

Anything But Casual:
The Worklife Experience of Casual Nurses

by

Myfanwy Lynne Simpkin
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We accept this thesis as conforming
to the required standard

[Redacted Signature]

Dr. M.J. Haylor, Supervisor (School of Nursing)

[Redacted Signature]

Dr. J.H. Brunt, Departmental Member (School of Nursing)

[Redacted Signature]

Dr. V.S. Kuehne, Outside Member (School of Child and Youth Care)

[Redacted Signature]

Dr. Michael Prince, External Examiner (Faculty of Human and Social Development)

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University of Victoria

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Supervisor: Dr. Martha J. Haylor

ABSTRACT

This study explored the worklives of nine casual nurses who were employed in home nursing care and acute care in the Capital Health Region. Recent statistics indicated that casual staffing in these areas can be as great as 50% of the total (Staff Scheduling, C.H.R., 1997) In the province of British Columbia, nurses who work as casuals constitute approximately 25% of the workforce (Registered Nurses Association of British Columbia, 1997) yet in published nursing research there was almost no mention of casual nurses.

The research question explored in this study was: What is the worklife experience of casual nurses?

In three audiotaped group interviews, five acute care nurses and four home care nurses described their worklives and their concerns. Through a qualitative analytic process, the themes that emerged fell into three areas of influence: the workplace; relationships with colleagues; and the effect of and influence on personal and family life.

The effect of marginalizing a large group of the nursing workforce has implications for the members, the employing organization, and the profession of nursing. The intent of this study was to increase the visibility of a group that has had little attention from their own professional bodies, their employers, and researchers in nursing.

Examiners:

[Redacted]

Dr. M.J. Haylor, Supervisor (School of Nursing)

[Redacted]

Dr. J.H. Brunt, Departmental Member (School of Nursing)

[Redacted]

Dr. V.S. Kuehne, Outside Member (School of Child and Youth Care)

[Redacted]

Dr. M. Prince, External Examiner (Faculty of Human and Social Development)

Table of Contents

Abstract.....	ii
Table of Contents.....	iv
Acknowledgements.....	v
Dedication.....	vi
Chapter One: Introduction.....	1
Chapter Two: Review of Literature.....	11
Chapter Three: Research Design and Methodology.....	37
Chapter Four: Results and Discussion.....	51
Chapter Five: Implications.....	91
Bibliography.....	98
Appendix A: Consent Form.....	101
Appendix B: Demographic Form.....	102

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Dedication

This is dedicated to the nurses who are "anything but casual".

May your worth be recognized.

Chapter One: Introduction

Casual Nurses - Who, Where, How Many and Why?

Although it is difficult to determine exact figures, the Registered Nurses Association of British Columbia (RNABC) estimates approximately 25% of the registered nurses working in British Columbia are employed casually. In 1992, of a total of 26,877 nurses employed in nursing in this province, 6,497 (24.2%) were working in casual positions (University of British Columbia, 1993) and in 1996 the number was 6,951 out of 27,780 (25%) (personal communication, Clare Kermacks, RNABC Executive Director, June 1997). The provincial percentage of nurses who work casually has remained consistent at the 25% mark over the past five years.

Casual nurses do not hold actual positions within a health care agency or facility. Rather, they are nurses with active practising RNABC registration hired to meet the patient care demands generated when regular nursing staff may be ill, on vacation or leave, or to fill the need created by an increased workload. Thus the numbers of casual nurses actually working in a specific workplace can vary greatly from day to day. Many workplaces rely on casual nurses on a regular basis, with frequently half the working staff on a given day being from this group as indicated by the figures following.

In Victoria the major agencies employing nurses have amalgamated under the single umbrella of the Capital Health Region and these include three hospitals, Victoria General Hospital, Royal Jubilee Hospital, Gorge Road Hospital, and the former offices of the Capital Regional District Continuing Care program which includes Home Nursing Care. Inquiries to the staffing/human resources offices of these agencies provided some recent figures on the numbers of nurses working full-time and casual. In acute care, the number of nurses working

full-time was 827 and the number of nurses on the casual roster was 655 (Human Resources schedulers, GVHS, 1997). Inquiry to individual surgical units indicated that there was about 50% staff coverage by casual nurses at most times, and frequently the percentage was higher. In Home Nursing Care, the number of nurses actively working full-time was 57 and casually was 59. In the largest (and busiest) Home Nursing Care office, study of a recent week's staffing indicated that 40% of the shifts were covered by full-time, and 60% were covered by casuals, with the following weekend coverage of 31% full-time and 69% casual (personal communication, staff scheduler, 1997).

These numbers are much greater than the provincial average indicated in the previous paragraph. Speculation on the rationale for this discrepancy includes the possibility of greater stability/predictability of client workload in other parts of the province or nurses working both part-time and casual and reporting only their part-time work on the forms used for annual registration with RNABC.

The proportion of graduating nurses who have full-time employment awaiting them has decreased in the last five years as employers prefer to hire experienced nurses for such positions. In addition, traditional management positions that were formerly won by persistence and hard work are no longer available as head nurse and assistant head nurse positions have been eliminated in management restructuring. Nurses who may be returning to the work force after an absence are often faced with only two options: casual employment or no employment. Yet the issues and concerns of an increasing population of casual nurses providing direct patient care appears to be almost invisible and silent in the burgeoning body of literature relating to quality of worklife, job satisfaction, competence and clinical judgement. This study was undertaken to give voice to some of these nurses regarding their issues and concerns in this time of radical health care reform, grinding fiscal restraint, complex ethical questions, and increasingly sophisticated and vocal health care consumers.

Compared to regular full- or part-time employees, the casual workers are much less expensive for an agency to employ as they receive minimal benefit packages beyond that required by the labour code. If casual nurses do not work, they do not get paid. There is no sick time, no stress leave, and vacation time is paid out. The meaning of these practices for institutions is a decrease in financial costs and expenses, an important factor for any health care system. Further, wage scales are determined by the accumulated hours of work rather than the years, and since a casual may only work one or two days a week, accumulation of hours may take much longer, with the result that salary increments are reached slowly.

While decreasing institutional financial cost/expenses is an important goal, there is a need to clearly understand the implications of the increasing trend toward using casual nurses. These implications include the effect on the provision of optimal health care to the populace, the need for a supportive work environment for casual nurses, and the impact on professional development and long term commitment to nursing. In other words, it is important to explore somewhat less visible costs that potentially undermine the very system of care we are striving to improve and maintain.

The trend towards larger numbers of casual nurses in health care is echoed in other fields. The names may be different – float pools, contingency, contract, temporary, auxiliary and so on, but to the employer, they essentially offer labor without the need for financial outlay for benefits. The workers face many of the same issues that will be explored in this study. What makes the issues of casual nurses of such great concern, however, is the level of risk involved. The day-to-day work of a casual nurse involves making decisions affecting the lives of the people in her care.

Depending on the policy of the agency, casual nurses may work in areas where they are clinically competent or may be sent to a short-staffed area where clinical nursing demands and expectations are completely unfamiliar. This can raise questions of nursing ethics in the

area of competent nursing care. A phrase in the 1991 Code of Ethics for Nursing (Canadian Nurses Association, 1991) that stated:

"...as a temporary measure, the safety and welfare of clients may be better served by the best efforts of the nurse under the circumstances than by no nursing care at all..."

has been replaced by a statement in the 1997 version that states:

"Nurses advocate for practice environments that have the organizational and human support systems, and the resource allocations necessary for safe, competent and ethical nursing care"

This would appear to recognize that there are increasingly perilous situations across the country and the responsibility for safe patient care must be taken on by both nurses and agencies. Nurses who have worked in other cities confirm this readily in anecdotal reports, such as Sarah Jane Growe's 1991 expose "Who Cares?" which describes the difficulties faced daily by individual nurses as well as by the profession in general. Nurses face increasing patient acuity in hospital environments. Technological breakthroughs in monitoring and service equipment and methodology require continuous skill updating, increasing the pressure on the registered nurse to perform with machinery, while still keeping in touch with the human skills. Acquisition of such equipment is used to justify reduced personnel in a unit, so fewer nurses are caring for clients with increased acuity (sicker patients). Although the data gathered in Growe's account is well over five years old, neither bedside working conditions nor the positions "between a rock and a hard place" of middle management have improved. Instead, continuing pressures to increase productivity directly affect the ability of staff to provide the care demanded both by the consumer and by the nurses' own high standards.

Although there have been ad hoc meetings of casual nurses to discuss issues of working conditions, proposed shift changes and contract negotiations, casuals have not formed into a solid group that can have a representative voice. Many of the issues that affect their worklives have an impact on the provision of care throughout agencies, as indicated by their sheer numbers in the workplace. Yet they describe themselves as a group to be voiceless and invisible at the level where the decisions are made about these issues. The intent of this study is to give voice to their concerns as well as explore the factors that have prevented them being heard and seen.

Casual nurses are in the front lines of patient and family care, where the budget cuts, the policy changes, and the shifts of political emphasis from institution to community are having their impact. Although there have been a few attempts on the part of management to hear from the front-line nurses about the effects of the unit amalgamations, bed closures and reductions in staff, researchers have not sought out the views of casual nurses on these issues. Their perspectives have a particular value, a viewpoint that is different from that of the permanently employed nurses whose work is stable (albeit under increasing pressure), relatively consistent and predictable, and whose workplace encourages the development of professional clinical knowledge. Because their work experience is separate from both the daily routine and the same regular work environment of full-time nurses, casual nurses have the potential of presenting the knowledge acquired from a variety of workplaces. What these nurses have to say will be important in the assessment of new programs, new practices, and the impact on patient and family care which have been brought about by the above-mentioned change.

Purpose of the study

The purpose of this study was to explore the worklife of casual nurses employed in acute care and home nursing care, and through the description of their worklife experience, air issues

important to them. Through reflection on the researcher's practice as a casual nurse, it was anticipated that issues of power, clinical competence, quality of worklife, job satisfaction, career goals, and education factors would be described by participants.

Significance of the study

The study of casual nurses' worklife is significant to policy and practice, nursing theory and research. The significance to policy and practice relate to evaluation of the continuing major changes in the field of health care.

As casual nurses continue to provide a workforce that is flexible and relatively inexpensive to the employer, there are indications that the use of casual nurses will increase even more. During this period of changing priorities, new systems of care provision are being trialed while old ones are being modified. Methods of staffing are under revision as care units are being amalgamated, downsized and transferred to new locations. Casual nurses are in the thick of this change. Their input is essential in evaluating the process as well as the results. By seeking and including this input in planning and evaluation, policymakers would be informed by frontline experience as well as by fiscal need.

Casual nurses may have a unique perspective on the effects of change, as their practice is frequently a series of encounters with new situations and new clients, working with unfamiliar colleagues who may be casuals themselves or regulars who are also experiencing change. Casual nurses' experience of such a worklife while still providing safe and appropriate care is helpful knowledge for the practice of nursing.

Conceptual knowledge of power and powerlessness in nurses' practice has been studied by researchers recently (Attridge, 1996). Although many casual nurses have years of varied experience in their worklife history, they are frequently the "new kid" in the unit and

consequently are not in a position of power with their colleagues. Descriptions of their experiences could add another dimension to the knowledge base.

The field of experiential learning is another area of nursing theory that could be enriched by the study of casual nurses. As their work is frequently sporadic, it would be valuable to know the effect of such discontinuous experiences on their progress from beginner to expert. The question arises of the possibility of becoming "expert" with such a worklife, or if becoming a proficient generalist is the most they can expect to achieve.

There has been recent study of the "interconnectedness" of nurses' lives (Glynn, Arndt, Beal & Bennett, 1996), how they balance career, education and personal lives. As casual nurses frequently are unable to plan their work schedules in advance, their coping skills and techniques are of interest, as well as the effect this has on the other domains of their lives.

Casual nurses appear to occupy something of a "no-man's land" in the area of labour relations. They receive few benefits and it is only recently that their work experience was recognized financially. The portability of this recognition is inconsistent at best. As they become more visible and vocal, these areas will receive attention, and knowledge of their worklives will contribute to the discussion.

As described previously, casual nurses as a separate body have not been visible in research. The value of studying their worklives as a whole or as part of other studies needs to be addressed. The researcher hopes that by presenting the worklife issues and experiences described by the casuals in this study, there will be the beginning of such recognition.

Research question

The primary question of this study is:

What is the worklife experience of casual nurses?

* * * *

The following vignettes are composites based on some of the stories and experiences described by casual nurses.

A Day (and Night) in the Lives

The ringing of the phone drags J up from the depths of sleep and before she can pick up the receiver, the sound is echoed by the wails of her teething eight-month old. She nudges her husband while both sounds mingle: "do I work this morning?" This is code for "are you up to looking after a miserable infant while you try to study?" Right now at 0630 with the baby howling , work is almost a guilty escape even after a night of broken sleep. Her husband could hire a baby sitter and may resort to that if he gets desperate but right now the decision concerns the next few hours. With no immediate signs of negative response, she picks up the receiver and agrees to be in to work a twelve hour shift on one of the three worksites where she is a casual nurse.

* * *

M picks up the bleating phone with a sense of foreboding. She had just booked reservations for dinner that evening with her friend from out of town. "I knew it, I knew it. Just because I haven't had work for three days, now is the time they pick to call..." but it isn't the shift scheduler calling, it was the school where her youngest was attending. The counsellor wanted to make an appointment with her because of a discipline problem. He had a space open the following afternoon at three-thirty, could she please be there then. "But I have an afternoon shift booked then, could it be in the morning? Or this afternoon?" Sorry, the schedule was very tight, didn't like to be inflexible, but that was the only time available until

next week, and it was a matter of some importance...M sighs, agrees, then dials the familiar number to the scheduler's office. If they couldn't replace her, she'd be late for the shift and still have to deal with the child's problem the next morning.

* * *

P is already aware that there is a problem when she walks through the unit's corridor to the nursing station, slipping off her jacket to hang in the staff room adjacent. A quick head count and the tense expressions tell her plenty. Who is not being replaced tonight? This is not a happy place to come to work, for the recent changes in policy had shifted and re-adjusted worksites so that staff who had worked together for years no longer did so, and the changes had come with little explanation. This came on top of a change in the type of patients that were now in their care, with a mix of surgical patients next door to short stay cardiac and several confused elderly calling out down the corridor. This will be another night when there will be only a slight chance for a break in the twelve hour shift. Because the cafeteria is closed after serving supper, there are few places to take that break anyhow, but at least a few months ago, you could team up with a buddy you knew from an adjacent unit to eat your bagged lunch with. Now so many of the staff weren't interested in anything but just getting through the shift...small wonder it was hard to replace personnel who called in sick...

* * *

B looked at the green digits glowing on her bedside clock. 2:32. At least there was no doubt whether it was a.m. or p.m. She never slept that well when on night call. She checked her beeper lying on the bedside table and jumped when the cellular in the next room rang at that moment. At the other end of the phone a support worker in a group home was wanting some advice about a resident who had just had a seizure. This in itself was not that unusual but her blood sugar had been a bit low at bedtime and they had followed protocol with the appropriate snack before her bedtime insulin. Should they take her blood sugar again? Did

she need to go to Emergency? B advised them to take the blood glucose again and said she would come out to examine the client. Many times the problem solving could be done over the phone, but this support worker sounded a bit anxious and B suspected that she wasn't yet very experienced. She pulled out the bulging chart files in the night bag that had been delivered to her earlier that evening and reviewed data on this client. While she pulled her jacket over the clothes she had worn when she lay down, she punched in the number on the cell phone of the messaging system to tell them where she would be and that she would let them know when she got there. She picked up the bag of charts, slid the beeper and the cell phone into her jacket pocket and with a check pat for her keys, slipped out of the house to where her car waited in the still night.

Chapter Two: Review of Literature

As described in the introduction, there is a dearth of research based nursing literature on the subject of casual nurses. Searches including "temporary", "auxiliary", "float", "contingency", "contract", which are alternative descriptors in other fields of human services work did not point to any helpful material. In fact, journals of human resources management, labor relations, education, and psychology describe the benefits and pitfalls of part-time employment from the perspectives of management and union but the researcher was unable to find descriptions from that of the casual worker. This absence of input from casual workers in the literature from other fields would appear to indicate that although their presence has started to become recognized from a labor-management perspective, their worklife experience has not. The reasons for this lie in the realm of speculation: they could include difficulty in locating available subjects, pinpointing members of a population that is shifting, or convincing a marginalized segment that their input is of value.

As stated previously, the researcher has practiced as a casual nurse and this experience triggered the interest in this research topic. As the interest was shaping into a question, there were many opportunities for reflection on personal experiences and for conversations with colleagues who were casual nurses. Through these reflections and conversations, certain aspects of the experience became highlighted as important. These common areas of reflection and discussion included: job satisfaction, frustration and concern with workplace demands, the impact of work on homelife and homelife on work, the demands of unrelenting change in the workplace and worry about caring for patients. With these ideas in mind, the literature was reviewed in order to explore what was already known and to become sensitive to issues that might not have been highlighted in previous reflections.

The literature reviewed is presented in the following way: part-time nursing employment, quality of worklife, the interface between nursing work and homelife, clinical knowledge and judgement of nurses, and managing issues dealing with workplace culture and change.

