Abstract

There are increasing numbers of Australian nurses working in part-time employment. This is important in a background where contemporary nursing shortages are a considerable barrier to the provision of adequate nursing personnel to meet nursing service demands. An accurate understanding of the situation of part-time nursing is necessary to enable effective human resource management of this segment of the nursing workforce. However, a paucity of available knowledge related to Australian part-time nursing represented a serious gap in the information required for effective and efficient management. Therefore the aim of this study was to discover and describe phenomena and develop theory that explains the 'realities' of part-time nursing in regional Queensland.

Strauss and Corbin's (1998) version of the grounded theory approach and methods were used to conduct this study. A sample of 86 regional Queensland part-time nurses and 18 nurse managers and nurse educators provided data that permitted the discovery of a substantive theory of part-time nursing. This theory has contributed knowledge relevant to practitioners in the substantive area by discovering, describing and explaining the phenomenon of part-time nursing, the conditions that influence the phenomenon and the responses that are made to adapt and adjust to the associated challenges. The developed grounded theory represents a significant contribution to the meagre base of knowledge that previously existed by offering insight, enhancing understanding and providing a valuable guide to action.

The 'realities' of part-time nursing in regional Queensland

by

Lynnette Noela Jamieson

Submitted in the fulfilment of the requirements of the degree of
Doctor of Philosophy through Central Queensland University,
Rockhampton
School of Nursing and Health Studies
Faculty of Arts, Health and Sciences

August 2005

Table of contents

List of tables

List of figures

Acknowledgements

The completion of this research would not have been possible without the contributions and generous support of many people. To all who have assisted me I would like to sincerely thank you. In particular I would like to take the opportunity to extend a special thanks to the following people.

My principal supervisor Dr. Leonie Mosel Williams has provided me with support, encouragement and her gentle and constructive direction. I am very appreciative of her knowledge of grounded theory, timely feedback and editorial assistance. Though geographically very distant, Professor William Lauder has been easily accessible and has allowed me to 'see' issues from differing viewpoints. Dr. Trudy Dwyer has been supportive and encouraging throughout this study and has proven to be a willing listener when one was needed.

I am very grateful to the nurses who participated in this study. They candidly shared their stories of part-time nursing by willingly contributing personal time and trust. I have felt privileged to be able to listen to and learn from these nurses. Without their contribution this research could not have been undertaken.

I am thankful to my many nursing colleagues, friends and family who have continually shown their interest in my study. I am deeply appreciative of my husband Phil and my children Brendan and Priscilla's tolerance of my distraction and their provision of the 'space' that I needed to complete this study. I am also grateful to my father and mother who have lovingly supported me during my study.

Declaration

The main text of this thesis is an original work developed under the guidance of my academic supervisors and does not contain material previously submitted as a requirement for the award of a degree at Central Queensland University or any other institution of higher education. To the best of my knowledge all sources of information have been acknowledged.

....

Lynnette Jamieson

Chapter 1

This chapter introduces the study that is reported in the following chapters of this thesis. Background information provides an understanding of the existing problem. It should be noted that the background information provided in this chapter is restricted to the relevant information that emanated from a limited literature review conducted prior to the study's commencement. As is reported in the following chapter (section 2.3.2), the methodology chosen for the study deemed that initial review of the literature should be limited to establishing a rationale for the need for the study. In this chapter the reader is provided with this initial background information so that their journey through the study follows a similar path to that of the researcher. The scope and aim of the study are articulated and these found the research questions that were used to guide the study. Terms and nomenclature that are used throughout this report are explained and the chapter concludes with an overview of the organisation of this thesis.

1.1.   Background to the study

There has been considerable expansion in part-time employment in Australia over the past two decades and currently females compose approximately 75% of all Australian part-time workers (de Ruyter & Burgess 2000). Australia has utilised part-time employment as a means to assist employees to gain a work-family balance that especially meets the needs of women, the predominant gender in part-time employment (Sheridan & Conway 2001). Organisations can also benefit from part-time employment as it provides a means for retention of

valued employees who may no longer want to work in full-time employment (Kropf 1999).

Sheridan and Conway (2001) offered their opinion that though part-time employment in Australia may represent a flexible work practice, employees' and organisations' perceptions of flexibility may be inconsistent. Markey, Hodgkinson and Kowalczyk's (2002) study using data from the 1995 Australian Workplace Industrial Relations Survey found strong evidence that Australian part-time employees have a lower level of workplace empowerment and participation than their full-time counterparts. This could be seen as a significant failure to implement 'best practice' in human resource management. However, the key to understanding why this factor exists may come from Kramar's (1998) proposal that there is a mismatch between Australian management and part-time employees' perceptions about the 'nature' of the work experience. Markey and associates' (2002) finding that the work experience differs for full-time and part-time workers established that information available for full-time employees should not automatically be transferred to the part-time employment situation.

Part-time workers in Australia are concentrated into a narrow range of occupations, with only a small percentage of part-time workers coming from the professions (ABS 2001). Reasons for growth in part-time work vary according to industry (ABS 2001). Therefore information related to the overall Australian part-time workforce may not be totally representative of all subgroups within that workforce. The part-time nursing workforce is one subgroup of the wider Australian part-time workforce.

In 1999 the percentage of Australian registered and enrolled nurses employed in a part-time capacity was 53.8% (AIHW 2003b), a significant segment of the overall Australian nursing profession. Unfortunately nursing labour force data are not current, a finding also noted in the report from the *National Review of Nursing Education 2002* (Commonwealth of Australia 2002b). Additionally nursing labour force data do not distinguish between casual and permanent part-time employment. Consequently there are no data available that accurately identifies the percentage of nurses who work in permanent part-time employment. However, this researcher's anecdotal evidence from the regional Queensland context suggested that a large proportion of Australian nurses are employed in a permanent part-time capacity.

Nurses represent the largest occupational group in the Australian healthcare system and without this group healthcare services would be in disarray (Borbasi 1999). There is a current national and in fact global nursing shortage caused by multifaceted factors, primarily related to problems in recruitment to and retention in the profession (Commonwealth of Australia 2002a). This shortage is problematic to the provision of adequately skilled nursing resources to meet current demand.

As previously stated, the 1999 nursing labour force data identified that 53.8% of registered and enrolled nurses employed in Australia were working in either a casual or part-time capacity (AIHW 2003b). This figure had increased substantially from 37.4% in 1988 (AIHW 2003b). Based on developing patterns,

there is the likelihood that Australian healthcare will continue to be heavily reliant on a part-time nursing workforce. As people are the most important asset of healthcare organisations, modern healthcare managers require information about their workforce to enhance effective human resource management practices (Zairi 1998). Thus managers of the part-time nursing workforce in Australia need to utilise information related to that workforce to found effective management practices.

In 1993 registered nurses represented only 3.6% of all Australian part-time workers (ABS 2001). Unfortunately more current statistics were not found. However, based on available figures, it would have been inappropriate to utilise literature that reports data from the larger Australian part-time workforce to develop an accurate understanding of the situation of part-time nursing. The Australian part-time nursing workforce is predominantly female (AIHW 2003b) which is consistent with the overall Australian part-time workforce. However, nurses are professionals and as such form a minority group that is potentially distinct from the majority of other Australian part-time workers.

A limited search of the literature identified the dearth that exists of Australian research studies related to part-time nursing. Additionally the literature accessed identified only a few relevant international research studies. Kemp (1994) conducted a longitudinal study that explored the cause and effect of British nursing graduates (n=45) leaving full-time employment. Kemp (1994 p.379) found that the reasons given for 'going part-time' were complex and included: predictability and control of work hours; avoidance of unsocial work hours; time

with children; relief from the stress of work; and freedom to pursue personal goals. Hiscott's (1994) survey study of Canadian registered nurses (n=1056) found that though part-time employment was increasing within the nursing profession in that country, individual nurses' employment status frequently changed with nurses increasing and decreasing their working hours. The findings from these two studies indicated that it was an individual nurse's preferences for part-time employment over full-time that initiated these work practices. In contrast, Kapborg's (2000) quantitative study of Swedish registered nurses (n=96) found that it was a common occurrence for nurses in Sweden to be forced into part-time work with the majority of nurses in that study wanting, but unable to gain, full-time positions.

In a mixed methods study of British qualified nurses (including nurses in three focus groups n=10-12x3; individual interviews with nurse managers n=7; and questionnaire survey of nurses n=643) working within the National Health Service, Lane (Lane 1998; 1999a) found that female nurses employed in a part-time capacity predominantly held positions in lower grades irrespective of their qualifications and experience, were excluded from training opportunities and were perceived as less committed than their full-time colleagues. In contrast, Jacobsen's (2000) study of Norwegian aged care employees (n=233 who were mostly nurses with many working part-time) found that part-time nurses may be more committed to their employing organisations than their full-time counterparts. The conditions surrounding these differing situations may be important.

Though the literature provided some research based findings on issues relevant to international part-time nursing, there were noticeable variations between countries. This factor made it impossible to refute or concur with any confidence that the issues identified in the international literature were significant to the Australian part-time nursing situation. Because of the unique social, cultural, political and professional milieu in which Australian nurses' practice, it was deemed inappropriate to transfer international data to the Australian context without exploration. However, international findings such as those by Lane (1998; 1999a) substantiated the need to explore part-time nursing from the Australian perspective.

Hawksworth (1999), a Queensland nursing union representative, proposed that a detailed analysis is needed of the causes for the increasing percentage of nurses who are working in a part-time capacity. Hawksworth (1999) provided the anecdotal suggestion that though nurses may 'prefer' to work part-time because of family responsibilities, it may be the lack of family friendly employment practices, pressure on full-time employees to contribute to administrative functions in personal time and the degree of work intensification that are also factors contributing to nurses seeking part-time employment. Whether Hawksworth's (1999) suggestions were correct were unknown.

