my same job in another organization with about the same salary	542	31.8	1,162	68.2
39. I believe my job is secure.	406	23.8	1,298	76.2
41. My work has an impact of the lives of patients/families.	143	8.4	1,561	91.6

(91.6%) of the nurses agreed that their work substantially affects the lives of their patients and their families.

4.7 | Factors associated with a higher total QNWL scores

The differences in total QNWL scores according sociodemographic characteristics were assessed by independent sample t-test or one-way ANOVA and are as shown in Table 2. Total QNWL scores were significantly higher among nurses who are 41 years old or over ($p = .001$) compared to other age groups, but there was no gender difference in total QNWL scores ($p = .78$). Overall, QNWL scores significantly vary with the qualification ($p < .001$), nationality ($p < .001$) and region of practice of the nurses ($p < .001$). Also, total QNWL scores significantly increased with nursing position ($p = .004$) and years of work experience in the study setting ($p < .001$). In addition, overall QNWL scores significantly vary with the acute care unit of work with nurses working in the burn's unit having the highest score of 190.1 and those working in the coronary care unit having the lowest score 172.6 ($p = .006$). A multivariable logistic regression analysis was carried to identify the independent predictors of poor QNWL (i.e. having a low or moderate QNWL score; Table 3). After adjusting for confounding effects; belonging to the 21 to 30 years age group (adjusted odds ratio [aOR] 1.7; 95% CI 1.1–2.4), or to the 31 to 40 years age group (aOR 1.7; 95% CI 1.2–2.3), being a Filipino (aOR 3.8; 95% CI 2.2–6.6) or Indian national (aOR 2.3; 95% CI 1.3–3.9), and practicing in the northern region of the country (aOR 1.6; 95% CI 1.1–2.3) were the independent predictors of poor QNWL (Table 3).

5 | DISCUSSION

In this study, the mean QNWL score among expatriate nurses was 175.3 (± 23.1), and only about two-fifths of the nurses experienced a high level of QWL. This indicate that on the average more than half of the nurses had moderate QNWL. Studies in KSA, Iran, Jordan and Ethiopia among nurses working in various health-care settings have reported moderate QNWL scores (Almalki et al., 2012a; Kaddourah et al., 2018; Kelbiso et al., 2017; Suleiman et al., 2019). A systematic review of studies from eight countries revealed that QNWL level was low (28.6%), moderate (52.4%) and high (19%) of the studies (Viselita et al., 2019). Thus, the finding of this study is consistent with previous reports and indicate that regardless of country or place of work only few nurses experience high QWL in their workplaces. Furthermore, in the work-life-home-life dimension, only about two-fifths of the nurses experienced a high level of QWL. This is because most nurses in this study reported having to deal with rotating schedules which negatively affected their lives; others reported having high workload leading lack energy after work and imbalance between home life and work life. In addition, a substantial proportion of the nurses were dissatisfied with their hospital policies for family-leave time. These findings generally agree with the finding of previous studies, which highlighted challenges with balancing home life and work life among nurses who practice in both public and private sectors (Alharbi et al., 2019; Almalki et al., 2012a, 2012b; Faizin et al., 2020; Viselita et al., 2019). Overall, the findings of this study indicate the need to improve work-life-home-life dimension of QNWL among expatriate nurses by addressing these concerns.

TABLE 2 Mean overall QNWL scores according to the demographic characteristics of the nurses