Part-time nursing employment

The journals in health economics, management and administration abound with studies of worklife influences that keep nurses in nursing practice. There is an obvious reason for the interest. High turnover is costly and these are times when there is little tolerance of avoidable cost. However when Kemp (1994) and Hiscott (1993) were published, there were still fewer nurses than there were positions, and this situation has changed due to major shifts in funding and health care priorities. How this change has affected the worklife of the casual nurse is of interest to this study. There are now ample nurses applying to fill any regular position vacancy, so the question arises about the urgency felt by agencies to enhance the workplace to attract and retain nurses. When casual nurses are readily available as less expensive options to fill gaps in regular personnel, they appear to supply the solution to the "work harder with less resources" ethic of productivity that prevails.

In 1994, Kemp studied the reasons nurses no longer work full time and the impact this decision had on the nurses' lives and careers. Data was collected using a questionnaire sent annually to nurses who graduated from the University of Hull. In this longitudinal study, conducted over a 10 year period, 45 of 171 nurses reported that they had left full time employment, 75% to go into part-time and 25% who left altogether. Comparison of graduating cohorts, that is different graduating classes, showed a considerable variation, some classes had much higher numbers of nurses that left full time work than others. From these 45 respondents, she found that there were five reasons nurses went from full time to part time work: predictability and control of hours of work, avoidance of unsocial hours of work, time

with children, relief from stress, and freedom to pursue personal goals. She also found there were two distinct perceptions of how the reduced employment affected the nurse: either it was a positive force that abetted the mother and children's well-being, or it was a negative effect on the woman's personal and/or professional development. There was one area where working part-time was a positive force in professional development and this was when the reduced responsibility was a means of gaining time for study and for writing for publication.

Through a telephone survey, Hiscott (1993) investigated changes in employment status of 1065 Ontario nurses. He noted that nursing reflects the Canadian labour force picture of 30% of women who worked part-time in the 1980's growing to 40% in the 1990's. He found that from 1960s to the 1990s, full-time employment among Ontario nurses decreased from 80% to 55%, part-time employment increased from less than 20% to approximately 35%, while casual employment increased only modestly. The nurses who worked full-time tended to be under 30 years old and single, while part-time nurses tended to be married with children and to have been in nursing for a longer period of time. There was a definite relationship between changes in kinship responsibility (marriage and/or dependants) and the tendency towards change in job status. For example, nurses worked part-time until their children grew up or the loss of a marriage partner necessitated a return to full-time status. The vast majority of changes in employment status tended to be voluntary and most frequently related to such altered kinship responsibility. Change could be within the job (internal) or one of leaving a job (external). On average, the mid-career registered nurse had held five different jobs over a 16-year employment career. In his survey, he found that where internal employment status changes occurred, the average job duration was markedly longer than where no changes in status occurred. This has implications for the employer, indicating that greater flexibility could serve to reduce turnover and the costs of recruiting and training new staff.

Quality of worklife

While studies examining the reasons for part-time employment of nurses are limited, there is a great deal in the literature regarding factors affecting quality of nursing worklife. Attridge (1996) explored the concept of powerlessness in nursing. Stress in worklife is a focus in the work of Hartrick and Hills (1994), Sawatsky (1996), and O'Brien and Page (1994). Factors that positively and negatively influence job satisfaction are the focus of papers by Oberle and Davies (1994), Armstrong-Stassen, Cameron, and Horsbrough (1996), Cairns and Cragg (1987), and Pilkington and Wood (1986)

Power Attridge (1996) studied incidents of powerlessness in work situations with data provided by 64 hospital staff nurses in British Columbia. This report was drawn from a larger project studying power, its meaning, and its relationship to the experience and work situation of two groups of professional women: nurses and child welfare workers. The intent of the report was to illuminate the frustration and inadequacy nurses experienced when faced with situations where they perceived themselves to have little or no power in providing the necessary action.

Based on critical incident analysis, consistent themes relating to experiences of powerlessness were identified from the data. Although the stories came from different areas of practice and levels of experience, there were consistent themes: the nurses described a sense of lack of control over the situations; they characterized the situations as being unsafe; they felt alone and unsupported; they were exposed to competing, very serious demands which required a choice being made and resulted in very visible, negative consequences; and they experienced a lack of resources.

These nurses defined power as "the ability to have control over the work situation to successfully bring about effective patient care or other work-related activity" and powerlessness was seen as the lack of this control.

To change the work situations to enable the nurse to have such control, Attridge suggests there needs to be: a) visible respect and value of the nurse, her work and her clinical judgement in performing that work; b) collegial support by peers, administrators, physicians and others; c) support for the nurses' autonomy in defining her work situation; and d) provision of the appropriate resource base.

Stress in the workplace. Hartrick and Hills (1994) explored staff nurses' perceptions of stressors and support needs in their workplace in two Victoria hospitals. As no description of employment status was provided, it is only speculative as to whether casual nurses were included. However, this work provides a good background for considering nurses employed casually in the same geographical area as those in the current study. As the first part of the project, 28 nurse participants kept a one-day log of their workday experiences. These logs were then used to assist participants in recalling instances of workplace stressors and support needs during a semi-structured interview that took place the following day. The stressors were identified, counted for frequency, and categorized. The categories generated were: a) organizational/ environmental stressors which included issues relating to workload and relationships with other health care team members; b) job component stressors which included pressures of time and patient/family needs; and c) intrapersonal stressors which included personal expectations, vulnerability and lack of knowledge/skill.

The chief contributor to organizational/environmental stress was workload - too many demands at once, assuming extra duties, and no time for meeting patients' emotional or learning needs. Other environmental stress related to interpersonal relationships including physicians' lack of understanding, lack of positive recognition and lack of input, and physical environment including insufficient resources and supplies.

Job component stressors were the next major category. These included time pressures and deadlines, being unable to fill the expectations of patients and their families,

the difficult patients' problems or conditions, and the demands and needs of the patients' families.

The third major category was intrapersonal stressors and included personal expectations, a sense of personal threat and vulnerability, and lack of knowledge/skills/procedures.

Support needs that were reported fell into 11 categories. The most frequently mentioned was help with physical work (71.4%) followed by a cluster of emotional support categories: listening/understanding, consult/problem solving, positive recognition/acknowledgement. Other areas of need were: support services, clinical coordinator, communication, input into changes, clear roles/policies, support group and physical change.

Sawatzky (1996) compared perceived and actual stress experienced by 96 female coronary care nurses in two Canadian tertiary care hospitals. The instrument used for measurement was the Critical Care Nursing Stress Scale (adapted from the Stress Audit) to elicit nurses' perceptions of stressful and satisfying aspects of their work. The researcher measured the frequency, intensity, threat and challenge of the work aspects using a 5-point Likert scale (0=never/not at all stressful/threatening /challenging to 4=very often, very stressful/threatening/ challenging). The total scores for intensity, threat and challenge measured perceived work stress, while the frequency of occurrence reflected the actual number of stressful events that occurred. In addition, she measured the subjects' perception of global or life stress with the Perceived Stress Scale.

The top six work stressors were ranked on the basis of total scores for frequency, intensity, threat and challenge. Patient-care related stressors ranked the highest overall and lack of control was a common element among the most stressful situations.

Frequency categories (measuring the actual number of stressful events) were, in order of rank: routine procedures, responsibility/decision making, noise,

emergencies/transfers/ admissions, critical/unstable patients, and unnecessary prolongation of life.

Intensity categories in order of rank were: unnecessary prolongation of life, insufficient/malfunctioning equipment, apathetic/incompetent medical staff, emergencies/arrests, uncooperative patients, and inability to meet patients needs.

Threat categories were: apathetic/incompetent medical staff, unnecessary prolongation of life, insufficient/malfunctioning equipment, inadequate knowledge, apathetic/incompetent nursing staff, and unavailability of physicians.

Challenge categories were: emergencies/arrests, critical/unstable patients, responsibility/ decision making, unfamiliar situations, emergencies/transfers/admissions, and inadequate knowledge.

The recommendations included recognizing the differences between the actual number of stressful events and the perceived work stress and then working on changing the perception. If the origins of stress can be identified and controlled, improved nursing performance will lead to consistent level of optimal care. The value of ongoing continuing education in clinical areas and learning assertive behaviors in order to gain a sense of mastery and control was emphasized.

To measure nursing stress, perfectionism, self-efficacy, job satisfaction and life satisfaction, O'Brien and Page (1994) used five different scales. The Nursing Stress Scale assessed the frequency with which nurses encounter a number of daily stressors by checking a 4-point frequency scale. The Multidimensional Perfectionism Scale assessed self-oriented perfectionism, other-oriented perfectionism, and socially-prescribed perfectionism. The Self-Efficacy Scale assesses an individual's agreement with statements about self-efficacy on a 5-point Likert scale, and job satisfaction was measured on the scale of that name. Global life

satisfaction was assessed with the Satisfaction with Life Scale. Participants were also asked three open-ended questions related to stress.

These open-ended questions and their answers ranked by frequency include:

"How could your job be made more satisfying?" Findings were: improved relations with administration, more flexible scheduling, more staff, and higher wages.

"What promotes and/or inhibits a high level of staff morale?" Findings were: respect from administration, degree of cooperation among other nurses, workload and staffing levels, relationships with physicians, and flexibility of scheduling.

"What are two significant factors contributing to the nursing shortage?" Findings were: low wages, inflexibility of hours, low prestige, too much work with too few staff, and lack of respect from administration.

Data analysis revealed high levels of work-related stress were correlated with low levels of job and work satisfaction, but not necessarily to satisfaction in life generally; that high levels of socially-prescribed perfectionism are related to low levels of both job and life satisfaction; and that low levels of self-efficacy are related to low levels of job and life satisfaction.

Nurses perceived that employers don't value employees' home and social schedules as much as their work schedules. They also felt they lacked control over their work schedules, and that they are expected to complete too many duties during a shift.

As participants with higher levels of self efficacy generally perceive they can control threatening events, persevere during adversity, and remain task-oriented during periods of stress, the implication is that steps should be taken to enhance self-efficacy. The authors acknowledge more research is required to assess the validity and generalizability of this implication. They further suggest that training procedures could be developed to enhance personal and professional self-esteem, work adjustment and morale.

Job satisfaction. Oberle and Davies' 1994 article introduces a model that helps to clarify the conflict nurses feel when they must deal with the reality of the workplace versus their internalized definition of what a nurse and the practice of nursing is all about. The Supportive Care Model is conceptualized as six dimensions of care, presented as four linked circles representing the dimensions of "connecting", "doing for", "finding meaning", and "empowering", around a centre circle of "preserving integrity". Surrounding these dimension circles is the encompassing circle of "valuing". Oberle and Davies define the centre core of "preserving integrity" as the "...nurse's ability to maintain a personal sense of coherence or oneness, while at the same time helping maintain the patient to wholeness".

To explain nursing disillusionment, this model is combined with ethical theory. The traditional view of ethics is based on "justice", that is, impartiality that takes no account of relationships and caring. However, current views include caring and connectedness as most important in the way some see the world, and this can be at the centre of the person's belief system. If nursing is based on an ethic of caring, then this is how nurses view their world. When an employing organization places more value on "doing for" (the task-oriented parts of nursing) to the detriment of caring and connectedness, the nurse experiences dissonance due to the incongruity between beliefs and practice. This is so uncomfortable that the nurse may need to adjust such beliefs and downplay the importance of connecting, empowering and finding meaning. The eventual cost to the caregiver is disillusionment.

Armstrong-Stassen, Cameron, and Horsburgh (1996) studied the impact of organizational downsizing on job satisfaction among 345 full-time and part-time nurses in three hospitals in Ontario. The met expectations theory of job satisfaction provided the theoretical framework for the study. This theory posits that individuals have unique job expectations of the organization embodied within psychological contracts, or the individual's perception of "fair". These job expectations include reciprocal expectations between the

employer and the employee. A violation of these psychological contracts produces a discrepancy between what was expected and what was received and results in reduced satisfaction with both the job and the organization itself. For example, in return for good job performance and loyalty to the organization, the employee expects employment security and commitment. If an employee has performed well and been loyal and a company downsizes this violates the expectation and leads to disillusionment.

The impact of downsizing was assessed through questionnaires measuring overall job satisfaction through the Minnesota Satisfaction Questionnaire and individual aspects of one's job and work environment through the Index of Organizational Reactions. The researchers describe a longitudinal study collecting data from nurses, first in early 1991 when hospitals were still experiencing a shortage of nurses. The second collection occurred in late 1992 following bed closures, and staff relocation and layoffs. Findings indicated that there was no difference between how full and part time nurses viewed aspects of their job and work environment either before or after the downsizing. They both expressed less satisfaction with supervision, the hospitals in general, with co-workers and the prospects for their career futures within the hospitals. They were more satisfied with their financial status, however, and this is undoubtedly due to the salary increase received between the two parts of the study. The nurses that survived the downsizing perceived the employer as uncaring and unfair in the treatment of its employees. Such perception emphasized the need for good communication, enabling employees to know both what is happening and what is likely to happen, as well as how those whose employment was terminated were treated. Recognition of the change in working conditions should be reflected in programs designed to assist the remaining nurses to cope with such change. Unit managers need educating on managing a workforce that is being downsized. These strategies fit with the met expectations theory of job satisfaction by either maintaining the psychological contract or working towards developing a new one.

Cairns and Cragg (1987) studied the "fit" between the work expectations of nurses graduated from university and the realities of hospital work in order to explore this group's job satisfaction and dissatisfaction. The conceptual model of expectation and reality fit postulates that the nurse brings the expectations that have been shaped by personal attitudes and circumstances, educational preparation, and psychomotor and interpersonal skills to the workplace where the realities of organizational structure, job definition, interpersonal climate, and working conditions await. If the nurse is able to apply the acquired education and skills and receive recognition within the institution, then the intrinsic reward will be there, and the fit will be a good one.

Cairns and Cragg collected data on job satisfaction among baccalaureate nurses using semi-structured interviews. Data analysis led to identification of satisfying and dissatisfying aspects of nursing work as markers of fit between expectations and reality. Job satisfiers included patients and their families and mental stimulation. Dissatisfiers included shift work (major dissatisfier), lack of autonomy and decision-making responsibility, feeling powerless, insufficient pay for the level of responsibility required, remote and dictatorial administrators, and boredom after the novelty wore off.

Participants described discrepancies between their personal expectations and the reality of the workplace and the baccalaureate nurses felt particularly unhappy about not being able to apply what they had learned in university. The dissonance between expectations and reality was evident when they experienced general duty work, including shift work and the time pressures that prevented them from providing the level of care they were taught to give. Another source of dissonance was encountering the expectation that they were to follow orders, policies and practices with little room for new ideas that didn't fit in. There was a poor fit between university programs and work reality in the area of leadership skills because leadership was not part of the staff nurses' job. Nursing theory was not commonly used on

the job because despite understanding the theorists and how they present their models "...when you're faced with this many patients on this particular day, what you do is move from one patient to the next doing what needs to be done." (p.25)

Implications of the research were discussed in relation to both university schools of nursing and hospitals. University education should include a curriculum focus on the realities of the workplace: coping with the demands of shift work, dealing with bureaucracy, and assisting students in seeing the application of nursing theory in high demand workplaces. For the hospital, the study implications included improving the intrinsic factor of work life by recognizing the strengths of degree nurses, involving them more in policy decision making and on committees, and improving flexibility in scheduling. Many new graduates today are finding work as casuals, not necessarily through choice. The findings of this study could influence the evaluation of personal and professional expectations of transitioning new graduates by orientating them to these workplace realities.

Pilkington and Wood (1986) explored job satisfaction, role conflict and role ambiguity among hospital nurses in a teaching hospital in New South Wales, and theirs was the only study found that included casual nurses as a specific group. Using a 71-item questionnaire, they surveyed 80 bedside nurses divided into groups of 40 full-time, 20 part-time and 20 casually employed nurses. They found that permanent part-time workers experienced more job satisfaction than full-time or casual workers. Casual workers experienced the greatest role ambiguity and role conflict between home/personal life and work. Role ambiguity was also experienced by full- and part-time workers and this is attributed to rapid organizational changes that had occurred (not dissimilar to the current health care picture in this province). Full-time workers also had to deal with role conflict between home and work to a lesser degree than casuals, while part-time workers were the most secure in this area. High level of

role conflict related to low level of job satisfaction and this in turn related to propensity to leave the position.

In summary, the nursing worklife literature described factors that enhanced nurses' worklife, by giving them the feeling of satisfaction, security, and fulfilment. Research has also described the negative aspects of the workplace and how this affected performance in the workplace. These influencing factors described in the literature are summarized below:

- 1) Job condition factors: pay, benefits, working hours and conditions.
- 2) Intrinsic factors; variety, autonomy, interest, creativity, importance, ability to use skills, recognition.
- 3) Organizational factors: how delivery of nursing care is organized, policies and procedures, support services available.
- 4) Interpersonal relationships: with peers, supervisors, physicians and members of other departments, and the sense of functioning in an effective nursing or interdisciplinary team.
- 5) Personal factors: include age, length of time on the job, educational level and family responsibilities

The Home Factor

Nurses are more than the persons who appear on the job. They are affected by their homelife, whether they are single or in relationships, with or without dependants, attending school or not. The following studies examined the interrelationship between the worklife and the personal life of nurses.

Glynn, Arndt, Beal and Bennett (1996) investigated the interconnectedness of nurses' work lives and personal lives through a 12-item interview of 25 female nurses in the United

States. The interview questions were open-ended and were aimed at investigating how nurses made changes in their lives and how these changes influenced and were affected by the various domains in their lives - careers, professional development and their personal and family commitments. The nurses were asked about changes they had made or that had occurred in their career or personal life within the past year, including questions regarding the cause of change, resources used in evaluating and implementing the change, problems encountered in making the change, and the effects of the change.