1.2. The problem

The previous pages have identified that nurses are the largest occupational group within the Australian healthcare system. Contemporary nursing shortages are placing considerable pressure on healthcare organisations' ability to meet the

demands for nursing services. In this landscape of nursing shortages the increasing numbers of nurses who are working in a part-time capacity is noteworthy.

If those in managerial positions within healthcare do not have an accurate understanding of the part-time nursing workforce, decisions may be made based on anecdotes, presumptions and/or myths that are not representative of reality. A potential outcome of this lack of knowledge is ineffective human resource management practices that are not characteristic of 'best practice', an expectation of contemporary healthcare organisations. In a background where there were already barriers to provision of adequately skilled nursing personnel to meet demand, ineffectual management of this workforce has potential deleterious consequences to the healthcare system. Whether the healthcare system can afford these consequences is questioned. Therefore information is needed related to the situation of part-time nursing in Australia to enable informed management decisions that would enhance the potential for effective human resource management. The report on *The National Review of Nursing Education 2002* (Commonwealth of Australia 2002b, p. 14) proposed that:

> (t)he availability of sound data and a valid, reliable evidence base
> provides the platform for decisions on supply, skill mix, work
> organisation and policy. Currently the availability of quality data and
> evidence in relation to the nursing workforce and nursing work is
> very limited.

Though there are limited data related to the overall Australian nursing workforce this situation is exacerbated for the situation of part-time nursing.

Information related to the wider Australian part-time workforce has been identified as unable to capture the essence of part-time nursing. Acknowledgement that the experience of full-time and part-time workers may vary identified that studies that explored full-time nursing may not be readily transferable to understanding part-time nursing. It was established that it would be a mistake to transport information from the international literature related to part-time nursing to the Australian context without exploration. A base of knowledge founded on sound data and a valid, reliable evidence base was needed to describe and explain the situation of part-time nursing in Australia. However, though considered important this information base did not exist and it wasn't possible to rely on data from other sources to gain an accurate understanding of part-time nursing in Australia. This paucity of available knowledge related to Australian part-time nursing represents a serious gap in the information required for the effective and efficient use of the nursing workforce.

1.3. The scope of the study

The problem that has been identified in the previous pages substantiated the rationale for conducting a study that would correct the dearth of knowledge that existed. Consideration was made of the sheer size of the Australian part-time nursing workforce and the wide geographical dispersion of this workforce. It was determined that to make the study more workable the scope would be limited to the regional Queensland context.

1.4.   The aim of the study

Based on the knowledge deficit that has been identified and the limitations on the scope of the study, the aim of this study was to discover and describe phenomena and develop theory that explains the 'realities' of part-time nursing in regional Queensland.

1.5.   Research questions

The source of the research question for this study came from the researcher's personal and professional experience, as suggested by Strauss and Corbin (1998). The grounded theory approach was selected as most appropriate for this study. As is common in qualitative research and specially in grounded theory research, a 'grand tour' question was developed to state the phenomena to be studied in a very general way (Creswell 1994). This led the researcher to frame the research question so that it was broad enough to enable flexibility and freedom to expansively explore the phenomena from differing perspectives (Strauss & Corbin 1998). The research question started out broadly and became more specific as the study progressed. For that reason the research question was modified, as commonly occurs in grounded theory (Strauss & Corbin 1998). Initially the research question was: 'What are the experiences and motivators of regional Queensland part-time nurses?'.

As the study progressed the research question was modified to three focussed questions. This study was guided by the following questions:

1.   What is the problem that is experienced when nursing part-time in regional Queensland?

2.   What are the conditions that influence this problem?

3.   What is the process that is used to respond to this problem?

These questions allowed findings related to the multiple realities of a diverse part-time nursing workforce. Therefore using these questions to guide this study was congruent with ensuring that the aim of the study was met.

1.6.   Explanation of terms and nomenclature

The following explain the terms and nomenclature that are used in the report of this study.

1.6.1.   Part-time employment

There is ambiguity related to the definition of 'part-time' employment. The Australian Bureau of Statistics defines part-time employment as being less than thirty five hours per week. This definition has been embraced by the Australian Institute of Health and Welfare (AIHW) who are the statistical and information agency responsible for the compilation and computation of Australian nursing labour force data. Operationally the Australian nursing workforce is categorised into the employment sub-divisions of full-time, part-time and casual employees. It should be noted that operationally any nurse who works less than 38 hours per week, which is the number of hours worked when in full-time employment, is considered to be part-time. Casual and part-time employees are not distinguishable as separate groups in Australian nursing labour force statistics but are instead amalgamated together under the term 'part-time'. For the purposes of this study, 'part-time' employment is defined as being permanently contracted to work a fixed number of hours that is less than thirty five hours per week and

consists of the same industrial conditions (prorated for hours of employment) as those working in full-time employment.

1.6.2. Part-time nurse/nursing

The literature provides a lack of clear, consistently used conceptual and operational understanding for the terms 'part-time nurse' and 'part-time nursing'. As previously suggested this is not the case in practice as operationally the Australian nursing workforce is categorised into the employment sub-divisions of full-time, part-time and casual nurses. For the purposes of this study the term 'part-time nurse' refers to a nurse who works in part-time employment (as defined previously) rather than referring to their approach to nursing. This study uses the term 'part-time nursing' to refer to the nursing services provided by a part-time nurse.

1.6.3. Registered nurse

A registered nurse is a 'person licensed to practice nursing under an Australian State or Territory Nurses Act' (Australian Nursing Council 2000, p. 27). Currently registered nurses in Australia gain their qualification through Bachelor level tertiary education (Commonwealth of Australia 2002b).

1.6.4. Enrolled nurse

An enrolled nurse is a 'person licensed under an Australian State or Territory Nurses Act to provide nursing care under the supervision of a Registered Nurse' (Australian Nursing Council 2000, p. 27). Currently enrolled nurses in Australia

gain their initial educational preparation through the Vocational Education and Training system.

1.6.5. Nurse manager

A nurse manager is a registered nurse whose role is primarily one of management.

1.6.6. Nurse educator

A nurse educator is a registered nurse whose role is primarily one of education.

1.6.7. Levels 1, 2 and 3 nurses

In the early 1990s Queensland incorporated a new nursing career structure. Registered nurses commence at the base level (Level 1) and higher levels are gained through promotion. The basic level (Level 1) of all registered nurses in this hierarchical position structure is predominantly a clinician role; as is the Level 2 position. However, the Level 2 position represents a promotion above the Level 1 position and Level 2 roles have greater responsibilities than Level 1 roles. The Level 3 position is a further step up the hierarchical structure and these nurses commonly perform nurse manager and nurse educator roles that are not primarily clinician roles.

In 2003 Queensland Health, the public healthcare organisation in Queensland, modified the nursing career structure position classification following the recommendations emanating from the *Ministerial Taskforce: Nursing Recruitment and Retention* (Queensland Health 1999). Level 1 and 2 positions

automatically translated to Nursing Officer (NO) 1 and 2 respectively. Level 3, 4 and 5 positions have been translated to NO3 through to NO9 commensurate to level of responsibility.

Though the revised Nursing Officer structure is currently included into Queensland nurses' industrial awards for the public sector, anecdotal evidence and the findings from this study are that nurses continue to refer to the previous 'level' structure. Additionally, the private sector has not revised their nurses' structure and continues to use the 'level' structure. Nursing labour force data are not current and consequently has used the previous 'level' structure for data. Therefore for the purposes of this study the 'level' career structure was used as it provided terminology that was consistent with the terms contained in this study's data and in nursing labour force data.

1.6.8. Regional

The terms 'rural' and 'regional' are commonly poorly defined in the literature. While at times these are recognised to differ, in other literature the terms are used synonymously (Wilkinson 2002). In 2001 the Australian Bureau of Statistics added the ASGC Remoteness Areas to the Australian Standard Geographical Classification (AIHW 2004). The current study's definition of 'regional' comes from this geographical classification. The classification uses five categories: 'Major cities', 'Inner regional', Outer regional', 'Remote' and 'Very remote' (AIHW 2003b). This study has used the 'inner regional' and 'outer regional' categories that for the purposes of this study have been termed as 'regional'.

1.7.   Organisation of thesis

The organisation of the report contained in this thesis is as follows. In order to meet the aim of the study the grounded theory approach was selected as most appropriate. Chapter two describes the grounded theory methodology that was used for this study including the theoretical underpinnings, selected version and the specific methods. The sample's demographic profile is also reported in this chapter. The grounded theory methods described in Chapter 2 provided the study with direction that led to progressive development of a substantive theory of part-time nursing. Chapters 3, 4 and 5 report the study's findings that led to this discovery. The problem that was discovered is reported in Chapter 3. Chapter 4 reports the conditions that were found to influence this problem and the process that was used to respond to this problem is reported in Chapter 5. The substantive theory that was discovered by this grounded theory study is presented in the final section of Chapter 5. Discussion of key findings in the context of their links to existing literature and how the developed theory goes beyond what is already known is presented in Chapter 6. Chapter 7 identifies the limitations of the study, conclusions made from the study and the recommendations that come from these conclusions.