Variables	N (%)	Mean	SD	t / F	p-value
Age (years)					
21–30	724 (42.5)	175.6	22.8	6.77	.001
31–40	681 (40.0)	173.4	24.1		
41–above	299 (17.5)	179.2	21.0		
Gender					
Male	26 (1.5)	174.1	28.1	0.08	.78
Female	1,678 (98.5)	175.4	23.0		
Qualification					
Diploma	200 (11.7)	181.2	20.2	7.97	<.001
Bachelor's degree	1,464 (85.9)	174.5	23.3		
Postgraduate degree	40 (2.3)	178.4	24.6		
Nationality					
Filipino	641 (37.6)	172.0	23.4	19.28	<.001
Indian	993 (58.3)	176.6	25.6		
Others	70 (4.1)	188.1	22.4		
Region of practice					
Central	713 (41.8)	174.6	22.0	7.03	<.001
Eastern	145 (8.6)	180.0	23.2		
Western	283 (16.6)	179.1	21.5		
Northern	282 (16.5)	170.3	24.4		
Southern	281 (16.5)	176.0	24.9		
Work experience					
1–3 years	609 (25.7)	177.1	22.0	7.29	<.001
3–5 years	406 (23.8)	172.9	23.7		
6–10 years	393 (23.1)	172.4	24.2		
>10 years	296 (17.4)	179.0	22.5		
Nursing position					
Staff Nurses	1,333 (78.2)	174.6	23.1	5.61	.004
In-charge Nurses	280 (16.4)	176.4	24.1		
Head Nurses	91 (5.3)	182.7	18.9		
Acute care unit of work					
Intensive care unit	402 (23.6)	173.0	24.3	2.5	.006
Coronary care unit	123 (7.2)	172.6	22.4		
Emergency department	385 (22.6)	174.9	24.3		
Operating room	145 (8.5)	177.8	22.5		
Burn unit	17 (1.0)	190.1	11.4		
Paediatric intensive care unit	106 (6.2)	174.0	24.6		
Neonatal intensive care unit	242 (14.2)	174.9	23.1		
Labour room	95 (5.6)	176.5	18.2		
Stroke unit	31 (1.8)	181.1	22.6		
Artificial kidney unit	114 (6.7)	180.9	18.9		
Day surgery unit	44 (2.6)	178.9	21.3		

Abbreviations: QNWL, quality of nursing work life; SD, standard deviation.

In the work-design dimension, over two-thirds of the respondents had moderate QNWL with less than a third having high quality work life in this dimension. This is because a substantial

proportion of the respondents reported shortage of Registered Nurses in their organizations coupled with insufficient amount of assistance from unlicensed support personnel, and even if

TABLE 3 Multivariable logistic regression analysis of factors associated with poor QNWL among expatriate nurses

Variables	Poor QNWL	Crude OR	Adjusted OR	Adjusted	p-value
	No, N (%)	Yes+, N (%)	(95% CI)	(95% CI)	
Age (years)					
21-30	302 (41.7)	422 (58.3)	1.5 (1.1-1.9)	1.7 (1.1-2.4)	.011
31-40	268 (39.4)	413 (60.6)	1.6 (1.2-2.1)	1.7 (1.2-2.3)	.001
41-above	153 (51.2)	146 (48.8)	1	1	
Gender					
Male	14 (53.8)	12 (46.2)	1	1	
Female	709 (42.3)	969 (57.7)	1.6 (0.7-3.5)	1.3 (0.6-3.0)	.52
Qualification					
Diploma	108 (54.0)	92 (46.0)	1	1	
Bachelor's degree	595 (40.6)	869 (59.4)	1.7 (1.3-2.3)	1.1 (0.8-1.6)	.58
Postgraduate degree	20 (50.0)	20 (50.0)	1.2 (0.6-2.3)	1.0 (0.5-2.2)	.94
Nationality					
Filipino	233 (36.3)	408 (63.7)	3.6 (2.1-6.0)	3.8 (2.2-6.6)	<.001
Indian	443 (44.6)	550 (55.4)	2.5 (1.5-4.2)	2.3 (1.3-3.9)	.003
Others	47 (67.1)	23 (32.9)	1	1	
Region of practice					
Central	294 (41.2)	419 (58.8)	1.2 (0.9-1.5)	1.1 (0.8-1.4)	.71
Eastern	75 (51.7)	70 (48.3)	0.8 (0.5-1.1)	0.8 (0.5-1.2)	.33
Western	136 (48.1)	147 (51.9)	0.9 (0.6-1.2)	0.8 (0.6-1.2)	.28
Northern	92 (32.6)	190 (67.4)	1.7 (1.2-2.4)	1.6 (1.1-2.3)	.008
Southern	126 (44.8)	155 (55.2)	1	1	
Work experience					
1-3 years	272 (44.7)	337 (55.3)	1.3 (1.1-1.8)	0.8 (0.6-1.2)	.37
3-5 years	153 (37.7)	253 (62.3)	1.8 (1.3-2.4)	1.2 (0.8-1.8)	.33
6-10 years	145 (36.9)	248 (63.1)	1.8 (1.4-2.5)	1.4 (1.0-2.0)	.06
>10 years	153 (51.7)	143 (48.3)	1	1	
Nursing position					
Staff Nurses	539 (40.4)	794 (59.6)	1.7 (1.1-2.6)	1.5 (0.9-2.4)	.09
In-charge Nurses	135 (48.2)	145 (51.8)	1.2 (0.8-2.0)	1.1 (0.6-1.7)	.93
Head Nurses	49 (53.8)	42 (46.2)	1	1	
Acute care unit of work					
Intensive care unit	159 (39.6)	243 (60.4)	1.5 (0.8-2.9)	1.4 (0.7-2.6)	.38
Coronary care unit	48 (39.0)	75 (61.0)	1.6 (0.8-3.1)	1.3 (0.6-2.7)	.50
Emergency department	161 (41.8)	224 (58.2)	1.4 (0.8-2.6)	1.2 (0.6-2.2)	.66
Operating room	68 (46.9)	77 (53.1)	1.1 (0.6-2.2)	1.0 (0.5-1.9)	.91
Burn unit	11 (64.7)	6 (35.3)	0.6 (0.2-2.7)	0.6 (0.2-1.8)	.33
Paediatric intensive care unit	45 (42.5)	61 (57.5)	1.4 (0.7-2.7)	1.1 (0.5-2.3)	.77
Neonatal intensive care unit	91 (37.6)	151 (62.4)	1.7 (0.9-3.2)	1.4 (0.7-2.8)	.31
Labour room	43 (45.3)	52 (54.7)	1.2 (0.6-2.5)	1.2 (0.6-2.6)	.60
Stroke unit	20 (64.5)	11 (35.5)	0.6 (0.2-1.4)	0.5 (0.2-1.4)	.17
Artificial kidney unit	55 (48.2)	59 (51.8)	1.1 (0.5-2.2)	0.9 (0.4-1.8)	.74
Day surgery unit	22 (50.0)	22 (50.0)	1	1	