As the study was conducted under the tenets of grounded theory method, the data analysis used constant comparison to examine the content of the interviews, leading to further interviews, data collection and analysis until a theoretical construct emerged.

Changes were described in the following classifications: a) adjustments in existing jobs, b) movement to a new job, c) professional development, and d) personal events. Specific changes were not viewed as entities with boundaries, rather, as connected to other aspects of the nurses' lives. A change at work, for example, influenced or was affected by other aspects of their lives and relationships. This was labelled "interconnectedness".

Interconnectedness was reflected in the nurses' choice of resources to facilitate the change. These resources included formal - counselling, reading, continuing education, and informal - discussions with family, friends and colleagues. Problems connected with change reflect interconnectedness as well. These included criticism and lack of support from family or colleagues at work and the need to balance the obligations of home, work, and school.

The study implied the need for management practices that acknowledge, respect and affirm the actual life circumstances of nurses and help them maintain the interconnectedness of their lives. This included fostering sustained collegial relationships which "downsizing" often unravels as positions are eliminated or nurses reassigned. Another implication called for policies respecting the nurses' commitments outside the job through expanding definitions

of success and appropriate job structures - job pooling and flexible on-site day care, as examples. A third implication involved accessible continuing education that would enhance clinical expertise as well as supporting nurses in making career decisions that are synchronous with their overall lives.

Gottlieb, Kelloway and Martin-Matthews (1996) studied the predictors of work-family conflict, stress and job satisfaction among 101 hospital-based nurses who were caring for either a child or an elderly relative. Using a four-part survey with five-point Likert-type response scale they assessed time-based and stress-based items of work interfering with family (WIF), and family interfering with work (FIW) as well as measuring global perceived stress and job satisfaction. They found that the factors that influenced work-family conflict, stress, and job satisfaction were family support, perceived organizational support for family life, perceived workload size and involvement in child care. Specifically, nurses who felt the burden of job-related workload were more inclined to take it home with them, while those who provided a large amount of assistance to their children found that there was a spillover from the family domain into the work domain. Workers who received satisfactory support from their families were less likely to be preoccupied with home issues at work. Interestingly, those who perceived co-worker support did not noticeably have less work-family conflicts, whereas those who perceived employer support apparently did. This suggested that co-worker support affects morale at work but compared to employer support has little bearing on the integration of work and family duties.

It was found that the only reliable predictor of work/family conflict was the perception of having too much to do and it proved to be a salient precursor of stress, job dissatisfaction, and strain-based WIF. Implications for researchers included the need to separately measure both the source and the direction of work-family conflict. Implications for employers included consideration of a more "family-friendly" workplace environment and all that this may entail.

In summary, this literature relating to quality of nursing worklife explored: the concept of powerlessness in nursing and how policies should be directed at alleviating powerlessness and promoting nurses' control of their practice; several studies on the effect of workplace stressors and the implications to researchers and policymakers; the effect and relationship of disillusionment, dissonance and downsizing on job satisfaction; and the influence that various domains of a nurses life have on each other - career, home, personal and professional. These studies were chosen to augment the researcher's personal knowledge and sensitize her to issues that may arise in the group discussions.

Clinical knowledge and judgement

Casual nurses frequently experience work that is discontinuous and fragmented, that is, only a shift or two at a time in the same location and caring for the same clients. As this probably has an effect on their experiential learning, the researcher wished to learn more about the relationship between experiential learning, clinical knowledge and nursing practice.

Benner (1983) examined the knowledge embedded in clinical practice as part of her larger studies of the knowledge acquired by acute care nurses in their work. This embedded knowledge is the "knowing how" knowledge that is gained in experience, not the "knowing that" knowledge acquired through scholarly inquiry. It is this "knowing how" kind of knowledge that enables an expert nurse to see critical situations as a whole, using past experience of "paradigm cases" to move directly to the area of concern without having to spend time on irrelevant options. To tease out incidents illustrating such knowledge, transcripts of small group interviews and field observation notes of expert and novice nurses at work were studied. In this particular paper there was no specific identification of the sample except to indicate they were from a variety of acute patient care settings.

Competencies were identified and classified into seven domains that are embedded in nursing practice. These domains were: a) the helping role of the nurse, b) the teaching-

coaching function, c) the diagnostic and patient monitoring function, d) effective management of rapidly changing situations, e) administering and monitoring therapeutic interventions and regimens, f) monitoring and ensuring the quality of health care practices, and g) organizational and work-role competencies.

Limited by space in the article, Benner chose the teaching-coaching domain of nursing practice and used exemplars to illustrate the five competencies identified: a) assisting patients to integrate the implications of their illness and recovery into their lifestyle; b) the coaching function of nursing, making culturally avoided aspects of an illness approachable and understandable; c) eliciting and understanding patients' interpretation of their illness; d) providing an interpretation of patients' condition and giving a rationale for procedures; e) timing - capturing a patient's readiness to learn.

Benner described how nurses enrich their practical knowledge through building up of experiences, enabling them to make qualitative distinctions such as recognizing subtle physiological changes. They also develop common meanings in the human situations they encounter that are shared among nurses. These lead to assumptions, expectations, and sets about particular situations. As knowledge progresses, it is influenced by paradigm cases in their experience which may change the nurses' perception - refining it or redefining it as the situation affects the knowledge.

Benner summarized with asserting the need to study nursing knowledge within the context of practice. This is essential to the development and extension of nursing theory.

Almost ten years later, Benner, Tanner, and Chesla (1992) described how nurses' view of their work evolves as they gained clinical experience and how they evolve themselves from beginning practitioners to expert. The sample consisted of 105 full-time ICU nurses with baccalaureate degrees who were interviewed in small groups clustered into three levels of practice: advanced beginner, intermediate, and expert. They were encouraged to describe

exemplars of specific situations requiring nursing interventions. As nurses evolve from beginner to expert, their world view of their situations changes. Such changes can be differentiated into four aspects: a) moving from relying on abstract principles and rules to the use of personal concrete experience; b) shift from reliance on analytic, rule-based thinking to intuition; c) change in the learner's perception of the situation as a compilation of equally relevant bits to an integrated, complex whole in which certain parts are relevant; and d) movement from position of detached outside observer to one of involvement, fully engaged in the situation. The clinical world of the expert nurse is shaped by learning from experience, and as illustrated by the exemplars, the nurse learns to value her emotional response to a situation, moving from the novice's generalized anxiety in a situation to recognizing the cue of uneasiness that alerts the expert to the significance of a changing situation.

The phenomenology of "knowing the patient" was explored by Tanner, Benner, Chesla, and Gordon (1993) as part of a major study of the development of expertise in ICU nurses using group interviews as described above. Clinical episodes containing themes relating to knowing the patient were sought as well as contrast cases where nurse described not knowing the patient. Two questions framed the interpretative analysis of the transcripts: "what do nurses mean by knowing the patient?" and "what difference does knowing the patient make in nursing care?" "Knowing the patient" was an interpretive phrase used by researchers to describe the knowledge of both the typical pattern of the patient's responses and knowing the patient as a person, getting a grasp of the patient's situation "in context with salience, nuances and qualitative distinctions" (p 275). It meant knowing the patient well enough to recognize the subtle differences that indicate a change even when not able to be verbalized by the patient as in a Neonate Intensive Care Unit. There were particular aspects of patterns of response including: a) responses to therapeutic measures, b) routines and

habits, c) coping resources, d) physical capabilities and endurance, and e) body topology and characteristics.

"Knowing the patient" meant an understanding that is involved rather than detached, and it may remain largely ineffable. The researchers concluded that knowing the patient is central to skilled clinical judgement, requires involvement, and sets up the possibility for patient advocacy and learning about the patient population.

These three papers on experiential knowledge emphasize the need for studying nurses in the context of their work, using the words of their experiences. Although the nurses studied were critical care nurses, the development from novice to expert is an experience that is repeated in many fields and is certainly transferable to the development of casual nurses.

Managing Change

Change in health care priorities was described briefly in the introduction. This shift in focus from heavy concentration on high-tech hospital care to development of community resources was accompanied by an adjustment in funding with the intention of giving the communities more power in determining where health care funds were to be spent. This pendulum swing is due in part to a recognition that the health care system is in trouble, and the best way to deal with it is to listen to what communities say they need in health care. The 1991 Seaton commission report "Closer to Home" was this province's version of studies conducted across Canada to garner relevant information. However, there were earlier signposts directing the path to follow. Consumers had been growing more sophisticated and knowledgeable about health, demanding more sources of information, and finding them.

Sutherland and Fulton (1988) admonish would-be leaders in health services to keep in mind "...your work world is in ferment. What was taken for granted two years ago and under review a year ago is probably in a state of change now." (p 3-4) Their book described Canadian health care a decade ago as well as indicating what direction changes should take.

Rachlis and Kushner's (1989) more popular book "Second Opinion" rattled Canadians' complacency over the state of their beloved health care system. Both books are in second editions now, with indications that although there are massive changes underway, there is a lot of upheaval still to come. Growe (1991) exposed to the general public what health care is like from the point of view of the ultimate insider - the nurse. This book was hailed by critics at large and within nursing as well for its graphic portrayals of a profession that was struggling and losing in the conflict between ideologies and policy makers.

The Seaton Commission (1991), after hearing from all levels of health care consumers and practitioners who were willing to speak out, made recommendations in a report that the provincial ministry of health took very seriously (New Directions, 1993). The changes that are taking place in British Columbia health care policy and described previously are the ministry's response to these indicators of changing requirements. The response in Victoria has been reflected in a mammoth overhaul in the infrastructure of health care facilities: amalgamation of hospitals, the health care sections of the Capital Regional District, and the long term care facilities in the region. The few other health care facilities that are not directly amalgamated have an associate status to bring them in contact with the umbrella organization. Within the facilities, the effect varies from the profound - unit closures, amalgamation, staff layoffs and relocations, to relatively minor - new faces and new titles in management and changes in workload.

Professional journals, particularly in nursing administration, have been focusing on the implementation of change and how nurses both on the front line as well as in middle and upper management are meeting and coping with change. How the environment of change affects the front-line nurses and their management is the focus of the next section of literature review. The following studies were chosen as they focused on work culture and management

style in dealing with change, areas the researcher thought would affect the casual nurses' worklife.

Nakuta and Saylor (1994) investigated management style and staff nurse satisfaction in a changing environment through a cross-sectional survey of 102 staff nurses in a California hospital. The nurses surveyed indicated their preference for a management style that was described as participative group, although they perceived the current management style on their units was benevolent-authoritative. Participative group style exemplifies widely shared control by all members of a unit, decisions made at all levels, communication path that is up, down and sideways, and the incorporation of staff ideas into the decisions affecting the unit. Nurses whose contribution is sought and expected felt valued, trusted and more likely to remain in the environment, reducing the costs of recruitment and orientation. Implied further benefits to the institution included positive influence on patient outcomes and public image. This would be due to the increased staff awareness of how actions and decisions made at the unit level influence the entire facility.

Seago (1996) explored the relationship between work group culture and the acceptance of change, stating that "understanding organizational culture is essential in making and surviving changes" (p.39).

Work group culture was defined as a pattern of behaviors, unique to a group, "the way things are done", manifesting itself in observable artifacts, values and basic underlying assumptions. Seago investigated the relationship between stress, hostility, and work group culture and nursing unit outcomes, expressed as absenteeism and turnover.

In this study the purposive sample consisted of the nursing personnel of two units from tertiary care hospitals where data were gathered on absenteeism and turnover. Work group culture was measured by the 120-item Organizational Culture Inventory which measured 12 distinct thinking styles organized into three factors: the passive-defensive factor

which was people-security oriented, the aggressive-defensive factor which was task-security oriented, and the constructive which was satisfaction oriented.

Stress could be displayed in both short-term and long-term behaviors. Short-term included quick temper, loss of concern for people, yelling, crying, and leaving. Long-term behaviors included smoking, leaving the job, leaving nursing, increased absenteeism, and work-related injuries or disabilities. Workplace stress was measured by the Job Content Questionnaire and include items measuring decision latitude and psychological demand.

Hostility is a stable anger personality trait, and hostile individuals tend to experience chronic hate and anger and view the world with suspicion. They may influence the environment in which they work. In some individuals, the environment may influence hostility. Hostility was measured by the Cook and Medley Hostility Scale.

Turnover was related to the factors of burnout, errors, absenteeism, expressions of negativism, subversive activities and increased physical illness. Associated factors included role ambiguity and conflict, job stress, work load, job satisfaction and intent to leave.

Unscheduled absenteeism was a disruptive factor in unit management, as it is unexpected and unpredictable and negatively impacts morale, cost, and quality of care. Factors relating to absenteeism include parenting responsibilities, scheduling, attitude, job dissatisfaction and employee ability and motivation to attend work. Absenteeism and turnover data on the units completed the collection.

There was found a positive correlation between psychological demand and aggressive defensive and passive defensive cultures, which means that when stress levels were high, security-oriented cultures developed. What appeared to be hostility was more appropriately defined as an anger reaction to the situation or the context and is more amenable to change than the personality trait of hostility. Implications to management included the acknowledgement that in these times, psychological demand is more likely to

increase rather than decrease, so the option open to managers was to take steps to increase decision latitude which may moderate demands and reduce job strain.

Coelling and Wilcox (1988) investigated understanding organizational culture to assist management decision-making. Using observation, group and individual interviews, the researchers conducted an ethnographic study of two nursing care units comparing the cultural differences in "work rules". These rules were divided into categories of working together, telling others what to do, following established standards, organization and use of time, psychosocial perspective-taking and change. There were considerable cultural differences between the two units. Unit A tended to work together, avoid competition and hierarchy among the staff nurses, preferred standardized guidelines, valued efficiency, organization and prioritizing, attended to obvious psychosocial needs of its members for a period of time, preferred the status quo and attended some classes in relation to the above categories. Unit B staff tended to work independently and compete among themselves, recognize hierarchy based on skills, knowledge and assertiveness, preferred to use their own judgement regarding procedures, limit emphasis on efficiency and identify numerous activities as priorities, actively look for members' psychosocial needs and show concern for such indefinitely, prefer a changing situation and attend as many classes as possible.

Implications for nursing administration are related to four areas in which cultural differences in units need to be considered before action is taken. These areas are: a) hiring personnel - ensuring the fit between newcomers and the unit culture is appropriate; b) orientating newcomers - assisting them to recognize the cultural norms both to avoid violations and to enhance the skills that fit in; c) facilitating organizational change - recognizing the way different units accept innovations and tailoring the approach to suit; and d) promoting the learning experience - using appropriate teaching methods and focusing on different aspects to enhance the process of learning.

Finally came a warning and an admonishment from Gregor (1997) describing the similarities between the ongoing changes that the American health care system is undergoing and those threatening (and happening) in Canada. She pointed out that the rhetoric of "community care" and "family care" serve to cover the gender issue of "women's work" and that the care is going from the women in nursing for their paid work to the women at home for their unpaid work of caring for family members. This is resulting in, among other things, the devaluation of much of the work that nurses are particularly skilled at, the "talk work" that is not related to machinery or equipment, but to skilled communication and assessment and knowing the client/family. This very meaningful aspect of nursing is not accounted for in the promotion of technology-based hospital work and is relegated to the unpaid "family care provider" (wife, daughter, mother). The admonishment was directed at the elite who have supported the "closer to home" rhetoric without taking this factor into consideration - the academics and the professional nursing associations, who are only recently modifying their unqualified support of the movement.

Critique of literature

One of the primary purposes of this study is to give voice to a large group of nurses who have not been previously heard in the literature. Although there was mention in the labor relations literature of the effect of contingency (auxiliary, contract, float, etc) work on the general workforce, there was found no description from the perspective of the worker. Thus the literature reviewed, although valuable for their studies of the subjects of interest - powerlessness, stress, disillusionment, job satisfaction, change, and so on, have the basic flaw of excluding, or at least not mentioning, the views of casual nurses. The "non-mention" could be due to the lack of differentiation in some of the samples, but most researchers describe participants as "full-time" or "permanent part-time" with only the Pilkington and Wood study of nurses in New South Wales specifying casual nurses as a specific entity.

In fact, the Pilkington-Wood study uses the participant proportions of ½ full-time, 1/4 part-time, and 1/4 casual nurses which is a significant portion. The response to the questions indicated that this group did not merely echo those of either of the other groups and thereby indicates the validity of viewing casual nurses separately. This would be particularly appropriate in studies of power/powerlessness, stress, and other factors that influence the quality of worklife.

The process of data collection was varied, from questionnaire to interviews of varying degrees of structure. As this study used group interview process, the conclusions found in the research reviewed helped to construct the open-ended questions that were asked, as well as the follow up probes.

Oberle and Davies' 1994 work described the Supportive Care Model and how such "caring" values colliding with the "justice" ethical values of most institutions impacted on nurses. The conflict needs to be resolved for the nurse to be comfortable in her workplace and sometimes requires adjusting her beliefs in what is a "good nurse". This provided the basis for one of the questions asked the casual nurses and is described in the next chapter.

The studies of the effect of worklife and personal life on each other acknowledged that nurses need to be viewed as holistic beings. The methods were different; Gottlieb et al used surveys and Glynn et al employed open-ended interview questions, but both showed clearly that the domains of a nurse's life are not discrete entities. This should be noted by both employers and researchers and is reflected in the probes used in this study.