Chapter 2
Grounded theory

2.1. Overview

As identified in Chapter 1, an initial limited review of the literature identified the dearth of knowledge that existed related to the research topic and this information led the researcher to an appreciation that a totally inductive approach would be needed for the study. This study aimed to be exploratory, using an inductive process of discovery to address an issue where little knowledge existed, which is consistent with the use of a qualitative approach (Creswell 1994). The premise of qualitative researchers is that 'reality' is the meaning constructed from shared and individual interactions with a given phenomenon (Cutcliffe 2000). Discovery of individual and shared meanings from a diverse part-time nurse cohort was considered to potentially result in multiple 'realities'; the general substance of this suggestion is supported by Wuest and Merritt-Gray (2001). This is consistent with the aim of the study that was articulated in Chapter 1. It was believed that these multiple realities could be captured by an appropriately developed study. The most appropriate qualitative methodology for the study was chosen through extensive reading of the literature to promote greater awareness of qualitative methodological genres.

Grounded theory methodology was chosen as the most appropriate approach for this study as it allows exploration into phenomena where little knowledge exists and it is recognised to be well-matched to nursing research (Lomborg & Kirkevold 2003; MacDonald & Schreiber 2001; McCann & Clark 2003; Schreiber 2001; Smith & Biley 1997). Another inducement to use the approach

was grounded theory's emphasis on theory development, a feature that distinguishes the approach from other qualitative approaches (Strauss & Corbin 1998). Additionally Morse (2001) posited that grounded theory is especially beneficial when the research question is concerned with participants' experiences and how they respond to experiences.

This chapter commences with a report of the grounded theory methodological approach including discussion related to links with symbolic interactionism, the versions and an overview of the approach. The report then describes the methods that have been used in this grounded theory study.

2.2. Methodology

Grounded theory methodology was originally developed in the mid-1960s by two North American sociologists, quantitative researcher Barney Glaser and Anselm Strauss a qualitative researcher. The methodology stems from and is fundamentally integrated with symbolic interactionism (Ezzy 2002; Milliken & Schreiber 2001; Smith & Biley 1997). The methodology represents the link between this theoretical underpinning and the methods of conducting grounded theory research (Milliken & Schreiber 2001).

2.2.1. Links to symbolic interactionism

Symbolic interactionism is a theoretical perspective that explains human group life and human conduct (Blumer 1969). This theoretical perspective was founded by a number of scholars including George Mead who has been recognised as the foremost originator (Blumer 1969). These foundations were further advanced by

Herbert Blumer who clarified Mead's original work and established symbolic

interactionism as a research approach (Blumer 1969; Jeon 2004). The notions of

interactionists had a significant influence on Strauss and this contributed

markedly to the development of the grounded theory approach (Ezzy 2002).

Therefore grounded theory emerged from and is intrinsically linked to symbolic

interactionism (Milliken & Schreiber 2001).

Blumer (1969) proposed that symbolic interactionism is based on three premises:

> ... that human beings act toward things on the basis of the meanings
> that the things have for them.
> ... that the meanings of such things is derived from, or arises out of,
> the social interaction that one has with one's fellows.
> ... that these meanings are handled in, and modified through, an
> interpretative process used by the person dealing with the things he
> (sic) encounters. (p. 2)

Therefore to understand a person's actions (behaviours) one must first discover

the underlying meanings that things have for them. Blumer (1969) proposed that

actions are defined and redefined by an interpretive process that takes place

through interaction with self and with others. Social interaction is achieved

through symbols with language being the most symbolic system (Annells 1996).

Individuals sharing common situations may give rise to what Blumer (1969)

called 'joint action', where members of a group display patterned behaviours.

This was considered important for this study as it was perceived that nurses

collectively, and part-time nurses as a sub-group of that collective, may display

shared behaviours that are consistent with the concept of joint action. However,

this study heeded Blumer's (1969) warning that it would be a mistake to fail to

recognise that joint action results from the interlinking of actions of the

individuals within the collective group. Joint action provides a level of stability and predictability to social interaction and any human society is based on manifestations of pre-established forms of joint actions (Blumer 1969; Milliken & Schreiber 2001). However, as new situations and problems emerge existing rules become inadequate (Blumer 1969). Recent years have seen a continuous increase in the numbers of nurses who work part-time that may represent a new situation leading to an inadequacy of previous 'rules' related to nursing.

The theoretical perspectives of symbolic interactionism provided an excellent foundation for the study of part-time nursing. Symbolic interactionism is premised on the fact that individuals base their actions on their interpretations of meanings and patterned behaviours (joint action) occur when there is an interlinking of the actions of individuals within a group. Morse (2001) proposed that a strength of grounded theory is this ability to recognise shared patterns of behaviours while maintaining the perspectives of the individual. Therefore symbolic interactionism provided an important theoretical underpinning to the grounded theory approach that was used by this study to discover individual's meanings so that patterned behaviours could be discovered and understood.

In one of his more recent writings Glaser (1999) suggested that grounded theory could be done without using the theoretical underpinnings of symbolic interactionism. However, Milliken and Schreiber (2001) examined this proposal and concluded that:

> symbolic interactionism penetrates even the technical level of grounded theory so that, ... [in their view], an adequate grounded theory cannot be divorced from it. Even the grounded theory researcher who is unfamiliar with symbolic interactionism *per se* is

necessarily enacting the epistemological underpinnings of the method through the conduct of her or his study. (p.187)

This researcher agrees with Milliken and Shreiber's (2001) conclusion that symbolic interactionism provides a basis for all grounded theory methods.

2.2.2.   Versions of grounded theory

A review of available grounded theory literature identified that after their initial work in the 1960s Glaser and Strauss diverged in their views and development of grounded theory. The original founders' divergence has led to two 'schools' or versions of grounded theory; the Glaserian version that is based on the original text and further writings by Glaser and the Straussian version that is based on developments to the original approach that were made by Strauss and his colleague Juliet Corbin (Benoliel 1996; Heath & Cowley 2003; McCallin 2003). Researchers intending to use grounded theory have to choose between the Glaserian and Straussian versions. To further confuse the novice grounded theorist there is the suggestion that differences between the original version and Glaser's later writings about the approach mandate that a choice be made between three versions of grounded theory (McCallin 2003). However, this researcher believed that a choice between two versions of grounded theory was adequate.

Wide reading of the grounded theory literature provided an opportunity to understand some of the differences between Glaser's and Strauss's writings that informed the choice of version that would be used for this study. The differences were found to incorporate both methodological and method issues. At the centre

of the methodology polarity is the underlying ontological and epistemological assumptions of each of the original founders of the approach.

One criticism of grounded theory methodology is that ambiguity has resulted because both founders of grounded theory have not openly articulated their underlying ontological and epistemological stances (Lomborg & Kirkevold 2003). Annells (1996) suggested that the Straussian version has ontological roots in relativism where reality is recognised to be interpreted. Certainly Strauss and Corbin's (1998) version encourages the researcher to be actively involved in the method. This stance differs from the Glaserian version that has its ontological roots in critical realism that assumes an objective world exists independently of our knowledge and beliefs and therefore considers the researcher as being independent of the research (Annells 1996; Lomborg & Kirkevold 2003).

Consideration of the ontological and epistemological premises of the versions of grounded theory prompted this researcher to openly articulate her own perspectives to assist to situate the study and to gain an understanding of which version of grounded theory would be followed. When considering the study topic this researcher believed that reality would be interpreted through individual and shared interactions with phenomena and could be pleuralistic. To discover reality this researcher considered that active interaction would be required between the researcher and those being researched so that their individual and shared meanings could be accurately interpreted.

In many ways both Glaser and Strauss seem to have maintained the basic tenets of their original grounded theory approach, a suggestion that was supported by Jeon (2004). However, Glaser's (1992) intent is to keep the grounded theory approach simple by providing a more relaxed method that patiently waits for theory to emerge. In contrast Strauss and Corbin (1998) provide multiple tools, techniques and analytical frameworks to assist in the development of theory.

Influenced by both the Glaserian and Straussian writings consideration was made of mixing versions. However, Morse (1991) recommended that only experienced researchers should mix methods. As a novice grounded theorist the issue of whether mixing 'versions' should also be limited to experienced researchers was considered (Heath & Cowley 2003). A number of authors have evaluated published nursing grounded theory research and have found a poor use of the methods (Becker 1993; Benoliel 1996; Wilson & Hutchinson 1996). Elliot and Lazenbatt (2005) proposed that the credibility of grounded theory studies is at risk when the methods are used incorrectly. Therefore version mixing was avoided in an attempt to ensure credibility through rigorous application of the methods.

The philosophical assumptions of this researcher were perceived to be more closely aligned to the interpretivist orientations of Strauss than to the objectivist orientations of Glaser. Glaser's (1992; Glaser & Strauss 1967) perspectives of simplicity and 'emergence' of theory were perceived by this researcher to have merit. However, the Glaserian methods seemed too *laissez faire* for this novice grounded theorist. At the other end of the scale the Straussian methods were too

prescriptive and complex and potentially led to 'forcing' of theory rather than allowing 'emergence'; a strong criticism that Glaser (1992) had of Strauss for his methodological divergence. This novice grounded theorist preferred to have the structure provided by Strauss and Corbin (1998). However, a highly prescriptive set of complex procedures that needed to be rigidly followed and that would potentially lead to 'forcing' of theory was not wanted. Barbour's (2001 p.1117) warning against reducing qualitative research to a list of technical procedures that result in 'the tail wagging the dog' was noted.

Strauss and Corbin (1998) specifically warned against rigidly following set procedures. This warning provided a resolution to the dilemma of how to incorporate the influences of both founders of the grounded theory approach into the study without explicitly mixing versions. Strauss and Corbin (1998) suggested that their structured approach enabled flexibility and creativity. Further investigation of this latest model of the Straussian version (Strauss & Corbin 1998) led to the recognition that flexibility and creativity in the use of set procedures would enable both Glaser's and Strauss's influences to be taken advantage of.