available, the quality of assistance from unlicensed support personnel was poor. Some of the nurses reported lacking autonomy for making patient care decisions. These barriers in the

work-design dimension experienced by the nurses can substantially affect the care they give to patients. Previous studies in Indonesia, Bangladesh, KSA, Ethiopia and Jordan have highlighted

similar barriers in the work design dimension (Akter et al., 2018; Alharbi et al., 2019; Almalki et al., 2012a, 2012b; Faizin et al., 2020; Kelbiso et al., 2017; Suleiman et al., 2019). However, in the work-context dimension, almost four-fifths of the nurses had a high level of QWL. This indicates that most of the expatriate nurses were quite satisfied with the work context in the regions and those who had moderate QNWL reported that the security departments in their facilities do not give a secure environment, and most reported feeling unsafe from personal harm in their hospital setting. This calls for the need to increase the level and availability of security in hospitals so that expatriate nurses can practice in a secure environment. This is particularly important as the fear of litigation and job insecurity has been shown to predispose expatriate nurses to developing anxiety, and/or depression (Saqib et al., 2020). A previous study among nurse managers in Malaysia showed that the work context strongest QNWL dimension that is significantly associated with the intention to remain in an employment (Agus & Selvaraj, 2020). This indicates that despite the challenges identified in this dimension most of the expatriate nurses will most likely not quit their jobs due to challenges with work-life balance. In the work-world dimension, only two-fifths of the nurses had a high QWL. This is because most of the nurses considered that their wages were inadequate compared to the job done, poor image of nurses in the society and lack of job security were other barriers identified.

This study revealed that age group, nationality and region were independent predictors for poor QNWL among expatriate nurses in KSA. More specifically, respondents who were in the 21 to 40 age groups were almost two times more likely to have poor QNWL. This finding differs from the results of studies in Ethiopia, and Jordan that showed no relationship between age and QNWL (Kelbiso et al., 2017; Suleiman et al., 2019), but was consistent with the findings in KSA, which showed that nurses belonging to older age groups were more likely to be satisfied with their QNWL (Akter et al., 2018; Albougami et al., 2020; Alharbi et al., 2019; Almalki et al., 2012a; Kaddourah et al., 2018). This is because older nurses are likely to be married; therefore, may have a better support structure. Moreover, older nurses are more likely to adopt higher emotional intelligence and maturity in handling situations, may be better adjusted to their environment and may have a more stable work life leading to better QNWL (Alharbi et al., 2019; Kaddourah et al., 2018).