Benner et al conducted group interviews for data collection which provided a rich source for studying nurses in the context of their work. These classic works have enriched knowledge from earlier studies of "novice to expert" in other fields. They have provided clear examples that helped to define the phrases "paradigm cases" and "exemplars" that are used now in many other qualitative nursing studies.

Benner studied the professional growth of nurses apparently wholly through their work experiences, and in the articles read by this researcher at least, did not introduce the potentially confounding factor of personal/family domains contributing to this growth. As the above studies have indicated, these areas have "interconnectedness" with each other and must surely have some effect on the maturing of the nurse in her work. Thus, the current study includes the effect of home, family/friends, and school as it applies to the casual nurses' worklife.

Summary

The literature was selected to enlarge the researcher's knowledge about hospital workplaces and the nurses who work there, including management strategies to introduce changes, the influence on the nurses who work there, and ways nurses respond. The importance of experiential learning was explored in the literature review as was the work/home interface. Some of the material was selected prior to undertaking the interviews, some concurrently, and some followed, the timing was related to perceived need as the study proceeded. As there was no literature found that dealt singularly on the subject of casual nurses and only one study found that identified casual nurses as a separate group in a job satisfaction study, the literature presented was studied for general information. The goal was to increase background knowledge in order to ask informed questions, clarify details and thereby enable the researcher to enter the world of the casual nurse not as a neophyte distracted by the novelty, but hearing with increased sensitivity the stories and descriptions as they were told. During the analysis, the enlarged knowledge sharpened the awareness of emerging themes, and at times led the search to adjacent studies for clarification. The following chapter includes how the literature review was incorporated into the design and methodology.

Chapter Three: Research Design and Methodology

As the researcher wished to understand the nature of worklife of casual nurses, a methodology that would allow the expression of experience in their own words would be appropriate. When there is an unexplored territory to enter, qualitative methodology that is descriptive brings the colour, texture and sound to the reader (Burns and Grove, 1987; Beck, 1994; Sandelowski, 1994). Creswell (1998) defined qualitative research as

“...an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting.” (p. 15)

Qualitative methodology is used when there is a need to explore a topic, presenting a detailed view of subjects in their natural setting. The researcher is part of the study, not distantly removed, but actively learning about the topics and the subjects (Creswell, 1998)

Data collection was accomplished through the use of group interviews drawing on ideas from Frey and Fontana (1991), Krueger (1993), and McDaniel and Bach (1994). For guidance in categorizing and working with emerging themes, Tesch (1987), Patton (1980), Taylor (1984), and Paterson (1994) were included in the literature.

Scientific adequacy issues - quality, validity, rigor and reactivity

As described previously, qualitative research is an appropriate methodology when entering a relatively unexplored area where the voices of participants will be most eloquent and relevant regarding their own experiences. As with any systematic enquiry, attention to issues of quality of the data, investigator bias, quality of the research process and usefulness of study findings, must be addressed.

In qualitative research, quality and validity have historically been issues of contention. In nursing research, qualitative studies frequently have used designs borrowed from other disciplines: phenomenology from philosophy, grounded theory and descriptive exploratory from sociology, ethnography from anthropology, heuristic research from humanistic psychology, narrative research from psychology, hermeneutics (interpretive studies) from theology, classical literature, law and history (Parse, 1996; Bailey, 1997; Thorne, Kirkham & MacDonald-Emes, 1997). The quality of the research has been defined according to the values of these disciplines.

The matter of rigor has been examined by nursing scholars and researchers who have been working in various forms of qualitative research. In 1985 Lincoln and Guba translated the positivist terms for quality criteria in quantitative research into what they termed the trustworthiness criteria suitable for qualitative research. Thus, the equivalent for internal validity was credibility; external validity translated into transferability; reliability became dependability; and objectivity, confirmability. In later years, Lincoln acknowledged that there was a need to reconceptualize the criteria as such mere translation was inappropriate. The positivist paradigm sought truth, the qualitative/interpretive sought trustworthiness by making practice visible and thereby auditable (Bailey, 1996).

The legitimacy of the standard practice of member validation or member check is questioned by Sandelowski (1994) who has regularly used this method to claim trustworthiness of her results. What she points out is that the very act of member checking has its limitations - both the researcher and the member have a stake in the project, there are social norms of politeness and desire to be helpful, and there is the effect of the interaction that takes place between the researcher, member and the audience. Therefore, the process itself is affected by social constraints.

Other strategies of seeking validation in qualitative studies include expert panel, peer debriefing, and triangulation. All of these are not infallible, according to Sandelowski, so they must be carefully scrutinized themselves for bias and appropriateness. The conclusion reached by many researchers and scholars on the subject of rigor in qualitative research is that the most appropriate assurance of trustworthiness is for the researcher to clearly outline the methodology and then present the findings so that others can participate in the analysis and evaluate accordingly (Bailey, 1996; Sandelowski, 1993). This research paper is presented with such an intent.

As previously mentioned, the researcher has been a casual nurse who worked in acute care and home nursing care and certainly there was a great deal that was familiar in the words and phrases heard. Consequently there was a need to identify reactivity in this work. Paterson (1994) defined reactivity as "the response of the researcher and the research participants to each other during the research process" Rather than something to be avoided, reactivity is part of the research, needing to be acknowledged and reflected upon.

Paterson goes on to describe five themes that are common sources of reactivity and form the basis for the reactivity analysis framework. This is a method of recognizing and acknowledging the potential or real incidents of reactivity taking place during interviews and also during the analysis of the data. The themes are:

- a) emotional valence, or feeling tone that exists between the researcher and the participant; distribution of power, or the perception of either the researcher or the participant that the other has more or less authority than themselves;
- c) importance of the interaction, described as how significant the interaction is seen to be by the researcher and/or the participant ;

- d) goal of the interaction, which may be stated or unstated, clear or unclear for either or both the researcher and participant; and
- e) the effect of normative or cultural criteria, which are the standards of norms of the participants, and are directed towards the data collectors.

The framework is suggested as a tool that enhances the researcher's reflexivity. Reflexivity is defined as the ability to critically examine and use previous experience to influence further action.

Certainly the researcher's experience as a casual nurse was a strong influence in the choice of subject for study, and this was reinforced by daily encounters with members of the large force of casuals in her workplace of home nursing care. She now works full-time in this workplace and does recognize that she is in the position of power described by the casual nurses, power ascribed through familiarity with her own district, the role of assigning clients to casuals "floating" or working in this district, the knowledge of "how things are done", and so forth. However, she felt that the emotional valence was one of comfort between equals, that she was the one seeking information from those who knew the answers, and in turn they would tell their stories to someone who cared about them and their stories. In other words, there was an atmosphere of trust. Although she did not personally know all the participants, they volunteered because they heard of the project through word of mouth; somebody who knew the researcher told them about the study.

Another point of awareness is the fact that although the researcher has worked night shifts in acute care, these were in a small community hospital, quite a different environment from the tertiary care facilities where the participants worked, Thus it was important that she seek additional information through follow up questions of participants about the experience of

night shift both in acute and home nursing care. This was consciously compared with the experiences of the researcher for reflection prior to inclusion in the study.

Recruitment procedure

Institutional approval was sought and obtained from acute care, home nursing care and long term care facilities in the Capital Health Region. An abbreviated research proposal was supplied to each facility outlining the research question, justification for study, methodology and methods, and data analysis plans. Once approval was obtained, small posters that highlighted research interest in talking with casual nurses and the researcher's telephone number were displayed on nursing unit bulletin boards. The long term care facilities were eventually not included in the study due to lack of response to posters displayed in the agencies. Responses to posters in other agencies was very limited with only two nurses inquiring. Other methods for recruiting participants included brief explanations of the project at meetings of casual nurses, introducing the subject at coffee breaks and word of mouth networking through casual and full-time nurses. In the end, word of mouth proved to be the most successful method of recruiting participants in that four casuals indicated that they had heard of the project through nurses who were interested but could not participate.

Sample and setting

Criteria for inclusion in the study included casual employment as a Registered Nurse for at least six months and a willingness to talk about worklife experiences within a group setting.

The sampling strategy is described as a combination of purposive and convenience.

Purposive sampling is a strategy in which participants are selected on the basis of the researcher's knowledge of the phenomenon and his or her personal judgement about who would be the best source of information. Because the researcher was interested in how worklife of casual nurses might be influenced by the context of practice, nurses working in home care and acute care facilities were sought out. The sample is also described as one of

The participants also filled out an unsigned demographic questionnaire as described previously. The questionnaire is kept separately from the consent form to protect the anonymity of the participant.

Data Analysis

The steps involved in the analysis of the data are as follows:

Transcription: as soon as possible after the session, the notes were reviewed and the tapes transcribed.

Transcription read and reviewed: the transcriptions were then reviewed while listening to the tapes and notes from the sessions and comments about the non-verbal activity were consolidated with the transcripts to flesh out the picture of the session. This raw data was then read repeatedly until there was a thorough familiarity with the content. These initial readings were to acquire an overall sense of the experience of being a casual nurse.

Transcription read by committee member: these transcripts were also read and interpreted by a committee member as an additional assurance of validity.

Emergence/extraction of themes: in this initial phase of analysis phrases, themes, and patterns began to emerge and notations of these were kept.

Clustering/consolidating themes into concepts: most of this stage occurred once all the raw data had been acquired

This data analysis started to take place after the first session and concurrently with the collection of further data from the following groups, serving to clarify and sharpen the way the questions were introduced. For example, the issue of collegial respect emerged through group dialogue. As it seemed an important issue, it was deliberately introduced in the following sessions.

Krueger (1994) describes several options for data analysis of focus groups, based on time investment and degree of rigor. The first option is transcript-based analysis, in which the

convenience as all of those nurses who came forward as volunteers were included in the study.

The nine participants were all female registered nurses whose nursing experience ranged from less than a year to approximately twenty years. Five nurses worked in acute care and four in home nursing care. The sample is detailed in the following table:

Experience		Position		Age	
< 1 year	1	always casual	4	20-29	
1-5 years	2	some full-time		30-39	1
6-10 years	2	some part-time	1	40-49	7
11-15 years	2	some full- and		50-55	1
>15 years	2	part-time	4		

Kinship		Education	
single 0 dependant	1	Basic R.N.	4
single 1 dependant	1	B.S.N.	5
single >1 dependant		Graduate degree	
married/equiv. 0 dep.	1	Specialty certification	2
married/equiv. 1 dep.	2	Other	
married/equiv. >1 dep.	4		

In the above table, "position" indicated whether they had worked other than casual any time during their nursing career. "Specialty certification" indicated official recognition of expertise in a particular field, for instance enterostomal therapy or diabetic education.

Group interviews were conducted in three different settings including a University lab room (home care nurses), coffee room at one of the hospitals (acute care nurses) and the researcher's home (acute care nurses). In each instance, the setting for interviews was based on convenience of participants and availability of rooms where distractions were at a minimum and quality of tape recordings could be maximized.

Data collection method

Although data collection through focus groups was the original intended method, there were several deviations from the methodology "rules" for focus group process. The recommended number of participants for focus groups is 8 to 12 and the number of participants in each group in this study ranged from 2 to 4. Usually participants in focus groups don't know each other and in this study introductions were rarely required as participants often worked together.

Thus, for the purposes of this study, the use of groups for data collection was to prompt stories and to clarify ideas. Each group was comprised of nurses representing a particular context of practice: acute care and home nursing care.

Frey and Fontana (1991) describe group interviews as being able to "provide data on group interaction, on realities as defined in a group context, and on interpretation of events that reflect group input" (p.175) The advantages of group interviews are:

- a) reduced cost compared to one-to-one interviews because more persons are interviewed at the same time;
- b) more efficient because group members can stimulate each other;
- c) they bring insight to the researcher into the relationships in the field that might not be apparent with observation and individual interview; and
- d) reduce distance between the researcher and the social context by being flexible and permitting considerable probing (Frey and Fontana, 1991)

Data collection process

The project was explained to the potential participants during a telephone contact. The terms of the consent were discussed, and arrangements made for a suitable time and location for the group data collection to take place.

Each participant signed a consent (appendix A) and filled in a brief individual demographic questionnaire (appendix B) when she arrived for the group interview. The sessions were audio-taped and in two of the three sessions, an assistant made notes while the researcher facilitated the process. Each participant was given a turn to speak with discussion encouraged to facilitate the dynamics of the interaction of the group. The researcher provided a summation, with verification sought from the participants. After the session, the researcher and the assistant debriefed, making note of ideas expressed, noteworthy quotes, unexpected or unanticipated feelings, and need for revision of questions.

At this point, the researcher wishes to make note that because all the participants were female, the corresponding pronouns of the feminine gender are used.

The sessions were started with two open-ended questions:

- a) What do you feel are the core components of a "good" nurse?
- b) What adjectives would you use to describe your worklife?

The first question was intended to encourage the participants to reflect on what the practice of nursing essentially was, as expressed through the practitioner. The second question was designed to develop an understanding of what the present conditions of working casually required of them. Oberle and Davies (1993) describe the disillusionment produced when the caring ideals of nurses clash with the demands of the workplace ethic of justice - equality regardless of relationship. Attridge (1996) relates the stories of powerlessness when nurses are faced with situations where they know what needs to be done, but don't have the resources, autonomy, or support to carry out the actions. Cairns and Craig (1987) examined

the “fit” between the expectations that new baccalaureate nurses brought to the workplace and the harsh reality of the job. These research articles helped to shape the questions asked.

However the questions were neutral and open-ended, leaving the participant openings to describe the positives as well as the negatives. It must be noted, in all fairness, that people with issues to discuss are more likely driven to participate than those who are completely happy in their situation.

The follow up probes asked for enlargement on the second set of descriptors, how they applied to everyday work, examples of situations the participants experienced to validate such adjectives.

Other major probes included the relationship/effect of personal and family life on work and/or the reverse as it applied. This was influenced by the work of Glynn et al (1996) and Gottlieb et al (1996) on the interrelationship of the domains of a nurse's life and the intent was to explore the similarities and/or differences casual nurses experience.

Another probe related to the effect of the ongoing changes that have been a major influence on the workplaces. At the time of the sessions, the acute care units were experiencing the major thrust of the changes while most of the effects in home nursing care were due to the spillover from the acute care workplace. This probe was intended to invoke descriptions of how the changes affected the participants as casual nurses in addition to obvious workload issues.

A final probe asked the nurses about how they saw the future in nursing, both for themselves personally and the direction nursing would take. This was to seek the degree of involvement they felt in the current picture: did they feel it could or would change; would it be for better or worse; did they feel they had a part to play in the change?

The individual sessions had variations on these probes because the process was structured informally to allow for expression, but still maintaining sufficient direction to gather

the needed information. The data from the earliest session influenced the following ones through seeking affirmation of the generalizability of the descriptions from that first session.

During the analysis phase, it became apparent to the researcher that she had need of more information about night shift experiences in both acute and home nursing care, so follow up telephone interviews were conducted with two of the participants to garner information on this subject. They had previously given written consent as described below and agreed verbally to extend this consent to these conversations with the application of the same conditions.

Ethical considerations

Prior to initiating data collection, the proposal for the research was submitted to the University of Victoria Ethics Review Committee in Research and Other Activities Involving Human Subjects. The proposal received approval from the committee prior to the formal commencement of the project.

Permission was sought from and granted by the research approval committees of the employing agencies with the assurances that the anonymity of the participants would remain intact. Although there was no direct contact with the agencies following the sessions in relation to the participants, they provided the statistics on the numbers of casuals employed that are indicated in the opening paragraphs of this paper.

All participants read and signed a consent form for participation in the study. It considers the issues of voluntary participation as well as withdrawal without jeopardy, how confidentiality and anonymity of data will be maintained, that consent is given for audiotaping and that the tapes will be erased following the study, and that participating in the study will have no bearing on the participants' employment status. A short verbal explanation had been given when the potential participant was first contacted, and questions were answered at the time of the interviews as needed. (See appendix A)

The participants also filled out an unsigned demographic questionnaire as described previously. The questionnaire is kept separately from the consent form to protect the anonymity of the participant.

Data Analysis

The steps involved in the analysis of the data are as follows:

Transcription: as soon as possible after the session, the notes were reviewed and the tapes transcribed.

Transcription read and reviewed: the transcriptions were then reviewed while listening to the tapes and notes from the sessions and comments about the non-verbal activity were consolidated with the transcripts to flesh out the picture of the session. This raw data was then read repeatedly until there was a thorough familiarity with the content. These initial readings were to acquire an overall sense of the experience of being a casual nurse.

Transcription read by committee member: these transcripts were also read and interpreted by a committee member as an additional assurance of validity.

Emergence/extraction of themes: in this initial phase of analysis phrases, themes, and patterns began to emerge and notations of these were kept.

Clustering/consolidating themes into concepts: most of this stage occurred once all the raw data had been acquired

This data analysis started to take place after the first session and concurrently with the collection of further data from the following groups, serving to clarify and sharpen the way the questions were introduced. For example, the issue of collegial respect emerged through group dialogue. As it seemed an important issue, it was deliberately introduced in the following sessions.