Therefore based on the reasons already described the decision was made to generally, rather than rigidly, follow Strauss and Corbin's (1998) version of grounded theory for the conduct of this study. As a novice grounded theorist this researcher was able to use the direction of Strauss and Corbin (1998) without being distracted by complicated and rigid procedures or being weighed down by the potential of 'forcing' theory (Robrecht 1995). Several procedures provided

by Strauss and Corbin (1998) were not strictly adhered to in an attempt to simplify the method and to enhance the inductive nature of theory development, thereby maintaining 'emergence' of theory. Becker (1993) recommended that modification of methods requires the rationales to be clearly given to ensure that they make logical and theoretical sense and therefore enhance the credibility of the grounded theory study. Any deviations to Strauss and Corbin's (1998) procedure are acknowledged during this report.

2.2.3. Overview of grounded theory

Even though Glaser and Strauss vary in their underlying philosophies of grounded theory and the methods used to develop theory they agree on the purpose of the approach (Duchscher & Morgan 2004). In the grounded theory approach, theory is inductively developed from interpreting the data generated by a study of the phenomenon it represents (Glaser & Strauss 1967). Thus the theory is grounded in data. Theory is a statement about relationships between variables or concepts that describe and explain patterns of social behaviour by focussing on meanings and interpretations (Ezzy 2002). In this grounded theory study simple descriptions of phenomena were superseded by theoretical conceptualisations that were developed by systematically integrating various concepts to identify relationships (Smith & Biley 1997; Strauss & Corbin 1998). Because the developed grounded theory was drawn from data it offers insight into the phenomena, improves understanding, and provides a valuable guide to action (Strauss & Corbin 1998).

Two basic kinds of theory can be constructed through the grounded theory approach - substantive and formal (Glaser & Strauss 1967; Strauss & Corbin 1998). A substantive theory is developed to be relevant to the situation or area being studied and is modifiable whereas a formal theory is a more developed theory that is not restricted to any one substantive area (Backman & Kyngas 1999; Glaser & Strauss 1967; Strauss & Corbin 1998). This study aimed to develop substantive theory that was relevant to the context boundaries determined by the research question. The theory developed by this study was highly reliant on emergent data and the researcher was very attentive to the potential of forcing theory development.

Because Strauss and Corbin's (1998) procedures have not been rigidly followed and to provide the reader with an audit trail, the methods used in this study are reported in the following pages.

2.3. Methods

The following pages report the methods used for maintaining researcher objectivity and sensitivity, incorporation of the literature, sampling, data collection and data analysis. It should be noted that while sampling, data collection and data analysis are described separately they were not distinct entities. Instead, they occurred simultaneously and sequentially and had a reciprocal relationship with each other.

2.3.1. Objectivity and sensitivity

The researcher was an essential instrument to the grounded theory approach, and played a vital and integral role in all aspects of the research. However, it was necessary prior to commencement of the study to make some decisions about how to best enhance the researcher's ability to perform this essential role. This researcher has worked as a part-time nurse in regional Queensland for more than twenty years. Conducting a study while concurrently being a member of the group being studied meant that this researcher was an 'insider' (Asselin 2003). It was therefore important to consider the benefits and disadvantages that this would possibly bring to the study (Tilley & Tilley 1999). Being a regional Queensland part-time nurse meant that this researcher potentially shared an identity, beliefs, language and a level of common professional experiential base with participants that would potentially assist to gain access to honest, rich data (Asselin 2003). It was perceived that sharing these commonalities would potentially assist in the analytic process by heightening sensitivity to data. However, this researcher acknowledged that previously gained beliefs, expectations, assumptions and past experiences could be a barrier to objective and inductive data analysis (Asselin 2003).

Smith and Biley (1997) proposed that the grounded theorist should be neutral and as such neither objective or biased. However, Strauss and Corbin (1998) suggested that objectivity is necessary to arrive at impartial and accurate interpretation. The researcher maintained objectivity in the research process by preserving an openness and willingness to 'give voice' to participants (Strauss & Corbin 1998 p. 43). A means of maintaining this objectivity, provided by Strauss

and Corbin (1998), was to gain wide ranging data, to compare data to other data, to validate interpretations with participants and to maintain an attitude of scepticism regarding all interpretations as provisional until they were validated against further data. Morse (1991) suggested that one means to avoid researcher assumptions related to the topic is to conduct the study in new settings so that the researcher is a stranger and not completely comfortable. Study participants were recruited from a variety of healthcare settings.

Prior to the commencement of the study this researcher developed self-awareness by taking time to introspectively analyse self values, perceptions and attitudes so that objectivity was maintained and the potential for introducing bias was limited. These were documented through self-reflective journaling. These values, perceptions and attitudes were not put aside or 'bracketed' to avoid introducing bias (Backman & Kyngas 1999). Instead they were used to assist to develop sensitivity to the meanings in data (Strauss & Corbin 1998). Strauss and Corbin (1998) proposed that it is impossible to disassociate oneself from '... who we are and what we know' (p. 47). Additionally, Strauss and Corbin (1998) suggested that it is appropriate to use this knowledge to enhance sensitivity to the meanings in data while avoiding forcing our explanations on data.

The researcher believed that objectivity would also need to be 'perceived' by participants. Throughout the study the researcher held a position as a nurse manager. While the researcher did not have direct line supervision of any participant recruited to the study, there was the potential that participants who knew her may be somewhat inhibited during interviews. If this occurred there

would have been a negative impact on the quality of data collected. The researcher attempted to distance herself from her nursing position and instead presented herself as a peer part-time nurse who was conducting a research study. Though it would have been easier at times to conduct interviews on the way to or from work, the researcher avoided these timeframes to avoid being dressed in uniform, thereby enhancing the potential to be perceived in a separate role. Nonetheless the researcher was constantly vigilant for the potential negative impact on the quality of data collected that not being perceived as objective may have. However, the level of participant honesty found in data substantiated achievement of the aim of being 'perceived' as objective.

2.3.2. The literature

One of the problems surrounding conducting a grounded theory study for award of a doctoral degree is that there is little to guide the researcher in how to use the literature for the study's conduct and for writing the report that is examined. Access of digitally available doctoral theses provided no clarity to this dilemma as there was no consistency in the use of the literature for conduct of these studies or in the writing of reports.

Documentation related to grounded theory methodology commonly suggests that a review of the literature should be avoided prior to commencement of a study to ensure that the nature of the study is inductive and bias is minimised (Cutcliffe 2000). However, a preliminary activity of this study included a limited review of the literature to identify the current level of knowledge that existed to provide a rationale for the need for the proposed research (Smith & Biley 1997). This was

considered an important initial activity as the study was being conducted for award of a doctoral degree that requires that there will be significant original contribution to knowledge in the subject area. The review of the literature identified a paucity of information and provided the rationale for the study.

Though review of the literature that was undertaken related to the research topic was initially limited this was not the case in relation to the methodology that was to be used for the study. Extensive reading of the literature was undertaken to promote greater awareness of qualitative methodological genres. These readings founded the decision to use the grounded theory approach. This researcher wanted to avoid conducting 'sloppy' research that would come from careless and badly informed application of the methodology and associated methods (McCallin 2003). Therefore a comprehensive review of the literature related to grounded theory was carried out to ensure an informed choice of the grounded theory version to be used and so that this novice grounded theorist could be appropriately prepared to conduct a rigorous and systematic study using the approach.

As the initial study findings began to emerge the literature was again reviewed related to specific findings in an attempt to use this to supplement interview data, as was one option provided by Strauss and Corbin (1998). However, the findings from the study were in the embryonic stages of development and a plethora of general and nursing literature was found that was deemed to be potentially relevant. For example, though there was a very limited literature related to the situation of part-time nursing there was an immense literature base related to

part-time employment in other occupations, such as in the retail industry. Reading these literatures became problematic as they focussed this researcher's thinking on issues that were quickly found to be irrelevant to the situation of part-time nursing. The researcher found that she was looking for issues in data rather than have them emerge by themselves; a factor that was inconsistent with the decision to avoid the use of Strauss and Corbin's (1998) theoretical comparisons technique (section 2.3.5.4). Therefore the decision was made to keep away from these literatures until a later stage of the study. This factor was perceived as important to ensuring that the developed theory was grounded in the data rather than being constrained by the literature (Strauss & Corbin 1998).

Further review of the literature related to the research topic was conducted towards the later stages of data collection and analysis to contextualise more developed findings to current knowledge (Smith & Biley 1997; Strauss & Corbin 1998). At this stage the literature provided a secondary source of data for consideration through the constant comparison method without constraining the analytic conceptualisation of the original data. Extensive literature searches identified a plethora of literature that held differing levels of relevance; with most having very limited application. This researcher read widely to determine the applicability of available literatures to the study findings. A limited volume of relevant literature has been used as data and has been included in this report to broaden the richness of discovery. Some Queensland healthcare organisational documents were found that pertained to the study topic and were used as data. Other literature has been used within the discussion chapter to contextualise how

the substantive theory developed by this study goes beyond what already is

known (Stern 2005).

2.3.3. Sampling

Grounded theory uses non-probability sampling, where sample numbers or data

sources are unknown at commencement of the study (Cutcliffe 2000). This study

initially used purposive sampling that attempted to access a sample of part-time

nurses who had a diversity of demographical characteristics. This sampling

technique was then superseded by theoretical sampling; as suggested by Coyne

(1997) and Cutcliffe (2000). Initial purposive sampling was used as the issues

were unknown prior to study commencement and this sampling method provided

the researcher with a sample where the phenomenon occurred (Coyne 1997;

Strauss & Corbin 1998). This study initially recruited two focus groups of

enrolled and registered nurses who were employed in a part-time capacity, were

willing to participate in the study and who had a diversity of demographic

attributes (e.g. age, practice setting, length of nursing experience, position level).