Furthermore, this study showed that among the nurses, Filipino and Indian nationals were 3.8 and 2.3 times more likely to have poor QNWL compared with nurses from other countries. This may be because the majority of expatriate nurses from "other" countries came from countries where Islam is the predominant religion and Arabic is one of the languages for communication. Thus, they tend to adjust earlier and better in the Saudi work environment (Albougami et al., 2020). A previous study has reported that being a non-Saudi nurse was significantly associated with having a higher QNWL probably because those nurses were unable to strike a balance between their family needs and work responsibilities (Alharbi et al., 2019).

However, the study did not adjust for the effects of potential confounders in the analysis.

This study also showed that expatriate nurses practicing in northern region of the country were 1.6 times more likely to have poor QNWL. The reason for this finding is possibly that the northern region is being less developed compared to other regions in KSA. For instance, the shopping malls, recreational centres, access to direct international flights, international schools and the variety of restaurants are very limited in the northern region. Additionally, unlike the northern region's main cities, major cities in the country have international and community support groups, cultural festivals, seasonal events and other social activities. This observation may also call for the need to further explore other factors in less developed cities. A recent Canadian study did not find differences in either job satisfaction or turnover intention between rural and urban acute care nurses (Yasin et al., 2020).

A number of factors have been identified as predictors of QNWL in previous studies such as qualification, nursing position, being married, income and whether the nurses work in inpatient or outpatient setting (Akter et al., 2018; Alharbi et al., 2019; Almalki et al., 2012a; Biresawa et al., 2020; Faizin et al., 2020; Kaddourah et al., 2018; Kelbiso et al., 2017). Some of these factors were not evaluated in the present study and needs to be considered in future studies.

5.1 | Strengths and limitations

This study has a number of strengths and limitations. This is the first study known to the authors that explored QNWL among expatriate nurses. Second, the study covered multiple regions of KSA, thereby strengthening its generalizability to the country. Third, the study used a standardized questionnaire which allowed comparability with other studies elsewhere. Finally, we prevented response bias by excluding Saudi nurses, who might have received the invitations for the survey, and we prevented duplicate responses from the same user by activating a code in the Qualtrics system. However, the study surveyed only expatriate nurses working in acute care settings and may therefore not be generalizable to other nurses working in non-acute care settings. Second, the data were collected using a self-administered questionnaire. Therefore, it is prone to various self-reporting bias (Althubaiti, 2016). Finally, given that this is descriptive survey, causal inferences need to be interpreted with caution. Despite these limitations, the study has given important findings and contributed new knowledge about QNWL among expatriate nurses, which could guide nurse managers and policymakers to design interventions to improve the work-life experiences of expatriate nurses.

6 | CONCLUSION

The present study investigated the pattern and level of QNWL among expatriate nurses working in acute care units in KSA. The study revealed

a moderate level of QNWL, and its dimensions among the nurses and that only about two-fifths of the nurses had a high quality of work life. Additionally, being a Filipino or Indian, belonging to the younger age group and working in the northern region of the country were independent predictors of poor QNWL among the expatriate nurses.

7 | IMPLICATIONS FOR NURSING AND HEALTH POLICY

The findings of this study call for the healthcare system, hospital administrators and nurse managers in KSA to show greater interests in the QNWL of expatriate nurses due to its impact on work productivity and patient care. Highly specialized nurses, who work in acute care settings, are on high demand worldwide. Therefore, some reformations are required including increase wages and ease housing restrictions to promote the expatriate nurses' level of satisfaction about the QNWL.

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CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

AUTHOR CONTRIBUTION

All authors have agreed on the final version and meet at least one of the following criteria [recommended by the ICMJE (<http://www.icmje.org/recommendations/>)]:

- substantial contributions to conception and design, acquisition of data or analysis and interpretation of data;
- drafting the article or revisiting it critically for important intellectual content.

RESEARCH ETHICS COMMITTEE APPROVAL

The Research Ethics Committee approval letter was obtained from the IRB of the General Directorate of Health Affairs, Hail region (approval no 2020-8).

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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