Krueger (1994) describes several options for data analysis of focus groups, based on time investment and degree of rigor. The first option is transcript-based analysis, in which the

tapes are transcribed and the analyst uses the transcript, the field notes from the session, and the debriefing discussion of the moderator team. Although this is the most time-intensive of the options, it is the most rigorous and thus was ultimately the one chosen, modified by eliminating the debriefing session in one of the smaller groups as there was no assistant. Other options included making an abridged transcript, note-based analysis and memory-based analysis.

Krueger recommended that researchers listen carefully to the tapes as well as reading and rereading the transcripts during the early analysis stage. The transcripts have limitations that do not reveal the atmosphere, the silences as well as the tones and emphases, or the pace of speech. Other areas to note that appear in the transcripts are consistency, frequency, and specificity. Intensity of interest is noteworthy when participants who are normally quiet are drawn in and interruptions occur, reinforcing or arguing with the speaker. Although Krueger's recommendations are directed at focus group analysis, the techniques are echoed in the descriptions of group interview analysis (Taylor, 1984; Sandelowski, 1994a).

The next step was to cluster the themes into typologies or classification themes, and from these form concepts (Taylor, 1984). Taylor describes concepts as abstract ideas generated from empirical facts; sensitizing instruments used to illuminate social processes or phenomena that are not readily apparent through specific incident description. The concept is adjusted to fit the data, never the reverse.

Morse (1996) defines concepts as "complex cognitive representations of perceptible realities formed by direct or indirect experiences". However, she also goes on to say:

"...the role that a concept plays in a research process depends on the selection and use of the concept by the researcher. For example, it may be treated as a concept, construct, model or theory...may be used as an attribute of another

concept or be a label for a category for a set of data." (p. 368)

It is this last definition, concept as a category label for a set of data, that describes the use of concept in this study.

As the process of developing concepts proceeded, the data continued to be studied, themes and concepts sharpened and refined, clustered and collapsed together or eventually discarded in favour of another. At this time as well, published literature relating to the emerging concepts and themes was studied: issues of managing change, stress, job satisfaction, workplace culture, powerlessness, interconnectedness of nurses' work lives and personal lives, development of clinical knowledge and judgement, and knowing the patient. This was to enrich the researcher's knowledge of the issues as well as to provide an illumination of the processes that were happening in the worlds of these casual nurses. Because there were ongoing discussions on the use of casual nurses in staffing, current bulletins from the British Columbia Nurses Union (BCNU) relating to provincial negotiations with management over the issue of casual staffing were also read.

The next step was to code the concepts, themes, notes, and phrases. The concepts were assigned numerical codes with subcodes of letters. As the coding process continued through the data from the three sessions, the themes continued to emerge, encouraging the development of more classifications in some areas, consolidations in others. There were eventually ten coded concepts

All the material containing raw data was then physically divided into these concept classifications; the transcripts, notes, written thoughts and ideas were cut up and separated into the categories above, those pertaining to each of the subcodes together, then these individual bundles placed in labelled envelopes with others of the coded concept category. Ten envelopes now contained the raw data that had been classified and coded. The

remaining data was then screened for possible further categorizing and then set aside. Intact copies were kept of the transcripts for auditing.

The next challenge was to cluster these ten concepts into a workable framework. Some of these concepts overlapped into others, some were background threads that ran through larger issues. What became the working framework was the answer to the question:

"What factors affect the worklife of casual nurses?"

The answers fell into three main categories which were designated the major themes, and lined up under them were the components and qualities that defined them. This became the working framework for the paper to clarify both to the researcher and to the reader the development of the issues presented in the next chapters.

Chapter Four: Results and Discussion

Being a casual nurse means that one is employed in a certain way. However, whatever the work pattern or the place of employment, one's professional ideals and identity remain present. As a means of better understanding the experience of casual nurse worklife, it seemed important to know something about their meanings of being a nurse. Therefore, the sessions started with two open-ended questions:

- a) What do you feel are the components of a "good" nurse?
- b) What adjectives would you use to describe your worklife?

The first question was asked to provide a baseline of the image participants had of the values and abilities that underpin quality nursing practice. The question was posed without reference to a particular work environment, just the core "makings" of a good nurse that could be carried into whatever work situation was presented. Initial responses to the first question, with one exception, were consistent with accepted practice standards in that participants used words and phrases such as: intelligent; skill knowledge, ability to apply knowledge, ability to consolidate observations and action; flexible; assertive; a skilled communicator; caring and words synonymous with caring - compassionate, empathetic, and kind; calm - able to separate self from situation; takes pride in nursing work. One participant used language that was descriptive of what she felt was needed in the workplace today: "speed, efficiency, a kick-ass attitude, brain cells, nerves of steel". This nurse said that the other descriptors were still important but they were eclipsed by the workplace demands: "We don't have time to show caring - it doesn't mean I don't value it".

The second question was intended to initiate the discussion of casual nurse worklife, to gather pictures of current working conditions of casual nurses. This question garnered graphic descriptions of their daily worklife: frustrating, frenzied, frantic, mind-boggling,

overwhelmingly busy, disrupted, disjointed, unsatisfying, and of course, "challenging", which brought laughter from everyone at all three sessions. Even the nurses who said they loved their work and were glad they were not in other workplace sites noted that morale was lower, and the atmosphere not as positive as even a year earlier. Their stories, descriptions and remarks flowed from these initial questions to provide the raw data. Participants became quite engaged in the group process with one nurse's story triggering another participant to share a story or elaborate on statements of the original storyteller.

To create some order in the synthesis of the raw data, the process of analysis took place as described in the previous chapter. The framework that evolved consisted of the "concepts as labels" as defined by Morse (1996). These concepts addressed the research purpose of describing the experience of casual nurse worklife. In other words, as nurses described their worklife experiences, they revealed both what it was like for them and what they felt influenced and defined the experience. As the data were analysed, ten components were identified:

a) Anxiety: Feelings expressed by participants that covered a sense of worry, uncertainty or distress. These anxious feelings came through in data as participants talked about finances, not understanding a workplace constantly in change, and worry over the effect of shiftwork on family relations.

b) Power dynamics in the workplace: Included descriptions of lack of control over aspects of worklife from workload to choice of work time. There was a sense of being controlled by the decisions and actions of others with little opportunity to partake in the process. Incidents of feeling in control and opportunities to contribute to the workplace were also described.

c) Lack of continuity: Lack of continuity means interruption in an ongoing process. This was a major negative factor in client care. It also addressed the decreasing opportunity

for nurses to acquire the depth of experiential knowledge that grows with repeat exposure to situations. Lack of continuity occasionally had a positive aspect in that the variety presented by changing workplaces and clients was interesting or satisfying to some.

d) Respect: As described by the nurses, respect refers to esteem, the acknowledgement of worth, recognition of one's ability to contribute usefully towards meeting the goals of the group or the individual. Self-respect is included here - acknowledgement for the contributions they made, the sense of accomplishment when they had learned new skills.

e) Effect on/of family and personal life: The interface of the domains of a nurse's life, how working casual was helpful in some instances, a major complication in others.

f) Common nursing concerns - compounded: Areas of practice or demands of worklife encountered by most nurses. The complexities of today's workplace other nurses faced, but with added imposition of not knowing essential details regular nurses take for granted.

g) Workplace culture: This involved the shared history of a workplace that affects "how things are done". Included are morale and atmosphere and the way casuals adapt to different environments.

h) Survival techniques: Included the skills necessary to adapt to the various workplaces and the changes that occurred within those workplaces. Casuals needed to balance worklife and homelife and deal with the conflicts that arise between these domains. This concept label encompassed the skills acquired and traits developed.

i) Developing comfort: As casuals gained experience in their various roles, they developed comfort in knowing their abilities and limitations, learned how to say "no", and acquired a sense of "home" in the more familiar workplaces.

j) Beyond the job description: Casual nurses, like their regular colleagues, worked to be the best they could be, but were sometimes driven to seek perfection to compensate for the lack of continuity in their work. They described the anxiety felt when there was insufficient

time to do the perfectly complete admission or the detailed care plan and worried that their full-time colleagues would consider their work inadequate.

These ten concepts provided the labelling for the envelopes containing the cut up pieces of raw data derived from analysis of the interview transcripts. As they were examined, the concepts were compared for commonalities and clustered or separated as themes emerged. Some were consolidated with others and the whole given another name. Through further analysis, the concept of "anxiety" was seen as filtering like background music through other concepts and so instead of being given individual status was incorporated into them.

Eventually, what started as ten components resulted in three main themes. These represent the domains that were most uniquely evident as participants talked about their experiences of being a casual nurse: the nature and climate of the workplace; relationships with colleagues; and their personal and family lives.

These domains in turn are separated into component themes that have been described by the nurses. The components were not necessarily divided neatly into these themes – "anxiety", as described above, pervaded throughout. "Common nursing concerns - compounded", and "beyond the job description" also overlapped boundaries. "Developing comfort" became "survival skills and personality traits". Thus, the labels of the components and qualities that define the major themes vary from the original ten concepts. This is the framework that evolved:

A. Workplace

1. change
2. lack of continuity
3. workplace culture

B. Relationships - Colleagues and Others

1. power

2. respect

3. communication

C. Personal and Family Life

1. dependants and family relationships needs

2. social life

3. personal and career plans

4. survival skills and personality traits

Workplace

Workplace in this study included nursing units in acute care hospitals, offices in home nursing care and in both areas the actual places where nursing care was accomplished, the bedsides and/or homes of the clients.

Woven throughout the descriptions of work was the frustration of trying to cope with *changes* that were viewed as the result of decisions made by administration with no input from the frontline nurse. From the casual nurses' viewpoint, these changes were evident in everyday nursing worklife and were frequent sources of anxiety. Infrastructure changes spread unit managers over more than one hospital site. Physical environments shifted significantly as beds were closed and "mapped" and care units "downsized". Fiscal cutbacks resulted in the decreased availability of resources and personnel. As a result, nursing care involved increased acuity of patients with insufficient resources to provide appropriate care.

Another major component that influenced how casuals viewed their workplace was the *lack of continuity*. This was expressed in five ways: patients potentially saw different nurses every day; the nurses did not "know" the clients; nurses did not have opportunities to gain experiential learning; nurses could not follow-up which was viewed as necessary in learning about specific patient population's care and teaching; and the nurses expressed concern for client safety when their familiarity with clients was an integral part of providing nursing care. These were described with varying degrees of anxiety.

Workplace culture is the third component described and it is expressed through its effect on the casual nurses' status and how it affects the receptivity to casual nurses' ideas and suggestions.

Change. When the interviews were conducted, the hospitals were undergoing major changes with more to come. Acute care participants working in this context used adjectives to describe their work such as "unsatisfactory" "mind-boggling" and "overwhelming".

Experienced hospital nurses felt that the acuity level and general pace had increased considerably. Follow-up conversations several months later indicated that the anxiety level had increased even further with many staff members falling ill and the casuals being heavily relied on to fill the gaps (personal communication, March 1997).

In acute care, the changes had been experienced in several ways. Patients admitted for surgery were staying only for the period of time it took to recover sufficiently to enable self-care or family provision of care at home. This enabled more rapid turnover of clients who, while they were hospitalised patients, required more intensive care than previously. Thus nursing staff were working harder with greater numbers of more seriously ill patients.

The physical organisation was also changing through restructuring of the hospital sites. This resulted in units being in transition, experienced as bed and unit closures, consolidation with other units, and nurses caring for clients with unfamiliar conditions. At the time of the interviews, the restructuring was underway, but on the units where these nurses worked, the impact was yet to be as fully experienced as described in the follow-up conversations several months later. These conversations revealed that three of the participants were no longer casuals in this area; two had left the agency altogether, and one was on a work-related disability leave. The informant blamed this on the prolonged period of increased workload.

Another form of workplace change that influenced the worklife of casuals lies in the multitude of paperwork. The forms, charts, referrals, requisitions, and care plans were frequently undergoing revision and modification. Several hours of the workday were spent recording events, requesting tests, and processing orders, and for a casual nurse it seemed that the paperflow needed for this work was constantly undergoing change. Casual nurses who may have appeared irregularly on the scene had to make adjustments in their workday to learn about all the changes that are described above.

The changes in acute care impacted home nursing care as well. As clients were discharged earlier from hospital, many had their care continued at home by themselves, by family caregivers, and by home care nurses. Thus, many of the procedures that once were done only within hospital walls were found in the community - I.V.-administered antibiotics, peritoneal dialysis, and major wound care, to name but a few. Home care nurses not only carried on the work started by their acute care colleagues, but continued the teaching and monitoring of family caregivers to provide such care.

At the time of the interviews, infrastructure change in community care was barely at the preliminary idea stage; at the time of writing, the planning is well underway. However, there had been introduced changes in both the kind of clients seen and the services provided. Mentally challenged clients who were former residents of institutional care facilities and now living in the community added a new focus of care provision to the home care nurse's caseload. Night shifts with casual nurses filling the on-call night nurse positions meant that for certain clients there were home care nurses available 24 hours a day.

Keeping up with the changes is a difficult task for full-time workers and can be overwhelming for casual nurses who may only be in the area once a week or less. This constant barrage of change was raising stress levels to an alarming degree. A casual nurse who returned to work after a maternity leave remarked on the difference:

"...it seems that people were a lot happier before, more cheerful and talkative and now...there's so much change...the whole mood...is dragging morale down because there's too much for it [change] to work for everybody in such a short time."

Because they may not be regularly on the workplace scene, casual nurses did not feel they had been given the opportunity to contribute their input to the changes. Literature reviewed on the subject of managing change emphasized participation of those workers who

were going to be most affected by the change. Nakuta and Saylor's 1994 research promoted the management style of "participative group" as that preferred by nurses in a California study of a hospital undergoing major changes. They cited both staff awareness of their own value in the agency and awareness of the change process as an influence on retention. Nurses whose contribution was sought and expected felt valued, trusted and more likely to remain in the workplace.

Although community involvement through public forums and debate was sought in the systemic health care changes, there was little or no input from the bedside and community nurses into how to make the changes work. Armstrong-Stassen et al (1996) using the "met expectations" theory of job satisfaction, indicated that when changes such as downsizing occur, if there has not been appropriate communication between management and staff, the staff feel that the psychological contract of the job expectation has been broken by the employer. This leads to disillusionment and the view that the employer is uncaring and unfair.

The comments of the nurses reflected the conclusions of these studies. They resented the changes that were made without any consultation with the workers who were most affected, and certainly did not feel valued by the administration who made these decisions.

Lack of Continuity. As described previously, lack of continuity means interruption in an ongoing process. In caregiving, lack of continuity occurs when nursing care is provided by frequently changing caregivers. The effect of this is felt by both the recipient and the caregiver. Clients may experience meeting a different nurse almost every day. Both acute care and home clients complain of having to repeat explanations of cause, treatment, reactions and so on to still another nurse. Although no data was collected directly from clients, it seems that this constant change could be annoying at least and could increase

stress through the need to be hypervigilant. Of greater concern were clients not having the opportunity to develop a therapeutic relationship with the care provider, a situation which can jeopardize optimum recovery in such divergent areas as psychiatry and post-cardiac teaching.

Casual nurses felt the effect of discontinuity as well. Acute care nurses described this "...like you're starting from scratch every time"... "it's always our first day". That first day is the one when the nurse starts to know the patients in her care, more than just their conditions, their medications and other therapies. To provide competent care, she needed to know what their normal baseline was, how they reacted or did not react to medications, situations and treatments. This "knowing" came with familiarity, and the casual nurse only got the opportunity to develop this if she was fortunate enough to be assigned to the same patients over several consecutive shifts. It was not unusual for an acute care casual nurse to spend a twelve-hour day shift caring for one group of patients, only to be switched to another group when she next returned to work...

"...if I came back for another day tomorrow, I'd know them all too, right? But I might come back in two days and be in a completely separate room and not know a soul"

Workplace discontinuity was felt in another form as well. One nurse expressed how difficult it was for her to get a picture of an individual patient's total post-surgical progress.

"I'll get one [post-op patient] day one and then not have somebody with that particular surgery for another three weeks...the next one I get might be day five. And it just doesn't come together"

"...It would be neat to be there on the day they have their surgery and do the whole thing, the whole recovery."

This lack of continuity meant that it took longer to develop the kind of knowledge that can only come from experience, such as patients' usual path of recovery. Thus, casual nurses remained in a longer period of being advanced beginners in practice and talked about the need for continuing to check out their perceptions with other nurses.

Lack of continuity means being unable to personally follow up on teaching, a major component of nursing care in both acute and home nursing.

"...You very rarely get a chance as a casual to follow through on that and that's probably one of the most exasperating things I've found. On the other side of it, it is one of the most fulfilling things to follow through by working a longer period of time, getting some sense of continuity."

To compensate, casual nurses rely heavily on communication with those who will be following them, and expect the same from those who came before. This can mean written care plans, notes and reports, but may also include telephone calls in their off-hours to discuss problems and solutions with their colleagues...

"...maybe call one of the other nurses who's going the next day just to let them know what I think about this and that...we actually do a fair bit in our group, just because we're all very conscientious."

Good communication is essential in other aspects of casual nursing and is discussed more fully in the section on relationships with colleagues and others.

A serious concern of discontinuity was the issue of safety. When patients were mobile and dressed, as on a psychiatric unit, a nurse assigned to care for them needed to know their faces as well as their conditions, medications, and schedules of therapy. There might have been five new faces to know on that first day, and "if you've got somebody on q [every] 15 minute checks and you don't know what their face looks like, it's quite worrisome."