As data collection and analysis of data from this sample would direct further data

collection and therefore sample choices, it was perceived that initial participant

diversity would enhance the potential for expansive exploration of the issues.

Purposive sampling is frequently used in qualitative research as a method of

extending knowledge by deliberately selecting sample participants who are

known to be rich data sources (Roberts 1997). Theoretical sampling is the

method used in the grounded theory approach. There is ambiguity in the

literature related to the distinction between purposive sampling and theoretical

sampling (Coyne 1997). Coyne (1997) suggested that theoretical sampling is a 'variation' within purposive sampling that is a complex, on-going process, rather than being predetermined, that interacts with data collection and simultaneous analysis to identify further data needs that are then met by the sampling strategy. Theoretical sampling was used in this study whereby the decision was made about what data to collect next based on data that had already been collected and analysed (Coyne 1997). Therefore it was perceived as suitable for this study to use purposive sampling at the outset and the sampling method then became theoretical.

The limitations of this report prohibit a comprehensive explanation of each decision that was made related to theoretical sampling. Therefore a memo that was written by the researcher after conduct of the second purposively selected focus group has been provided as an exemplar of how data collection and analysis determined theoretical sampling choices:

> *It appears from this latest data that the issues related to working in a part-time capacity are different depending on the number of hours that are worked. Now I think about it this was somewhat evident in what was said in the first focus group. But because participants in this latest focus group were at opposite ends of the number of hours worked the differences were especially highlighted. Those who work fewer hours identify more difficulties (and even when they have the same difficulties as those who work more hours these difficulties seem to be more problematic). I need to recruit participants from all numbers of work hours into the sample to get a better look at this. I especially need to get those who work very few hours and those who work nearly full-time to compare their experiences. (Extract from this researcher's memos, dated 9 August 2003)*

Theoretical sampling was commonly not founded on all of the demographic characteristics of an individual participant. Instead theoretical sampling sought out certain characteristics that had been identified through analysis of previously

collected data as potentially important for exploration. Therefore at times the attempt to access particular demographics for exploration led to a seeming surfeit of other demographic characteristics.

It was not an aim of this study for the sample demographics to mimic the prevalence of those found in the wider regional Queensland part-time nursing population. Rather, a broadness and diversity of participant demographics was sought. Morse (2001) proposed that variation in the sample ensures that the theory represents a well rounded and balanced explanation of the phenomenon. Patton (2002 p.235) posited that 'any common patterns that emerge from great variation are of particular interest and value in capturing the core experiences and central, shared dimensions of a setting or phenomenon'. Smith and Biley (1997) suggested that using a wide range of participants acts as a validity check. Morse (2001), Patton (2002) and Smith and Biley (1997) substantiated this study's theoretical sampling for broad ranging demographics. However, the purpose of theoretical sampling changed as it was directed by whether open, axial or selective coding was the initiator of further data collection (Strauss & Corbin 1998).

2.3.3.1.   Sample profile

The sample was large for a grounded theory study. However, this was based on an attempt to include as much variation in the sample as possible so that the theory that was developed was well rounded and accounted for variation. Diversity of participant demographical characteristics is believed to have enhanced the quality and richness of data.

During the conduct of this study significant professional and personal commitments were a barrier to the researcher travelling throughout regional Queensland to carry out interviews. Consideration of access to participants led to recruitment of the majority of the sample from a wide variety of settings within the one regional Queensland geographical district. Towards the later stages of the study a letter was placed in the Queensland Nurses' Union journal *'The Queensland Nurse'* to recruit part-time nurses to the study from other regional Queensland districts. Sixteen nurses responded and four of these had to be excluded as they were employed casually rather than part-time. Therefore only twelve participants were recruited to the study from four other geographical districts in regional Queensland. However, geographies were not found to be significant to the experiences of nursing while in part-time employment. Instead recruitment of part-time nurses from other geographical regions substantiated earlier study findings and assisted to saturate previously developed concepts. Therefore no further attempt was made to access more participants from other regional Queensland areas.

Though it was not an aim of this study for sample demographics to mimic the wider population it is essential that similarities and dissimilarities are acknowledged at the outset to provide a basis for the interpretation of findings. Therefore, wider nursing labour force data are referred to as these data provide a context to this study. Where sample demographics are inconsistent with that of the wider population a rationale is provided.

The data from demographic survey (Appendices C & D) have been utilised to profile the 103 participants who were recruited to the study. These participants' demographics were divided into findings from the eighty six part-time nurse participants' demographic survey and findings from the thirteen nurse manager and five nurse educator participants' demographic survey. One nurse was employed part-time as a nurse manager. As data were collected from this participant as both a part-time nurse and a manager of part-time nurses, the demographic data have been included in both data sets. Where considered prudent, interview data has been used to further profile sample demographics. As part-time nurse participants were the primary sample cohort of this study they will be referred to as 'participants' in this and the following chapters of this report.

Part-time nurse participants

Tables 1 through to 15 and the associated descriptions present findings from demographic survey of the 86 participants included in the sample.

Table 1: **Gender**

	Sample Number	Total % of Sample (approx)
Male	**6**	**7**
Female	**80**	**93**
TOTAL	86	100

Table 1 identifies that the minority of participants in this study were male which is consistent with the 2001 Australian nursing labour force data that found 8.4% of the Australian nursing population are male (AIHW 2003b).

Table 2:   **Age – part-time nurses**

	Sample Number	Total % of Sample (approx)
< 25 years	**0**	**0**
25 to < 30 years	**3**	**3.5**
30 to < 40 years	**30**	**35**
40 to < 50 years	**40**	**46.5**
≥ 50 years	**13**	**15**
TOTAL	86	100

This study did not directly theoretically sample for the demographic attribute of

age. However, early data analysis identified that a diverse sample age profile

may broaden the richness of data. Thus the researcher monitored, rather than

theoretically sampled, to ensure the recruitment of participants from a range of

ages. The age of participants in this study ranged from twenty five years to over

fifty years (Table 2). The majority were forty years of age or over (Table 2).

Therefore the majority of participants in this study can be said to be part of the

aging Australian nursing labour force (AIHW 2003b).

No participants in this study were less than twenty five years of age (Table 2).

The 1999 nursing labour force data may provide justification to this failure in

recruitment as that source found that only 4.5% of all Queensland employed

nurses were less than twenty five years of age (AIHW 2003a). Somewhat similar

to this study's participants' age profile, 55.5% of all employed Queensland

nurses were aged forty years or more in 1999 (AIHW 2003a).

Table 3:   **Years of nursing experience**

	Sample Number	Total % of Sample (approx)
< 2 years	**1**	**1**
2 to < 5 years	**5**	**6**
5 to < 10 years	**8**	**9**
10 to < 15 years	**12**	**14**
≥ 15 years	**60**	**70**
TOTAL	86	100

Only one part-time nurse participant in this study had less than two years nursing experience (Table 3). This is consistent with anecdotal evidence that nurses in their initial post graduation years tend to primarily work in full-time employment. This may also provide a rationale for the failure of this study to recruit part-time nurses aged less than twenty five years. A substantial majority of participants had fifteen years or more nursing experience (Table 3). Consequently it is realistic to suggest that this sample came from a background of significant nursing experience.

Table 4:   **Healthcare sector where employed**

	Sample Number	Total % of Sample (approx)
Public	**76**	**88**
Private	**10**	**12**
TOTAL	86	100

Table 4 identifies that a large majority of participants in this study were employed in the public healthcare sector. Nursing labour force data (AIHW 2003a, 2003b) ascertains that the majority of Australian nurses are employed in the public healthcare sector however the prevalence in that wider population is smaller than occurs in this study's sample. Australian nursing labour force data recognises that there is a greater tendency for private sector nurses to work in a part-time capacity in comparison with public sector nurses (AIHW 2003a). Also data from this source demonstrates that the average number of hours worked is less for private sector nurses when compared to their public sector counterparts (AIHW 2003a).

Theoretical sampling deliberately included participants from both healthcare sectors to explore whether issues differed based on this demographic characteristic. Findings from data analysis refuted healthcare sector as a

characteristic that specifically impacted on issues. Therefore, the surplus proportion of public healthcare sector participants was a non-deliberate associated outcome of theoretical sampling for other demographical characteristics.

Table 5:   **Practice setting – part-time nurses**

	Sample Number	Total % of Sample (approx)
Acute Care Hospital	**69**	**80**
Nursing Home	**8**	**9**
Mental Health	**4**	**5**
Community	**4**	**5**
General Practice	**1**	**1**
TOTAL	86	100

A large majority of participants in this study were employed in the acute care hospital setting (Table 5). In 1999, 70% of all employed Queensland nurses worked in acute care hospital settings (AIHW 2003a). Based on a theoretical sampling strategy, an attempt was made to recruit part-time nurses from a wide variety of practice settings. Participants were recruited from sixteen of the twenty three areas of nursing that were used to collate Australian nursing labour force data (AIHW 2003b, p. 14). Many of these clinical areas are situated in acute care hospital settings. Therefore, although there is an over-proportion of study participants who work in acute care hospital settings when compared to the Queensland nursing labour force data, the clinical areas where participants are employed is largely reflective of the diversity of areas where Australian nurses work.