This concern led one participant to describe her role as a casual nurse in the following way:

"[I] keep a lid on things, hand out medications, try to prevent people from hurting themselves or others." This was a marked contrast to "therapeutic use of self" which formed the basis for much of the care of a psychiatric patient and the nurse was not able to provide the level of care she knew was optimum.

Lack of continuity manifested itself in a different way for the home nursing participants. The nurse may have been assigned to fill in for an absent district nurse or to "float" in order to cover the spillover from a workload that was larger than the regularly designated nurses could manage. Floating might have involved travelling to two or three districts to cover those work overloads and seeing any one client only one time. This meant constantly finding her way in new geographical territory as well as working with unfamiliar clients.

Lack of continuity could adversely affect provision of care when a new client was being admitted. Longer counts of work time were assigned for this admission process and official policy stated that the procedure did not need to be completed in one visit. Despite the official policy, some casual nurses felt an obligation to get this accomplished rather than leaving any leftover tasks for the regular nurse to finish up. Thus, they found themselves assessing clients' condition and needs, developing care plans, making referrals and confirming orders

"based on an hour with the person who's fatigued...just home from the hospital ...in a lot of stress themselves and you're basing so much of what you're telling other people about them on a really short, fleeting impression".

Because an admission took 1½ to 2 hours, the task was frequently assigned to a casual nurse who was floating, enabling the regular district nurse to continue to provide care to two or three of her established clients in that time frame. The new patient was usually blended into the regular nurse's workload on the next scheduled visit day to continue the treatment

initiated by the casual float. However, as the number and acuity of clients discharged from hospital to home care continued to rise, the districts got heavier, and more of these clients were assigned to floats, so it could be several weeks before the regular nurse got to visit. Indeed, this situation has led to the formation of new districts in almost all of the home nursing care offices in the Capital Health Region, as adjoining pieces of overloaded districts were split off to form new districts. Despite this, at the time of writing, casual nurses were still needed as floats to cover overloads on a daily basis. The above information was not obtained through the data acquired during the group sessions but from the researcher's knowledge based on her current experience working in home nursing care and included to clarify the picture of working conditions in this locale.

In the review of literature, continuity was not identified as an important aspect of patient care. The reader might speculate that this aspect of care may not be considered essential, and that with adequate communication, a "generic nurse" should be able to fulfil the care needs. As the quotes indicate, the casual nurses interviewed did not appear to share this view. Perhaps, the essential nature of continuity only becomes noticeable when we see the effects of its absence.

The effect on the professional development of the casual nurse was also questioned. How did casual nurses, whose work experience was as broken up as those described, get a chance to reach the "expert" level? Benner's studies were based in nurses' experiential learning, the "knowing how" rather than the "knowing that" of learning in practice. Some casual nurses did practice almost exclusively in a "home" unit, and after years of experience became a resource to newcomers for their knowledge of the routines, equipment and environment. Perhaps, in this aspect they have become expert. The issue of professional development will be more fully explored in a later section.

Workplace Culture. Workplace culture was the element of an environment that was a combination of atmosphere and attitude among the workers that influenced "how things are done". The shared history of the workplace had a major effect on the prevailing culture. When questioned, casual nurses described workplaces where they felt at home, where the familiarity of "knowing how it is" meant less of an adjustment to get on with their working day. Workplace culture to these nurses was evident in the morale or atmosphere of the workplace, how the nurses routinely worked together and where the casuals fit into this routine, and "the way of doing things". This was not decreed by official policy, but rather how the action took place to accomplish what needed to be done. For example, when there was an issue to be resolved, in some workplaces one person took on the task, in others, several people volunteered to form a committee to deal with it and a third method chosen could involve the whole staff working to arrive at a consensus.

Casual nurses often moved between units and several of the participants worked in both acute care and home nursing care. Two others had a specialty background which took them to various areas within the acute care setting. All were aware of the differences in culture between workplaces, and described how this was reflected often in their reception.

"...you have to learn who does what, even little things..."

"...for me there's basically four different areas where there's four different philosophies of staff and I found that I'm always sort of pulling my punches ...I'm not usually outspoken...I just feel almost like I don't have the right to do it..."

"...there's a lot of things that you have to watch what you say to people because they're pretty stressed out."

They found it was necessary to be sensitive to the atmosphere and the conditions of the workplace. For one nurse, this awareness was a necessity to facilitate her work which

involved teaching and consultation. She knew that for her teaching to be effective, her audience had to be ready to listen, not distracted by the urgency of other tasks. For another nurse, sensitivity to the atmosphere was needed for working as a part of a therapeutic team in psychiatry.

In the literature, the culture of the workplace was seen to be significant in the acceptance of new policies and in selecting and orientating new staff. Coelling and Wilcox (1988). described some of the differences between the philosophies of two workplaces. Neither was described as more desirable than the other, but presented a distinct contrast in how things were done on a day-to-day basis. One area was more laid-back, discouraged competition, shared workloads, did not actively seek educational opportunities, and preferred the status quo. The other area was actively competitive, based hierarchy on skills and knowledge, worked independently, and sought change. The differences were not a matter of policy, but would have a major influence on the comfort level of a newcomer trying to fit into the units.

For the newly-hired casual nurse, the home unit (identified as the "cost centre" on acute care) was where they were orientated to "how things are done". Work unit culture was displayed in a common attitude towards the degree of priority awarded certain factors or concepts (Seago, 1996; Van Ess Coeling & Wilcox, 1988). For example, in some workplaces, initiative was expected from casuals

"...You learn...who's district you are encouraged to go in and use our own initiative and usually 'do what you think best, give me some suggestions' and there are other nurses that very clearly set the boundaries ' this is my district, this is the way I run it and you will kindly stay within these parameters".

On other units, the emphasis was on survival: just coping with the daily workload, getting through the shift as safely as possible, hoping to get the relief breaks that were due, but not being surprised if it did not happen:

"... there's a backup in your mind that Mr. B wants Maalox but meanwhile Mr. C. has got pain medication too but oh my God that thing's beeping down the hall...you feel real busy."

Even in the areas that were normally comfortable, change influenced the work atmosphere,

"...at work there's this undercurrent of rumours of this and that and all these things create a lack of trust and an uneasy work environment"...

For the casual nurse on acute care it could seem to be "always the first day" unless some care and thought was given to their assignment by the team leader, and if the culture of the unit reflected this caring, the work anxiety was considerably lessened. If a veteran casual was working on her home unit, her expertise was usually recognized by her colleagues. If it was another unit the culture of that workplace helped determine if she was treated like "just another warm body" to fill the gap or welcomed for her contribution.

"It depends on where you are...here, my knowledge base is not as high, because I'm learning...but I work at another place in acute care where I have been on that floor for about seven or eight years so I have a big knowledge base compared to a lot of others"

"...Probably the best wards...are where they know why we're there and we really fulfil a need and they really are aware of what we do"

A positive example of office culture was informal networking, creating and utilizing the opportunity for exchange of information. In home nursing care, informal networking was accomplished in different ways and to different degrees. In one office, the nurses made a point of meeting at coffee break so they could "check in" with each other and talk about

everything from their workload to their family problems. At this time, workloads were sometimes adjusted and rebalanced if someone had run into an unexpected problem, or a cancellation had opened up a space. This kind of networking happened in other offices in smaller groups at different times of the day. It was a particularly positive example of workplace culture when much of the work was done in solitude. (Researcher's personal experience)

Another nurse described what she saw as an unsuccessful attempt to combine socializing and work - the workplace potluck party:

"Pot lucks at work suck. It's a nightmare. Everybody brings lovely things and you don't have time to enjoy it. People are racing in and out, cramming things into their mouths, and I'm going, is this fun?"

This nurse was describing a workplace that was experiencing a particularly stressful series of bed closures, moves and re-assignments with more anticipated in the next few months. The nurses who worked there felt exhausted, frustrated and unsupported, and this nurse was not prepared to participate in what she felt was an attempt at socializing which backfired. The culture of this workplace did not support the attempt, and it was felt therefore to be inappropriate, an added burden instead of added cheer.

Relationships - Colleagues and Others

Relationships were those connections between casual nurses and those who have influence in their worklives. These people included staff schedulers, various levels of management, their union, physicians, other nurses, and their clients.

Relationships with colleagues and other personnel had a major influence on the worklife of casual nurses. They described encounters with shift schedulers, other nurses, physicians, managers, and union reps and the effects these encounters had on their lives. Relationships could be based on isolated encounters with individuals or ongoing dialogue with

a collective group. Thus, relationship, as used here, connotated a type of connectedness between a casual nurse and at least the professional "roles" of others, if not the actual people themselves. The individuals were remembered as representative of their groups, and encounters with them were recalled when casuals were asked about relationships.

Three aspects of relationships stood out as casual nurses discussed professional encounters with others. One component of described worklife relationship was *power*. Casual nurses frequently saw themselves as having very little power in their relationships with other colleagues such as shift schedulers, management at various levels, full-time nurses, and their own union. A second aspect of worklife relationship was *respect*. This was described by the casuals in their contacts with other nurses - full-time, part-time, and other casuals, as well as physicians and the other personnel named above. A third aspect of their described worklife relationships was *communication* and was expressed in their encounters with the same colleagues.

In the literature review, all of these aspects of relationships were discussed in terms of the need for support and recognition from colleagues and management. Attridge(1996) recommended policy changes in agencies that would encourage collegiality and increase the visibility of respect and value of the nurse. Hartrick and Hills' 1994 study recognized relationships with other health care team members as a stressor and the participants' support needs included listening and understanding, consultation/problem solving, and positive recognition/ acknowledgement. O'Brien and Page (1994) found among the contributors to job satisfaction included degree of cooperation among other nurses as well as improved relationships with administration.

Power. A sense of powerlessness came through in the stories participants told regarding their relationships with shift schedulers, management, union, and their regularly-employed colleagues. Powerlessness was manifested in a feeling of lack of control over

factors that influenced their worklives, These people and the roles and functions they represented were perceived to have varying degrees of control over central and basic components of casual worklife and thus were viewed as more powerful than casual nurses on a more global, "big picture" sense.

In both acute care and home nursing care, the shift scheduler was described as powerful in relation to the amount of work a casual was offered. The shift scheduler's role was to fill the gaps in work schedules with casual nurses. These gaps often were generated because of temporary staff shortages due to vacation, sick time, education or other leave. They filled position vacancies in order to cover projected work overloads and emergencies, if possible. Although this seemed relatively straightforward, the process was fraught with complexities involving union contracts, labour laws, current budget status, varying shift lengths, and the fact that many casual nurses had multiple workplaces in order to ensure adequate income. (Personal communication, shift scheduler, January 1997).

From the perspective of casual nurses, the scheduler represented the direct link to work, and the indirect influence over the size of the paycheck and the personal plans for the next few days to the next few months if vacation booking is involved. Although casual nurses recognized that they could say "no" to shifts offered, it was only with experience that they could do so comfortably.

"...you start taking everything that comes along and you find yourself working nights and evenings and days. You never sleep. You're always tired. You're always stumbling around..."

Many nurses in the study were self-supporters, some were single parents or had other dependants, still others were contributing necessary funds to a two income family. The cultural image of a casual nurse who worked to provide the additional niceties was a holdout from more affluent times. Some nurses did have the cushion of a spousal income, and theirs

was a cache for children's education, or paying down the mortgage. For nurses who did not have that cushion, in their anxiety to ensure enough shifts had been worked to meet their financial obligations, they "stockpiled" - took as many shifts as came along. Eventually, participants recognized this "stockpiling" was neither necessary nor advisable, and the nurse learned to choose the shifts she could manage safely - learned to say "no" to the shift scheduler.

Another two groups that casual nurses considered as having power over their worklives were management and the union. In their relationship with representatives of these groups, there was no ambiguity in how they saw their position:

"...I don't think our voice is heard in the Union at all.."

"And I definitely don't think it's heard at the hospital"

"I guess we haven't got a voice yet"

Mentioned earlier was the implementation of the night shift service offered from home nursing care. Casual nurses felt that their voice was never heard in developing the plan and that the union at best was caught off guard and at worst did not have the interests of casual nurses as high priority. In this and other changes that affected their worklives, casual nurses felt that if there was any attempt to consult with them it was merely tokenism and the changes were already well underway.

Casuals also considered their full-time colleagues to have a certain amount of power over their worklife - at least in relation to their workload. Full time nurses rotated as team leaders as well as working in their own districts/areas and in both roles assigned workload to casual nurses. In home nursing care, team leaders made general assignments but the district nurses had the role of distributing the specific clients.

"I find most of the regular staff tries to give you good patients and then a few other people just dump whatever they want on you...sometimes you'll be in a

minus or something [workload assignment is over capacity]...you're on for one day in a district and it's really difficult to deal with."

In acute care, some nurses making assignments expected that casuals "...[are] willing and able to take on four, six, eight new patients without a problem..." It was not lost on this nurse that such assignments did not fall to regularly scheduled nurses who expected to have the same areas on the consecutive days they worked. This was seen as an abuse of the power that nurses making assignments had over casuals.

There are other colleagues that casual nurses worked with who had more power than they did, but the relationship issues were seen as those of respect, rather than ones exemplifying power. These colleagues, physicians, will be discussed in the next section.

In the nursing literature, the subject of power and powerlessness was not uncommon, particularly in studies of worklife quality. Cairns and Craig (1987) determined that one of the disillusioning factors expressed by university-educated nurses was their lack of autonomy. O'Brien and Page (1994) were told that more flexibility and control over work schedules would increase staff morale. Attridge and Callahan studied the aspect of powerlessness in women working in nursing and child welfare, from which Attridge's 1996 article on staff nurses was drawn. In these incidents, nurses were in situations where they felt they lacked the necessary power to accomplish what needed to be done to help their patients. In the present study, the casual nurses felt powerless in managing aspects of their own worklives in addition to meeting the needs of their clients/patients.

Respect. Respect, as described by the nurses, refers to esteem, the acknowledgement of worth, recognition of one's ability to contribute usefully towards meeting the goals of the group or the individual. Instances of respectful relationships, although evident in the stories, were not experienced as often as (some) participants would have liked.

Casual nurses working in acute care described ambivalent relationships with full-time colleagues. Although some experienced respect for their contribution of knowledge and background, others described feeling like "just another warm body" to fill the space, do the work, and go home. This was a source of irritation, since in many cases the casual nurse's body of knowledge was just as appropriate as that of the regular nurse. One casual who felt that the superior attitude of a regular nurse was based on longevity rather than a knowledge base expressed her feelings with the comment "She's been there ten years; so what? The patients haven't been." Her point was that useful knowledge did not just come from knowing the unit where work was accomplished, but from a variety of sources including experience elsewhere that casuals and nurses new to the unit could bring with them. Individual patients' needs can be served by knowledge that is enriched by the contributions of many such experiences.

Participants also discussed full-time colleagues who appreciated them for being more than "warm bodies". Newly-hired full-time nurses sought out information from veteran casuals, regulars taught new casuals the skills needed to survive a busy surgical unit.

There was an ambivalent relationship with physicians. "...some of them are really good, but..." One casual indignantly described the treatment received from a surgeon, who, rather than referring to her about his patients in her care, sought out a full-time nurse. The casual had worked for several years on this unit, and when she asked nurses on other units about his usual relationship with nurses was informed that he "never speaks to casuals". Another incident directly related to client care involved a physician who disregarded a casual nurse's input which resulted in the patient having to spend a prolonged stay in a cardiac intensive care unit. The knowledge and observations that the nurse offered were discounted and she strongly felt that this was due to her position as a casual. As she had experience to draw on, was familiar with the unit, and had no previous history of negative encounters with

the physician, she was left with this factor as the only reason to account for such disregard. Physicians' discounting of nurses' contributions was not new, but in this case it was particularly frustrating when the physician had a record for hearing the nurses who work full time.

When juggling other components of their lives around sporadic workdays, casual nurses working in acute care expressed great exasperation over middle management decisions they believed had contributed to the scheduling chaos. Participants felt that if their input had been sought, they would have been able to arrive at schedules that would have been more equitable and less disruptive to the lives of the nurses. They put in a great deal of overtime yet had to deal with arbitrary decisions from management over whether they would be paid for such:

“You worked overtime? You have to submit your overtime slip and I'll review it and decide if I'll pay you”.

They particularly resented the lack of two-way communication from managers they perceived as distant and uninvolved and felt they not only had no idea of what conditions were like, but didn't want to know.

“I want to be treated like an adult and appreciated rather than [have] somebody who isn't even at this site -- who's at another building across town, tell me 'you will do this because I have sent out memos”

Although the actual physical presence of middle management in the workplace may have been sporadic, manager influence was felt through their determination of workloads, break times and decision making on whether the overtime worked will get overtime pay. Research and administration journals contain abundant articles on effective management styles to promote dealing with change (Nakata & Saylor, 1994; Nagaike, 1997; Hartrick & Hills, 1994;

Hiscott, 1993). The participants who spoke were not describing such effective management techniques..

Casual nurses felt they were invisible and inaudible to those who made the changes in most agencies. They felt the same about the union that represented them at the bargaining table and in grievance issues. Recently groups of casual nurses began meeting to air their issues in home nursing care and this was triggered by the manner in which night shift work was thrust upon them and the fact that they felt the union was not hearing what they were saying (personal communication, May, 1997). A current issue is the calling of casuals for work by seniority, which will favour those with long time experience in one area, but not those who are spreading their labour over several workplaces. At this writing, the definition of "blocks of work" was at issue throughout the province, interpretations varying between agencies. The "block" refers to a period of work made available as a result of a nurse taking a leave, for example, a vacation break. Because many of these agencies were recently amalgamated, contracts are under review and the B.C. Nurses Union is negotiating with HEABC (Health Employers Association of British Columbia) on a wide range of issues. However, one casual said, after she read the latest bulletin from the union, "I feel disenfranchised - there was nothing, again, about us". Casual nurses, despite their large numbers, were not of high priority at this time. It was difficult to consider yourself respected when there was no sign that your issues are of importance.

In the literature review, the concept of respect was described with different phrases, including positive recognition and value of input. O'Brien and Page (1994) indicated that lack of respect from administration increased the stress level and contributed to nursing shortage. Attridge (1996) recommended agency policy changes that would attend to increasing visible respect and value for the nurse. Hartick and Hills (1994) included in the list of stressors described by nurses in acute care settings: issues of relationships with other care team

members, environmental/ organizational stress related to lack of understandings by physicians, lack of positive recognition, and lack of input. Many of these conclusions are reflected in the current study.

Communication. Alluded to previously, fine-tuned communication skills were a necessity for a casual nurse to function optimally. This not only included the written communication of charting, care plans, and referrals, but the ability to listen to what was being said, and what was not. It meant being sensitive to the non-verbal communications of body language and atmosphere. These skills were necessary across the spectrum of nursing practice. Nurses whose work included teaching and consultation needed to know if the timing was appropriate for learning or if there were too many other tasks demanding nursing staff attention. Nurses in psychiatry needed to build working relationships based on trust and communicating with each other to function effectively as a therapeutic team "...you have to be trusting of people you're working with...it takes a long time for people to work together really well." The same could be said of all care teams. Casual nurses needed to fit into such teams with the minimum of disruption to the team functioning. They relied on communication to ease the transition.

In home nursing care, communication was important not only between individual nurses, but between shifts. The evening coverage was handled by a few nurses from three different offices to cover the nursing care of clients from six offices. This meant that nurses on evening shift needed to know their own geographic and client territory and that of any of the three territories added on for the evening shift. Casual nurses usually worked evenings as relief or extra to cover a heavy workload. As clients were often seen on evenings because their treatments were required at least twice daily, good communication between shifts and offices was essential to chart progress, confer about treatment changes, and address continuity of care.

Home nursing care on evenings had some hazards, and the solitude was one of them. In one office, the nurse worked alone. Her communication link was via cellular phone to the central intake clerk when she was out of her own office. The other offices had two or three nurses who again left to work on their own. In the winter, this meant navigating often unfamiliar areas in the dark, and depending on communication from others for the reliability of directions. There were certain areas of the city that evening nurses did not visit and certain clients they did not see because working alone there was not safe. Regular evening nurses were aware of the potential hazards, and the casual nurse relied on this knowledge being passed on. Communication was vital on this shift, not only for continuity of care, but for the safety of the nurses working. This information came from the researcher's personal knowledge as well as personal communication in follow up conversations with nurses in the study.

Casual home care nurses described the "grapevine", an informal network of communication which informed them about the particular likes and dislikes of some district nurses, who was most open to suggestions for trying a change in treatment, and who was fussy about their vehicles, their charts and their routines. These essential pieces of information were not covered by policies, often not communicated directly by the full-time nurse and were another aspect of workplace culture that was picked up almost intuitively and "casually" passed along.

Another way nurses communicated frequently was by using a diagnosis, a condition, or a treatment to designate a client rather than a name. This was an efficient way of communicating a great deal, a code to the initiated that could maintain confidentiality when information is exchanged where others can hear.

For example, "a palliative" didn't reveal the client's name, but between home care nurses, this meant the client was at some stage of dying. If the designation was

accompanied by a "30% PPR" (palliative performance rating) the nurse knew that considerable amount of care was required, the client was likely bedbound, oral intake was reduced, mental status might or might not have been clear, other symptoms might have required controlling and so forth. This was also a cue to check on how family members are coping, if referral was needed for either home support help or the Palliative Response Team (PRT) from Hospice, and many other aspects of care triggered by only a short phrase. This was a shorthand language that serves the purpose of communicating general principles or requirements of nursing care.

Comparable cues peppered reports and conversations between nurses in acute care. "A 2-day post-op TUPR" told a urology nurse what to expect in the way of normal drainage, potential for bleeding, pain and activity level in the patient recovering from prostate resection surgery. A casual new to the area needed to learn the meanings behind the phrases as well as the norms.

Personal and Family Life

This domain is the large "other" that affected and was influenced by what happened at work. It included spouses and dependants and their needs, the area of education and professional development, and that of personal growth.

When asked directly, some casual nurses said that concerns about their home life did not enter the workplace, but they frequently thought about work when at home. Although some casual nurses said actual thoughts of home did not intrude into the workplace, they acknowledged that what was happening in their personal lives did have its influence on their worklife. Factors that included the changing needs of dependants, their own education, and personal and family health issues could influence their ability or choice to take on shifts when offered.

In their study on the interconnectedness of nurses' lives, Glynn, Arndt, Beal, & Bennett (1996) recognized that changes in women's worklives and their personal lives were not a series of sequential steps (as was the usual pattern with men), but were a fluid movement refocusing between career, school and personal aspects. Priorities were not set in a hierarchical fashion, but as a matter of timing, moving into career changes when there was space in their personal lives to accommodate this, postponing school plans when family needs were deemed more urgent.

This was reflected in the comments of the casual nurses. Although many of them were not casual through choice and would have preferred regular full- or part-time work, they found one of the benefits was the ability to take on the shifts when there was not a conflict with child care and school. This flexibility enabled some who were students to enrol in one or two courses at a time and still support themselves, while for others it supplemented student loans and later became a means of paying them back. The negative impact of casual work on relationships included the difficulty of making plans which may be cancelled by calls to work.

Dependent and Family Relationship Needs. Family relationship needs covered a range of issues such as child care, spending time with family all together, arranging transportation to a child's activities, attending special family and child events, and handling emergencies. A major source of expressed anxiety, these demands of managing work and home have been experienced by many working parents, particularly by working mothers. The difference between being a regularly scheduled nurse and a casual nurse was the unpredictability of work opportunities; as there was no routine work schedule for casual nurses. This unpredictability could upset plans with family if the financial need took precedence over the desire or need to be with family. The financial need in itself was often

due to very basic family requirements, so the choice would be to sacrifice the lower ranked plans.

Child care was less of an issue if the nurse could choose the shifts that coincided with the off-duty hours of a spouse so care could be divided between family adults. Nurses who were single parents, however, needed to arrange outside caregiving for their children. This was certainly made easier with predictable pre-arranged shifts. However, finding child care on short notice (sometimes two or three hours ahead of shift start) was challenging for many and impossible for some. A major consideration for casuals in home nursing care was the on-call night system. Providing adequate child care between 2300 (11p.m.) and 0800 (8 a.m.) was difficult for single parents as well as nurses with partners. For single parents, there were limited resources for night time child care. . Since the whole shift was worth fifteen dollars to the nurse if she was not called, it would have been absurd to pay the much greater cost of child care for the whole shift to avoid waking the children to transport them to care when their mother was called out. For partnered nurses, children were cared for by the other parent at night, but they ran into difficulty during the overlap period between nights and the day shift of the other parent. As children grew older, their needs changed to requiring transport to extra-curricular activities and parental participation and/or contribution in such. This could lead to diminished availability for work, or guilt feelings about not being able to meet such "obligations". The situation was exacerbated when much of the work opportunity for casuals was presented at short notice.

Even when children were past the age of requiring child care, there were still conflicts and anxieties. A single mother who was also a student at the time talked about working nights

"...when my teenagers were home doing I don't know what...but what am I going to do, it was that or be on welfare".

She went on to put into words the feelings that frequently haunt mothers who work:

"...you feel like you're telling your family sometimes that nope, work is more important . And it's not more important than them but that's the message that you feel like you're giving them."

Gottlieb, Kelloway and Martin-Matthews (1996) found that nurses who felt the burden of job-related workload were more inclined to take it home with them, and those who were heavily involved in their children's care found that there was a spillover from the family domain into the work domain. This was reflected in the study of casual nurses.

Family issues did affect work, as the stories of casual nurses described. Asked if there were instances when this occurred, one nurse described having a close relative recently die of a condition similar to that of a client she was seeing and finding it very hard to "be there" fully for the client. Participants identified other ways in which home and work were interrelated such as fatigue at work caused by an interruption of your sleep, marital discord or financial obligations that put pressure on how much work you took on. Most participants felt there was an expectation of themselves that the "home" issues did not interfere with the delivery of care. Even the nurse describing her difficulty with the terminally ill client expected to continue to provide care under those circumstances.

The nurses felt there was self-expectation that "at work you feel you have to be more 'on', so you're willing to grind up that extra ounce of energy" whereas at home you could let your real feelings show. This "on" performance was necessary to get through the day, and indeed, once swept up in the pace of the workplace, focus on the job at hand could take over and the home problem could be displaced until the end of the day.

Social Life. The negotiation and balance between work and social life was an ongoing issue for many employed women. The nurses in this study were no exception. In many cases, they described the conflict as quite easily resolved if they only had to consider their

own interests.. Then, frequently a sense of duty won out, either through guilt at the thought of letting colleagues down who were struggling with a heavy workload, or the opportunity to increase the financial gain of another shift of work - "work means paid bills". However the choice was much less clear-cut if it involved family, even just the chance "to sit down to eat dinner with both my husband and my kids". The need for recreation time with family competed with the need for earning the money to make the recreation possible. For casual nurses, family vacations were booked around the vacations of full-time nurses because a block of vacation relief work meant being able to say "no" to a sporadic series of shifts. Sometimes this arrangement could backfire, however. One nurse described how she had arranged a working Christmas Day and because she would be working, her family would eat dinner at their friends. Because it was a "superstat" (double time and a half pay), she could afford to say "no" to her other jobs for a day or two before and after. At short notice her shift was cancelled by the unit. She spent Christmas alone at home, and also lost the money she would have made from the other shifts she could have taken.

One single nurse indicated that her social life was practically non-existent due to the difficulty in making a commitment to future plans. If a shift came up and the money was needed, then the plans lost out. Over a period of time, she found that the impromptu things she could do were done alone or shared only if by happy accident a friend was off at the same time. "Almost all my friends are nurses. They understand." In other words, nurses, especially casual nurses, knew that the call from work has priority over social arrangements when the financial need was great.

Personal needs and career plans. Personal and career plans were discussed in relation to casual work and included schooling, leisure activities, future goals and casual nurses' concern about how much they were learning and developing professionally. Here, working casually could be a bonus if the opportunities for work were plentiful enough to

choose shifts that accommodated classes without jeopardizing financial commitments. The negative aspects included the diminished chance to advance both in career and in experiential learning without consistent work experience.

Almost all the nurses readily admitted that the problems at work came home with them at least occasionally. Sometimes the presence of work would just make itself felt in low energy or "no energy" as a mother of a young child described. Another nurse expressed dissatisfaction with having to mete out her time and energy for her off-duty pastimes. This resulted in not choosing to read...

"...the Pulitzer-prize winner because it's going to take some work and I resent that because what I really would like to do is be reading that book and go to book club and be talking about it. But I don't have the energy and some days the Times-Colonist [newspaper] is a struggle."

She went on to say...

"I don't like that because I feel I've reached definitely over the halfway part in my life and I need to do certain things for myself and I no longer want to give uptime."

This expression of frustration at not accomplishing what she wished for herself was only partly attributed to working casual with broken stretches of leisure time resulting in limited energy and concentration. The other anxiety was a sense of time running out. This may become an increasingly expressed concern as the women of the baby boomer generation see the majority of their productive years slipping behind them instead of still to come.

Sometimes there was a recognition that the lines between work and home were definitely blurred. To the dismay of one nurse, she discovered that she was committed to the maternal role most of her waking hours. The similarity of nursing and being a mother resonated with others in the group "...you guide them towards self-care...you want them to be

responsible..." The nurse felt vaguely negative about this discovery and decided that this was why she sought outside activities that were definitely not in the nurturing role.

"What happens at school is here (gesturing to her head) and I really like that.

It's totally different from being a male person or a female person or a mothering person or a crabby person. It's how you do on that paper, how you relate."

How did working casual affect career plans? The effect on seniority in relation to call-in was previously described - if a nurse was working in several areas it would take longer to accrue much seniority than if her hours were centered in one workplace. When asked, career plans did not seem to be an issue for many of them. That is, they did not describe frustrations at lost opportunities for advancement. Several felt that casual work was appropriate when their personal life at the moment included the schooling necessary to obtain a degree. One nurse had decided very shortly after starting work in acute care that she needed much more autonomy in her work and so her goal was to become a nurse practitioner. Another had started her own business of providing foot care by referral in addition to casually working in acute care. One nurse remarked that she felt at a crossroads since her child started school, and now that she was actually experiencing the work in longer blocks she was finding something missing, and that maybe there was a related field of work that would be more fulfilling. So it would seem that working casually was giving these nurses an experience "sample" without the full-time commitment.

The position of career plans as described by casual nurses reflected the findings in the 1996 Glynn study. As changes occurred in the casual nurses' personal and work lives, the priority of career plans rose and fell.

One area of concern with casual nursing was the level of expertise that could be acquired through work that had little continuity. When a nurse who had graduated only a year previously expressed her anxiety and astonishment at still not knowing some things, her more

experienced colleagues assured her that this was not unusual. They told her that it took "a lot of time for it to all come together" and that it was easy to lose knowledge gained from the experience of nursing an unusual post-surgical case when it may be a long time before you see another similar case.

"Even if you've done it once, if you asked me about a renal ultrasound today, and I've seen one a year ago, I don't remember."

"...it takes that much longer for the first day or two and then you might not go there for another few weeks so it's like learning the process again."

One of the discoveries of Benner's 1992 study of development of clinical expertise was how accrued experiential learning was necessary to arrive at the level of expert. Certainly, casual nurses who worked in the discontinuous manner described did not have the opportunity to gain experiential knowledge in other than the care required for the routine work.

As the voices above described, it took a longer time for casual nurses to acquire the knowledge of what is considered routine. Benner (1992) described the process of moving from advanced beginner to competent nurse to include applying order and structure to the task world in order to limit the unexpected. But in order to practice at the expert level, a nurse needed to see beyond the standard and routine and apply the learning acquired through experiencing cases of the unexpected. These cases were a necessary piece of the knowledge the expert used to anticipate outcomes, seeing the total complexity of the picture rather than being caught up only in the individual components.

To reach this level required an abundance of experiences in one area of nursing. Casual nurses whose work was not continuous and took place with a wide variety of patient populations and practice settings might not acquire such experience. Fortunately, at most institutions and facilities the standard expected was not expert but competent - "not needing

help, ordering the task world, and planning based upon goals and predictions” (Benner et al, 1992, p.21). Experienced casual nurses reach this level.

Survival skills and personality traits. One of the direct questions asked of the groups was what they felt were the traits they needed to be a successful casual nurse. From the direct answers in the transcripts as well as listening to the audiotape, the researcher developed the following list of traits: perseverance, flexibility, sense of humour, optimism, concern for others, and assertiveness. Nurses also described strategies for survival – enhanced communication, observation, assimilation, and organizational skills. These are traits and skills required by nurses everywhere in today’s workplaces, but casual nurses drew on them for survival and growth as professionals in a worklife that was frequently chaotic and unpredictable.

The casual nurses interviewed described themselves as feeling powerless, less respected than their regularly-working colleagues, frequently worried about getting enough work to meet financial obligations, concerned about the effect on their families, worried about their abilities to meet the standards of the workplace, and angry about not having a voice in the sweeping changes that were impacting hugely on their work. In addition to these negative expressions, many of them were not working casually by choice, but by default; there were no full- or part-time positions available in their areas of choice. Given these demands, one wonders how they continued to work under the conditions described.

Their stories and descriptions included both overt and covert clues to the answer. Because a group interview is interactive, the nurses talked to each other as well as to the interviewer, sharing their experience and the skills and strategies they had found helpful. These included enhanced communication and observation skills, ability to quickly assimilate information, organizational strategies, safety/check systems, and recognizing their own limitations. Although they didn’t specifically name all the personal attributes, these became

self-evident through the stories - perseverance, flexibility, a sense of humour, concern for others, assertiveness and optimism.

Communication skills were fine-tuned in the successful casual nurse. The need to receive information from colleagues, clients, and administration was paramount to surviving in the workplace as well as providing appropriate care. The official communication vehicles of charts, reports, referrals, care plans and the like were particularly important to the "first day" nurse, but there was other equally important information required by a casual nurse.

"...I think there's a lot of intuitive learning that goes on when you're new. You have to learn the skills, you have to learn who does what, even little things like who likes their charts on the desk after the weekend and who doesn't, who wants them filed away... whose district you're encouraged to go out and use your own initiative...and others that very clearly set the boundaries..."

A barrage of questions would not meet with a favourable response in an overloaded workplace, so observation and assimilation of previous experience in similar situations and use of the "grapevine" helped to provide an experience described as "intuitive" by several nurses. This was particularly helpful in whittling down the questions to the essential few. In home nursing care, the questions were particularly important since the actual work is solitary and there were fewer opportunities for enquiries once out of the office, whereas in a hospital unit, the answers could be more immediate. In the researcher's experience, much of the necessary information was obtained through networking with other casuals and could occur at breaks, supplemental to official reports, or in the process of organizing for the day.