Participants in this study were employed in nursing homes, mental health, community, private medical practice and acute care hospital settings. The acute care hospital specialties in which participants were employed included: medical;

surgical; rehabilitation; oncology; renal; intensive care; high dependency; coronary care; emergency department; outpatient department; midwifery; paediatrics; and peri-operative (operating rooms, anaesthetics, recovery, day surgery, sterilising department).

Table 6:   **Employment position level**

	Sample Number	Total % of Sample (approx)
Enrolled Nurse	**7**	**8**
Level 1 Registered Nurse	**54**	**63**
Level 2 Registered Nurse	**23**	**27**
Level 3 Registered Nurse	**2**	**2**
TOTAL	86	100

The majority of participants in this study were employed in Level 1 positions (Table 6). Only two participants were employed in a Level 3 position and none came from higher level positions (Table 6). Therefore the majority of participants in this study held positions as clinicians at the lower end of the Queensland nursing career structure. The 1999 nursing labour force data identified that approximately 89% of all employed Queensland nurses worked as nurse clinicians (AIHW 2003a). Consequently, the large proportion of study participants' in lower employment position levels is similar to that found in the wider Queensland nursing population.

2001 nursing labour force data identified that between 18.5 (Outer Regional) and 25.1 (Inner Regional) percent of regional Queensland nurses employed at Level 3 and above worked in part-time employment (AIHW Unpublished). Though perceived to be beneficial, unfortunately the recruitment strategies utilised in this study failed to gain access to a larger proportion of part-time nurses employed at higher levels. A small minority of participants in this study were enrolled nurses (Table 6). This proportion is smaller than the 16% of enrolled nurses in the wider

Queensland nursing population (AIHW 2003b). Theoretical sampling ensured

recruitment of enrolled nurses to the study and data analysis determined that this

cohort was sufficient to meet this study's data collection needs.

Table 7:   **Years employed in current organisation – part-time nurses**

	Sample Number	Total % of Sample (approx)
< 2 years	**15**	**17.5**
2 to < 5 years	**18**	**21**
5 to < 10 years	**21**	**24.5**
10 to < 15 years	**9**	**10**
≥ 15 years	**23**	**27**
TOTAL	86	100

The majority of participants had been employed in their current organisation for

five years or more (Table 7). A sizeable minority of these participants had been

working in the same organisation for fifteen years or more (Table 7). However,

while Table 3 identified that 70% of participants had fifteen years or more

nursing experience, only 27% had been employed in their current organisation

for fifteen years or more. (Table 7).

Table 8:   **Employment hours per week**

	Sample Number	Total % of Sample (approx)
32 hours	**29**	**34**
28 hours	**9**	**10**
20 - 24 hours	**23**	**27**
16 hours	**17**	**20**
12 - 14 hours	**3**	**3**
4 – 8 hours	**5**	**6**
TOTAL	86	100

Table 8 identifies that the most common employment hours worked by

participants in this study was thirty two hours per week. A notable percentage

was employed to work sixteen hours or less per week (Table 8). The average

employment hours for all participants in this study was 23.7 hours per week

which is lower than the 31.2 hours per week that is found in the wider

Queensland part-time nursing population (AIHW 2003b). The lower average

employment hours for this study's part-time nurse cohort are probably an

outcome of a theoretical sampling strategy to access a range of participant

employment hours.

Only six participants were regularly rostered to work less than eight hour shifts

while the remainder primarily worked eight hour shifts. A small number of

participants were employed in practice settings where ten hour night duty shifts

existed and these participants sometimes worked six hour day or evening shifts to

counterbalance hours. Eight participants permanently worked one time schedule

and for all but one participant these were day shifts. Three of the nurses who

worked one time schedule worked in practice settings where nurses commonly

were expected to rotate shifts throughout the twenty four hour cycle.

Table 9:   **Regularly work extra hours**

	Sample Number	Total % of Sample (approx)
No	**47**	**55**
Yes	**39**	**45**
TOTAL	86	100

A little under half of the participants in this study regularly worked extra hours in

their part-time position (Table 9).

Table 10:   **Employed in more than one job**

	Sample Number	Total % of Sample (approx)
No	**61**	**71**
Yes	**25**	**29**
TOTAL	86	100

A minority of participants were employed in more than one job (Table 10). Most

of these participants worked eight hours or less a week in their additional

position. Further analysis of interview data identified that those employed in an

additional nursing position most commonly traversed sectors to work for another

agency. As the majority of participants in this study were employed in the public

healthcare sector (Table 4), additional nursing employment had commonly been

accessed in the private sector and for a small number, by accessing nursing

employment in the tertiary educational system.

Table 11:   **Educational forum for basic nursing qualification**

	Sample Number	Total % of Sample (approx)
Hospital	**71**	**83**
TAFE	**1**	**1**
Tertiary	**14**	**16**
TOTAL	86	100

A majority of participants had gained their basic nursing qualification through a

hospital-based program (Table 11). This demographic characteristic could

reasonably be expected when considering the relative recency of availability of

undergraduate tertiary nursing education in Queensland and that the majority of

participants had fifteen years or more nursing experience (Table 3).

Table 12:   **Highest post-registration qualification**

	Sample Number	Total % of Sample (approx)
Nil	**25**	**29**
Other	**8**	**9**
Hospital-Based Certificate	**14**	**17**
Bachelor	**13**	**15**
Graduate Certificate	**12**	**14**
Graduate Diploma	**8**	**9**
Master	**5**	**6**
Ph.D	**1**	**1**
TOTAL	86	100

Table 12 shows that a significant majority of participants in this study had

attained post-registration qualifications. A notable minority had achieved a

highest post-registration qualification of equal to or higher than graduate diploma

level (Table 12). The seven enrolled nurse participants in this study are included

with the thirty three participants who had 'nil' or 'other' as their highest post-registration qualification (Table 12). The remaining twenty six participants were registered nurses. Further analysis identified that one third (33%) of all registered nurse participants in this study had less than a hospital-based certificate as their highest post-registration qualification.

Table 13: **Current study towards post-registration qualification**

	Sample Number	Total % of Sample (approx)
Nil	**65**	**76**
Other	**6**	**7**
Bachelor	**1**	**1**
Graduate Certificate	**3**	**3**
Graduate Diploma	**2**	**2**
Master	**5**	**6**
Ph.D	**4**	**5**
TOTAL	86	100

Data in Table 13 identifies that most of the participants in this study were not studying towards a post-registration qualification. Further analysis identified that 62% of the registered nurse participants who had 'nil' or 'other' as their highest post-registration qualification were not studying towards any level of post-registration qualification and a further 8% were studying towards the qualification category of 'other'. Cross analysis of data also identified that a majority of these registered nurses had a youngest dependant child at or below primary school age. Additional analysis ascertained that because of their non-participation in formal learning, just less than one quarter (23%) of all registered nurse participants in this study would, at least in the short-term, continue to have less than a hospital-based certificate as their highest post-registration qualification. A small percentage of participants were studying towards a master or doctorate level of post-registration qualification (Table 13).

Table 14:   **Youngest child dependant**

	Sample Number	Total % of Sample (approx)
< Preschool	**20**	**23**
Preschool	**4**	**5**
Primary School	**23**	**27**
Secondary School	**15**	**17.5**
> Secondary School	**9**	**10**
N/A	**15**	**17.5**
TOTAL	86	100

The majority of participants in this study had a youngest dependant child of

primary school age or less (Table 14).

Table 15:   **Aged dependants**

	Sample Number	Total % of Sample (approx)
No	**71**	**82.5**
Yes	**15**	**17.5**
TOTAL	86	100

Table 15 identifies that a minority of participants in this study had responsibility

for an aged dependant. Cross analysis of demographic data ascertained that

thirteen (15%) of all participants had no responsibility for dependants. Further

analysis identified that 87% of those participants with aged dependant

responsibilities also had simultaneous dependant child responsibilities.

Nurse manager and nurse educator participants

Tables 16 through to 19 and the associated descriptions presents findings from

demographic survey of the thirteen nurse manager and five nurse educator

participants who were included in the sample. Demographic data collected from

the nurse manager and nurse educator participants were combined prior to

analysis. The rationale for this emanated from interview data analysis identifying

that though the two roles have separate responsibilities for management of part-time nurses, there is also much overlap of responsibilities.

Of the eighteen participants in this sample, only one (6%) was male. Two (11%) participants were employed in the private healthcare sector while the remainder (89%) were employed in the public sector. The researcher deliberately theoretically sampled for these participants to mimic the healthcare sector demographic proportions of participants. All except one nurse manager was in full-time employment. Eleven (61%) had experience working in part-time employment.

Nurse manager participants in this study were employed in varying practice settings that impacted on the size of the nursing workforce that they were directly responsible for. These participants directly managed from twelve to forty four registered and enrolled nurses each. The proportion of nurses working part-time for which each manager had direct responsibility varied widely from twenty five to 83%. The average proportion of nurses working part-time that nurse manager participants were responsible for was 53% which is consistent with the proportion of employed Australian nurses working part-time (AIHW 2003b).

Table 16:   **Age – NM/ NE**

	Sample Number	Total % of Sample (approx)
< 30 years	**0**	**0**
30 to < 40 years	**2**	**11**
40 to < 50 years	**9**	**50**
≥ 50 years	**7**	**39**
TOTAL	18	100

Table 16 demonstrates that the majority of nurse manager and nurse educator participants were forty years of age or over and a significant percentage were fifty years of age or over. Collation of nursing labour force data combines nurse clinicians and clinical nurse managers making it difficult to get an accurate appreciation of age related factors for those nurses employed at Level 3 and above (AIHW 2003a, 2003b). However, data that are available suggests that Australian nurses who are employed at higher levels are on average older by several years when compared to the average age of those who are employed at lower level positions (AIHW 2003b).