The next survival strategy, organizational skill, was developed to an art in the successful casual nurse. There seemed to be an endless combination of factors that shifted in and out of an individual's life that required juggling:

"I'm working four shifts a week and ideally I'd like to work two, and now I have a kid, I would like the predictability of arranging child care, of having regularly scheduled shifts...so I don't have to work as many weekends so that I can have time with both my husband and my kid at the same time."

"...you have to schedule your casual work life around when you can pick up your child from school or the babysitter and hope he doesn't get sick... husband's out of town..."

"...I wanted to be more available for ET [enterostomal therapy] and the wards don't like that...so I went back to University and took my ET course... then I just started work here and I have my private foot care business..."

When work was not regular, but rather might be initiated by a phone call only hours (or less) from the required start time, factors such as childcare needs, personal education, and spousal responsibilities needed to be assessed and priorities readjusted. At times, saying "no" was the only answer that could work. Casual nurses however, developed alternative strategies for childcare and transportation, asked class buddies to take notes and stocked up freezers. They also learned from the experience of other casuals, through networking at work (personal communication, and researcher's personal experience).

As previously discussed, casual nurses were aware of the problems presented by the lack of continuity in their work including the safety issues involved in not knowing the patients, their norms and their environments. To counter this, nurses in this study had adopted their own systems of double-checking, looking up references and resources, making lists as necessary, picking up cues of potential problems.

"...you have to do an awful lot of background..."

"...that's when you're even more careful about what you're doing..."

"...you check things three times..."

“...you can't just give a med to a mannequin so you have to know their condition and everything...”

As experience grew and the workplace became familiar, the need for such additional safety measures lessened, and instead was part of the accumulated knowledge of being a casual.

“...you're also making a mental note about all that stuff. I have to write a lot more of it down [than you] although less than I used to...”

These systems were resurrected, however, when situations changed.

“Always ask questions when you go anyplace different...”

Another important survival skill was in learning to recognize their own limits. This could be a limited personal work experience, as when one beginner described feeling so uncomfortable working on an unfamiliar unit that she decided not to do this again until she'd gained more confidence through experience in a “home base”.

Physical limits must also be recognized. Several nurses described the effects of “stockpiling” shifts of work in their anxiety to make enough money:

“Last week I worked sixty hours”

“You're going to say yes to everything cause you're afraid you may be cut off the next week. The next week there will be no work,”

The price of stockpiling became evident in physical expression of stress...

“You start taking everything that comes along and you find yourself working night and evenings and days. You never sleep. You're always tired. You're always stupid. You're stumbling around.”

“I'll get really tired. I always get a sinus infection by the end of November.”

As the nurses learned to recognize the physical symptoms of overwork, they also recognized how to prevent it...

"...so what do I do at 2:00 in the morning? Say no. I'm sorry I have to take a break."

Casual nurses developed assertiveness. This for many was not a natural part of their personality, but grew out of the necessity to advocate for themselves as well as the clients they served. To say "no" to shift schedulers was one manifestation of this assertiveness, as was saying "no" to those who assigned a workload beyond the abilities of the casual. This could be harder, for it is admitting limitations, and nurses (and women) have a long history of coping to meet the needs of the task at hand.

One of the questions asked of casual nurses was "what traits do you need to perform your daily work?" The answers included knowledgeable, flexible, assertive, skilled communicator, caring and calm - "nerves of steel". These attributes definitely came through clearly in their descriptions of their worklife but also there were others that were apparent, if not named - perseverance, a sense of humour and optimism.

Perseverance was evident when the nurses described continuing to do their work and "ignore the negative stuff". This meant that despite feeling powerless at present to change some things, they continued to "hang in there".

Contributing to the perseverance was the optimism that nursing itself was changing, evolving into a fulfilling career with "tremendous possibilities".

"I think there's a lot of options out there and I think there are going to be more options down the road for nurses...I'm truly hopeful that things in the next ten - fifteen years are really going to shake down because I'm only thirty and I imagine if I've got to do this for another thirty years, I can't"

" I see things that give us much greater freedom to reach and expand what nursing looks like now. For that, it's worthwhile keeping going on."

And the sense of humour? Although again, not a trait named specifically, it was evident in the descriptions of predicaments nurses found themselves in. Transcripts didn't display what audiotape revealed in abundance; the laughter as nurses recognized the commonality of experiences that transcend specific environments. Exasperation over management decisions, reflections on their own progress from novice to competent practitioners, the idiosyncrasies of individuals they work with; laughter and bemusement tempered the frustration without dulling the expression of the stories.

Knowledgeable, flexible, assertive, skilful communicator, caring, calm, persevering, optimistic, and blessed with a sense of humour; these attributes were obviously not unique to casual nurses. However, these traits combined with the skills and strategies acquired through experience have resulted in a workforce that has adapted to the ever-changing challenges of the evolving workplace.

"I think sometimes as a casual... you're fresh...you can go in and look like the knight in shining armour."

Chapter Five: Implications

As indicated in the introduction, the number of nurses who worked as casuals in Victoria is large – in some facilities on weekends, half or more of the staff was casual, and on weekdays the casual coverage would be one-third to one-half or even greater (GVHS Human Resources, 1997; Home Nursing Care shift scheduler, 1997). According to registration figures collected by the RNABC, about one quarter of the provincial working nurse population was employed casually (RNABC, June 1997).

However, this was a shifting population – some participants said they were working casually because it was the only work they could find, and others had chosen casual work because it currently fit with other aspects of their lives. In either case, working casual was viewed by participants as an interim experience. This chapter will discuss the possible implications of the study findings of these “interim” nurses who continue to make up a significant number of the nursing workforce.

Marginalization and its effects

Marginalization occurs when a population segment experiences exclusion from the main body and is thereby bereft of some of the consequent benefits of being a part of that body. In this case, the casual nurses experienced fewer benefits, less power and/or control, fewer learning opportunities, and perceived less respect from their colleagues. The marginalization of such a large, shifting population has some problematic effects on not only the members, but on the nursing profession, the employing organization, and the clients served.

First, the personal effects of marginalization were expressed by the casuals themselves. For some, there was a diminished sense of self-esteem or value as a result of several factors. Study findings such as perceived lack of respect from colleagues, feeling

powerlessness because they had no voice in decision-making, feeling anxious about their ability to meet professional standards of care, and being frustrated at not being heard by the union and organizational management when they expressed their needs contributed to this diminished sense of self-worth. Some described physical symptoms of fatigue due to overwork, sleep deprivation and shift changes. Another aspect of marginalization was the necessity of changing social plans due to a call to work. This can limit the building of a social support structure of friends which can be called upon for assistance in times of stress.

Nurses whose work experience leaves them feeling devalued and fatigued do not feel any particular loyalty to an organization that they perceive treats them as a workforce of voiceless, faceless, interchangeable parts. If another employment opportunity arises that is viewed as a better prospect, there is little reason to stay. The cost to the employer lies not only in the hiring and orientation of new staff, but the loss of what might have been a knowledgeable contributor to the present and future functioning of the organization.

The effect on the profession of nursing is essentially in the area of long term commitment. Because they feel their voices were not heard by the union, casual nurses do not feel supported by their professional bodies. This raises the question about the extent to which they in turn will commit personal energy and time in active participation within these bodies. Further, there is concern about the effect of the casual experience undermining the nurses' professional identity, which could lead to leaving the profession altogether. The consequence of such a movement is discussed in the policy implications section that follows.

A major concern expressed by the nurses was the discontinuity of their practice and its effects on both the clients and the professional development of the nurse herself. The clients who are cared for by a series of casual nurses may not have the opportunity to develop a trusting relationship as well as being subjected to the time-consuming experience of repeated introductions and explanations needed for new care providers. The nurse in turn is

very much aware that there are safety issues that require careful review of unfamiliar procedures, clients and workplaces. As noted in the previous chapter, there is a longer time frame needed to learn and become comfortable with less routine conditions, surgeries, and procedures and their usual progression.

It is the accumulation of experiences that moves a nurse from novice through competent to expert level (Benner, 1992). For nurses with little opportunity for continuous experience, the chance of such accumulation is minimized. This is the effect of marginalization – the casual nurses are interchangeable. “generic” parts, and there is little opportunity for focus on their professional development.

Policy implications

As we move into the next millennium, we need to face the implications of an ageing client population (the large baby boomer cohort will be over fifty years old) and their consequently increasing need for health care. Compounding the problem is the fact that the number of nurses graduating comes nowhere near to meeting the projected need. The Canadian Nurses Association’s study released in November 1997 indicated that by 2011 the projected shortfall would range from 59,000 (low demand for nurses) to 113,000 (high demand for nurses). Thus the need to retain experienced nurses in the workforce has again become important. If casual nurses remain a large percentage of this workforce, the implications clearly point towards policies that support their retention.

The policy adaptations need to start at the beginning of a future nurse’s career – in universities, community colleges and other institutions where nursing degrees are granted. Most nurses do not graduate into the job of their dreams, but instead work casually to build up the experience required for the desired position. The preference of most employers is at least “two years experience in this or related fields”. Students need to be aware of this reality and exposure to the worklife of casual nurses will be an important step in adapting to the real

world. The opportunity to "shadow" an experienced casual nurse for a day or two may be helpful, but at the very least, the students should hear from casual nurses about the adaptations and adjustments needed to survive in different workplaces on short notice. Education policies that encourage such experience in the curriculum would be a major step toward awareness.

The issue of lack of casual input into workplace decision-making needs to be addressed at the policy level. There not only needs to be casual representation, but assurance that their voices are heard. This would require organization of the casual nurses themselves to discuss issues important to them and to select representatives who would put forth their views, partake in the decision-making and ensure information was relayed to the casuals directly. One path would be through union-management meetings, but at present, many casuals are wary of union credibility in representing their views.

Another policy implication at the organization/institution level is the need for appropriate childcare, accessible 24 hours a day. In a profession that has a large population of women of childbearing age, it is remarkable that little has been accomplished in this area on a national level. If there has been any concerted lobbying for national policies and funding by nurses, publicity as well as results have been negligible. Therefore, it would seem to be a project that needs to be accomplished at the local level and demonstrated as an example of "local initiative".

The recent "settlement" between BCNU and HEABC (Health Employers Association of British Columbia) of the seniority issues has not solved the problems and needs to be re-worked with the BCNU seeking more input from those affected. This statement is based on the following information gathered from personal communication with shift schedulers and casual nurses. First, relief work is now offered in blocks, initially to the most senior casuals, progressing on down to the least senior. The blocks, which could be several weeks in length,

are only broken up if they are not taken in their entirety, and again the seniors get first offers. The effect of this system is to reinforce the seniority status of the most experienced casuals and leave the "pickings" for the rest. Prior to this system, the shift schedulers had the leeway to attempt to equalize the offerings but this left opening for claims of "favoritism"

Another effect of this system is to penalize newer casuals who wish to apply for regular positions that are being offered internally. One of the current requirements is 2400 hours of work before casuals are considered for interviews, regardless of experience prior to working for the organization.

An unresolved seniority issue relates to casuals who work in both acute care and home nursing care. The seniority lists remain separate even though there is now one umbrella employer, the Capital Health Region. The effect on the casual nurses' seniority status is obvious – little ground is gained by splitting work time.

The RNABC indicated interest in hearing from casual and part-time nurses in 1995. Focus groups were held, and the professional body was told that this segment of the working population felt under-represented (Stone, 1995). Such interest is encouraging and may lead to official recognition of their needs. However the vehicle for expressing these needs would be most effective if there was a united voice. As this population tends to shift with employment patterns, it may not be easy to create a stable membership. Past history of the rise and fall of special interest groups and chapters within the province would indicate that such organizing would need to have a flexible structure to survive the vagaries of population size, changing membership and fluctuating levels of interest in current issues.

Limitations of the study

There are limitations of this study that must be acknowledged. The first is the number of participants. Those who participated spoke freely and their stories contained similarities in the descriptions of worklife. The differences essentially lay in the individual worksites and the

age and experience of the individual nurses. However, the limited number of participants raises the question of whether saturation of data was reached. In other words, with more stories heard, would there have been other variations and permutations on the themes that emerged?

The second limitation lies in the experience of the researcher in this role. Throughout the process, learning was constant, and reviewing tapes and transcripts often led to questioning the helpfulness of some probes and their refinement or replacement in ensuing interviews. However, when the final interview transcript was reviewed, there were still areas that needed clarification. The follow-up telephone interviews were made to fill some knowledge gaps that became apparent during the analysis, and have been identified.

One of the difficulties encountered when collecting and analyzing data in a period of major change is that what was accurate and "true" at the time of data collection was changing even as the analysis took place. This leads to the temptation to keep "following-up" in order to have a current picture. However, such limitations must be accepted or the project will never be completed.

Implications for future study

Casual nurses in this study have both similar and different experiences as their full-time counterparts. In the one study found in the literature review that mentioned them individually (Pilkington & Wood, 1986), their responses to questions of role conflict and role ambiguity were different from those of full-time as well as part-time nurses. This should indicate reason for continuing to differentiate their contribution from those of others in studies of nursing workplace conditions and worklife experiences.

The subject of women in the workforce continues to interest researchers in sociology, education, psychology, economics and the specific areas of labour and family studies. Casual nurses offer the perspective of a group within a professional workforce with unique

needs and conditions. Thus, they are of interest in themselves, in addition to the issues raised but not studied in depth in this project.

One such issue lies in the field of experiential learning, and that is the effect of discontinuous work experience on the individual's development of practice knowledge. Employers would benefit from knowledge of the level of expertise casual nurses attain and how this could best be facilitated.

Another issue that warrants further study is the experience casual nurses have in their relationships with other colleagues and the adjustments and adaptations made in response to the position of marginalization. Researchers focusing on work/home interface in women's lives and the effect on their families may find this group of interest. As many women become parents later in life, adjusting to smaller paychecks and dealing with conflicting family and work issues are relevant to many professional women.

During the interviews, there were several references to anxiety over finances. With base salaries at approximately \$20 per hour, nurses' wages are high compared to many other fields where women are the majority of the workforce. However, as casual work can be very sporadic and debts and other financial obligations can plunder a paycheck, it is possible that some casual nurses and their families are living at or below the poverty line. This is an area for study by researchers in women's and family studies as well as economics.

It is hoped that this study will pique interest in casual nurses and what they have to offer to research, to nursing and to their employers and colleagues. They need to be recognized for their current and potential contributions as the demand increases for flexible, high quality providers of health care in all its complex aspects.

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Appendix A – Consent

I understand that the purpose of this research project is to explore the issues that are important to casual nurses working in British Columbia. I understand that I will be participating in a focus group session and will be asked questions about these issues and that the session will be moderated by the researcher, Myfanwy (Vonnie) Simpkin. The session will take place at a time and location mutually agreed upon by the participants and the researcher.

I understand that this project is to provide data for a Master in Nursing thesis for the researcher and that the sessions will be audiotaped and videotaped where feasible.

I understand that my participation is completely voluntary and that I may withdraw at any time, without explanation and at no risk of penalty.

I understand that any data collected in the study will remain confidential; audiotapes, videotapes, transcripts and notes will be kept in a locked room and that transcripts, audio and video tapes will be erased five years following the study. The consent forms will be kept separate from the data to preserve anonymity. Only the research investigators, thesis committee members and data assessment consultants will have access to the data. Furthermore, I understand my name will not be attached to any published results, that my anonymity will be protected by using codes to identify the subjects and the groups, and that the coding key and the data material will be kept separately.

I understand that I will be given a copy of this consent.

I understand that whether I participate or choose not to participate will have no bearing on my employment status.

Date:

Signature:

Experimenter:

Appendix B – Demographic Questionnaire

Thank you for the time you're giving to partake in this project. As you will note from the informed consent form, your views will remain anonymous in the study. We ask you to please maintain the confidentiality of the views expressed by the other participants in the focus group.

Would you please take a few minutes to fill in this questionnaire so that we can establish the demographics of the participants. Do not sign the form.

1. I have been working as a registered nurse for:
 - a) less than one year
 - b) one to five years
 - c) six to ten years
 - d) eleven to fifteen years
 - e) more than fifteen years

2. During this time I have worked:
 - a) always in a casual position
 - b) sometimes in a full-time position
 - c) sometimes in a part-time position
 - d) sometimes in both full-time and part-time positions

3. My age bracket is:
 - a) 20-29
 - b) 30-39
 - c) 40-49
 - d) 50-55
 - e) over

4. My gender is
 - a) male
 - b) female

5. My marital/kinship status is:
 - a) single with no dependants
 - b) single with one dependant
 - c) single with more than one dependant
 - d) married or similar with no other dependants
 - e) married or similar with one dependant
 - f) married or similar with more than one dependant

6. The level of education (nursing or other) I have currently attained:
- a) RN
 - b) Undergraduate (Bachelor)
 - c) Graduate (Master)
 - d) Doctorate
 - e) Specialty certification
 - f) Other

Thank you very much for your time. We hope you enjoy this focus group session. It's a chance to air your views on the issues we're exploring, as well as hear what others have to say.

VITA

Surname: Simpkin

Given Names: Myfanwy Lynne

Place of Birth: Victoria, British Columbia, Canada

Educational Institutions Attended:

University of Victoria	1963-1964
Royal Jubilee Hospital School of Nursing	1964-1967
University of Victoria	1990-1992

Degrees Awarded:

B.S.N,	University of Victoria	1992
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Author



Myfanwy Lynne Simpkin

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