Table 17:   **Years managerial/ educational experience**

	Sample Number	Total % of Sample (approx)
< 2 years	**3**	**17**
2 to < 5 years	**3**	**17**
5 to < 10 years	**2**	**11**
10 to < 15 years	**2**	**11**
≥ 15 years	**8**	**44**
TOTAL	18	100

The majority of nurse manager and nurse educator participants in this study had ten years or more of relevant managerial/educational experience (Table 17).

Table 18:   **Practice setting – NM/ NE**

	Sample Number	Total % of Sample (approx)
Acute Care Hospital	**15**	**82**
Nursing Home	**1**	**6**
Mental Health	**1**	**6**
Community	**1**	**6**
Private Medical Practice	**0**	**0**
TOTAL	18	100

Nurse manager and nurse educator participants were recruited from diverse practice settings; as was used in the recruitment of part-time nurses. The majority of nurse manager and nurse educator participants in this study were employed in

the acute care hospital setting (Table 18). It was not the aim of this study to replicate the proportions found in the wider nursing population in relation to practice setting. Rather the aim was to survey a diversity of practice settings where these nurses were employed; as was the case for the part-time nurse cohort of this study.

Table 19:   **Years employed in current organisation – NM/ NE**

	Sample Number	Total % of Sample (approx)
< 2 years	**1**	**6**
2 to < 5 years	**0**	**0**
5 to < 10 years	**4**	**22**
10 to < 15 years	**4**	**22**
≥ 15 years	**9**	**50**
TOTAL	18	100

Half of the nurse manager and nurse educator participants in this study had been employed in their current organisation for fifteen or more years and only one participant for less than five years (Table 19).

The report from the demographic survey of the sample has identified a diversity of characteristics that is believed to have enhanced the quality and richness of data in this study. Reference to these data will be made to extend analysis when reporting the findings from the grounded theory analysis of interview data.

2.3.4.   Data collection

The grounded theory approach commonly collects data using a variety of methods. There were a variety of potential data sources available for use in this study including demographic survey, participant observation, literature review and interview (Benoliel 1996; Creswell 1994). Demographic survey data was used in this study as a form of adjunct data to enhance understanding by testing

concepts and developing theory. When considering the aim of the study, participant observation was not perceived as a suitable source of data as the researcher believed that this would merely provide snapshots that would not contribute significantly to theory development (Morse 2001). However, this data source was not totally discounted. Rather the grounded theory method was used to identify if it would be useful to compare observed against reported incidents.

As already discussed earlier in this chapter, a large and varied sample was recruited to the study to provide multiple sources of data. This enabled comparisons of self-reported incidents against other self-reported incidents. Common patterns that emerged through a preponderance of data provided validation to these self-reports that negated the need to confirm them through participant observation. Additionally this study's underlying assumptions of symbolic interactionism determined that participants' perceptions of their social worlds were more important than trying to access objective reality. Another inducement to forgo participant observation as a means of data collection was that interviews enabled access to descriptions of continuous experiences that contrasted favourably with the snapshots that would be gained through observational data (Morse 2001). The use of the literature has been discussed earlier in this chapter and a limited volume of relevant literature was used as data.

Interview is the main source of data in nursing studies that use a grounded theory approach (Backman & Kyngas 1999; Schreiber 2001). As already suggested, the premise of this study was that 'reality' is the meaning interpreted from shared

and individual interactions with phenomena (Cutcliffe 2000). Grounded theory has emerged from symbolic interactionism whereby social life is expressed through symbols with language being the most symbolic system (Annells 1996). Based on this factor it was perceived appropriate that interviews were the prime source of data for this study. However, Benoliel (1996) proposed that use of interviews as a sole data source can result in the focus of the study being narrowed to the lived experiences of participants rather than incorporating the social processes that take place over time. This researcher was aware of this potential. Evaluation of the interview data collected by this study determined that there was description and explanation of both the experiences and the social processes that were taking place over time.

2.3.4.1.   Selection of types of interviews

Interviews can be individual or group and can be conducted face-to-face, by telephone or via email (Bampton & Cowton 2002; Creswell 1994). Therefore this researcher had to make some decisions related to data collection through interviews. Sword (2003) incorporated both focus group and individual interviews as data collection strategies for that grounded theory study. The decision was made to use both individual interviews and focus groups to collect data for the study as this would result in data that identified shared and individual perceptions to the topic. Focus group interviews have been suggested to permit a less structured interview format than individual interviews (Nyamathi & Shuler 1990; Stewart & Shamdasani 1990). However, in both focus group and individual interviews it was possible to use an unstructured to semi-structured question guide to avoid the potential for limiting discussion and introducing

researcher bias that may accompany a list of detailed questions. Interviewer bias can present when the emphasis is on the researcher's rather than the participants' perceptions of the issues (Morgan 1995).

Milliken and Schrieber (2001) proposed that focus group interviews were ideal in grounded theory studies of nurses' work lives. As this was consistent with the aim of this study the focus group technique was considered an appropriate starting point for data collection. However, Morse (2001) proposed that focus groups were not suited for developing grounded theory as they provide data that is disjointed. Initially participants were purposively recruited to two focus groups as a means to enable the researcher to gather rich and wide ranging data that was based on participants' perceptions of the issues, rather than the researcher's perceptions. Apart from another two focus group interviews that were conducted early in the study, individual interviews were used to collect data from participants.

Focus groups have been defined by Nyamathi and Shuler (1990 p. 1282) as:

> ... a qualitative research method for gathering information which ...
> allows the investigation of a multitude of perceptions on a defined
> area of interest.

Focus groups provided an excellent forum for generating authentic data, rich in quality, due to the candour and spontaneity of the participants in an atmosphere of dynamic group interaction (Jamieson & Mosel Williams 2003). Critical analysis of available literature deduced that ideally focus groups consist of 4 to 12 relatively homogenous participants (Jamieson & Mosel Williams 2003; Kreuger 1994; Stewart & Shamdasani 1990). Each focus group in this study

consisted of four or five participants (n=5+5+4+4). The rationale for these smaller numbers of participants was that time constraints would limit optimal participation by all members if groups were large (Jamieson & Mosel Williams 2003). Additionally an operational rationale was the difficulty of getting larger numbers of nurses in the same place at the same time when they were attending in personal time. Homogeneity of focus groups facilitated group cohesiveness and permitted open and active discussion (Jamieson & Mosel Williams 2003). Part-time employment was the homogenous characteristic used. However, variation in other participant attributes was sought. This heterogeneity among participants' other characteristics encouraged dynamic group interaction and allowed diversity of opinion (Ekblad, Marttila & Emilsson 2000; Kitzinger 1994).

The grounded theory approach required a close interplay between sampling, data collection and data analysis that directed impending sources for data. As the study progressed, this interplay determined the type of interview that was most appropriate to gain needed data. Morse's (2001) suggestion that focus groups may not be appropriate and recognition that individual interviews would be the best strategy to gain an insight into individual's interpretations of meaning led to this strategy being most commonly used in this study.

All focus group and most individual interviews were conducted face-to-face. This was perceived to be the best method for interviewing participants as it allowed a rapport to be established with participants that was believed to enhance the potential for collection of rich data. This strategy also allowed observation of

non-verbal cues that assisted in interpretation of meaning. However, face-to-face interviews were not suitable in all cases. Seven interviewees who were geographically distant from the researcher were interviewed by phone. Both face-to-face and phone interviews are well established methods of interviewing (Bampton & Cowton 2002). Phone interviews provided similar benefits to face-to-face interviews. However, because the researcher could not observe non-verbal cues an increased sensitivity to the tones of participants' voices was needed. All participants who were geographically distant to the researcher were given the option of phone or email interviews. Five participants chose to be interviewed via email.

There is a small literature related to online interviews (Heflich & Rice 2001). Selwyn and Robson (1998) suggested that this medium may be conducive to qualitative research such as grounded theory studies. Each email interview comprised of three to five episodes of questioning. The decision was made to give questions in small clusters to avoid overloading participants. The email interviews attempted to adopt a conversational tone by using a chatty genre on first and subsequent email contacts and by ensuring that all subsequent questions also contained probes that were referenced to previous responses (Heflich & Rice 2001). The advantages of this interview method were that: interviews were inexpensive and overcame barriers of time, space and location; responses from researcher and participants could be at the convenience of each; there was time for both researcher and participants to reflect on responses; and responses were already transcribed (Bampton & Cowton 2002; Heflich & Rice 2001; Selwyn & Robson 1998). However, a number of disadvantages were experienced including:

loss of access to non-verbal communications; and the length of time two participants took to respond to each episode of questioning fragmented the interviews (Bampton & Cowton 2002). Nonetheless the email interviews added a diversity of interview methods that contributed to the quality data collected by this study.

2.3.4.2.   Interview process

The researcher acknowledged that the interview process would impact upon the data collected (Wimpenny & Gass 2000). As already discussed, the researcher presented herself as a peer part-time nurse. A casual and relaxed atmosphere was deliberately encouraged and interviewing primarily took on a conversational tone to enhance this aim. Researcher sensitivity to interviewee and data was used to assist to know when to probe and ask questions and when to just listen so that participants maintained maximum control of the interview (Charmaz 1994; Duffy, Ferguson & Watson 2004). The researcher was also attentive to her own non-verbal communications so that these did not negatively impact upon the interview (Duffy, Ferguson & Watson 2004).

The settings for each face-to-face interview was carefully considered as these decisions were perceived to potentially impact on the quality of data collected. The initial two focus group interviews were held in the researcher's home. Lunch was provided to facilitate a relaxed and conversational atmosphere in an attempt to set a scene for unstructured interviews that would gain spontaneous quality data. The majority of the face-to-face interviews were conducted in participants' workplaces as this was the 'natural setting' of the phenomenon being

investigated. Additionally all participants were interviewed in their personal time and it was often convenient for participants to be interviewed in their workplaces before or after their shift. When workplaces were used organisational permission was gained to use a room that had a power point for audio-tape equipment, was quiet, would maintain confidentiality and avoid distractions and interruptions. A small number of individual interviews were held in participants' homes as child caring responsibilities made it difficult to meet at an alternate location.

May (1991) proposed that though precise description of data collection procedures is a hallmark of scientific work, this is challenging in the case of interview procedures. This study's interview procedures were adjusted in response to ongoing theoretical sampling, data collection and analysis making it difficult to articulate all specific procedures. The conduct of interviews was directed by the methodology to ensure that interviewing methods were appropriate (Wimpenny & Gass 2000). This study's use of unstructured interviews initially and semi-structured interviews as the study progressed was consistent with the grounded theory approach (Duffy, Ferguson & Watson 2004). Face to face and phone individual interviews lasted from 20 to 95 minutes and focus group interviews lasted from 65 to 130 minutes. Each interview commenced with two broad and open ended questions '*Can you tell me what lead you to work part-time?*' and '*Can you tell me about your nursing experiences as a part-timer?*' (probe that was not often needed: '*Have you experienced any benefits or difficulties to your nursing practice while you have been employed part-time?*'). These two questions were used in every interview as it was found that they were broad enough to open up discussions that allowed

participants to lead the interview into the issues that were important to them. The aim was to conduct unstructured in-depth interviews so that participants' stories could be fully recounted without being constrained by researcher questioning; thereby enabling collection of data related to the concerns and view points of participants (Wimpenny & Gass 2000).

This strategy avoided the interviews being narrowly focussed towards the researcher's impressions of the issues. New data were eagerly sought throughout the entire study to both develop new concepts and saturate previously identified concepts. As a result this study remained predominantly inductive (Strauss & Corbin 1998). As the study proceeded the initial part of each interview remained unstructured but a semi-structured approach was used in the later parts of interviews to enable the researcher to more comprehensively explore issues of interest which had not spontaneously been brought into the discussion (May 1991). Therefore as the study progressed the interviews became more driven by emergent theory (Wimpenny & Gass 2000). Ongoing analysis influenced theoretical sampling and the interview questions that formed the basis for data collection. To ensure that all relevant data had been accessed each interview ended with the question 'Is there anything else that I should know that we haven't discussed?' (Schreiber 2001).

2.3.4.3.   Data

Demographic data was collected from all study participants to provide the researcher with a basis to theoretically sample and with an opportunity to comparatively analyse data. Without prior knowledge of the issues that were

identified by this study, it was difficult to predetermine what demographic data was relevant. Because of this, general demographic data related to individual, social and professional characteristics was collected. Though the researcher asked each study participant to consent to be contacted again if further demographic data was required, contact for that reason was not necessary. Findings from demographical survey have been reported earlier in this chapter (section 2.3.3.1).

Observational notes were taken from focus group sessions to ensure that the data collected included group dynamics and unspoken communications. This was an important aspect of data collection from focus groups as dynamic group interaction is central to quality data collection. As already discussed there is ambiguity about how to use the literature in grounded theory. The literature was reviewed at a later stage in the study and a limited volume of relevant literature was used as data.

This researcher was employed as a nurse in a healthcare facility throughout the entire study. During this time many part-time nursing colleagues enquired about the study and spontaneously shared their own stories with the researcher. All is proposed to be data in grounded theory which potentially included these informal conversations (Glaser 2002a; Schreiber 2001). However, this researcher believed that use of informal conversations as data was fraught with ethical dilemmas as permission had not been gained from these nurses to participate in the study. Therefore the researcher limited use of informal conversations to the confirmation of emerging issues (Strauss & Corbin 1998).

Grounded theorists disagree about whether or not tape recording of interviews is appropriate (Schreiber 2001; Stern & Covan 2001). Data was collected in this study using audio-recording of individual and focus group interviews. Audio-recording was preferred as it removed the distraction of detailed note taking (Schreiber 2001). Additionally it permitted full transcription of the interviews which assisted analysis because the exact statements of participants were available (Bertrand, Brown & Ward 1992; Sim 1998). This strategy also assisted to limit researcher bias. Human beings hear only some of what is said by others and may focus on what they want to hear. Reading the transcriptions of taped interviews enabled retrospective insight into issues that were missed during the actual interview. Also when new issues emerged during the study the researcher was able to revisit earlier interview transcripts to identify if these phenomena had been previously mentioned but had not been recognised as important. This was the case in a number of instances.

2.3.5. Data analysis

As already stated, the researcher was an instrument of the research process and data analysis was reliant on the researcher's analytical thinking skills and creativity so that meaning and connections could be interpreted from the data to develop theory (Strauss & Corbin 1998). The interplay between the researcher and the data was the foundation of the analytic process (Strauss & Corbin 1998). As already discussed, this researcher aimed to balance objectivity with sensitivity to maximise accurate interpretation of meaning from data. This study generally

followed Strauss and Corbin's (1998) procedure for analysis of data without rigidly following all procedural steps.

2.3.5.1. Focus group data

Individual interviews resulted in audio-recorded data and resultant transcriptions that were available for analysis of individual meanings. However, focus group interviews presented some variations to analysis. Because the uniqueness of focus group data is based in the group interaction, focus groups' interaction/ dynamics and non-verbal behaviours observed and recorded for each group session were analysed in conjunction with the audio-recorded focus group data and the resultant transcriptions. The group interaction that occurred during focus groups determined that the 'group' should be the primary unit of analysis. However, data analysis took into account both the individual and the group and was sufficiently flexible to identify if one was influencing the other before conclusions were drawn (Kidd & Parshall 2000). Carey and Smith (1994) used this concept when they suggested that focus group data be analysed:

1.   At the group level: this includes interactional and sequential analysis with potential consideration of censoring, conformity and 'group think'.

2.   At the individual level: responses are analysed without regard to group context.

3.   As comparison: of individual responses against group data where responses are contextually analysed.

2.3.5.2. Preliminary procedures

Whether gathered data was from individual or focus group interviews, preliminary activities of data analysis were attended. As the researcher's

secretarial skills are limited, the audio-taped interviews were sent to a research assistant within a few days after collection to be transcribed verbatim. Though the turn around-time for these transcriptions was fast, a copy of the audio-tapes was kept so that immediate analysis could be initiated (Duffy, Ferguson & Watson 2004). This was an attempt to lessen the timeframes between analysis and further theoretical sampling and data collection. When transcriptions of the audio-tapes were returned they were subsequently audited for quality. This was achieved by listening to the audio-taped interview whilst reading the transcription. During this procedure, a code was attached to anonymously identify the participant responsible for responses. When data was from focus groups, multiple codes were necessary within one transcript to discriminate between respondents.

The transcripts were read a number of times in conjunction with the audio-taped interviews, and the observational notes taken for focus group interviews, to enable the researcher to become immersed in the data. Analysis of data consistently utilised memo writing and comparative analysis and followed a process of open, axial and selective coding, as suggested by Strauss and Corbin (1998).

2.3.5.3. Memo writing

Memo writing is central to the grounded theory approach. The strategy was used from the very beginning of this study and only ceased when the findings chapters of this report had been written. Memos were used as notes written to self that provided a means to document any thoughts related to the study (Goulding 1999;

Smith & Biley 1997). An example of a memo was provided earlier in this chapter. They were used as a form of documentation of ideas that were separate from data and it was through these ideas that data were raised to the conceptual level (Duchscher & Morgan 2004). That is certainly not to say that all memos were conceptual writings because many were far from that. However, they were ideas that continuously contributed towards theory development.

Strauss and Corbin (1998) expanded the original grounded theory notion of memoing by identifying various types of memos including code notes, theoretical notes, operational notes, and logical and integrative diagrams. Their expectation is that the memos that are written will be at the conceptual level of complexity that corresponds to the coding stage that they relate to. This researcher considered that this view of memoing was far too procedural and complex; a suggestion that was substantiated by Duchscher and Morgan (2004). Rather than being concerned with literary precision, this researcher continuously wrote memos that were anything from mere 'scratchings' in the half dark when ideas came after going to bed at night to many pages of insightful conceptualisations. Irrespective of the quality or level of the memos, the process provided a means to conceptualise data and provided an excellent audit trail for decision making processes. Diagrams were also continuously used throughout the study as a means to gain visual representation of conceptualisations. The diagrams used in Chapters 3, 4 and 5 are the end products of continuously evolving schematic conceptualisations.

Though no attempt was made to follow Strauss and Corbin's (1998) memoing techniques in this study later assessment of the memos that had been written found that they did in fact fall into the types identified. While this factor validates the merit of Strauss and Corbin's (1998) memoing techniques this researcher retrospectively believes that a deliberate attempt to follow the techniques would have been detrimental to the process. However, Strauss and Corbin's (1998 p.241) simpler suggestion that '(m)emos contain the products of coding, provide direction for theoretical sampling, and enable the analyst to sort out ideas in his or her mind' was deliberately followed.

2.3.5.4. Comparative analysis

Comparative analysis is an essential feature of grounded theory methodology (Strauss & Corbin 1998). Strauss and Corbin (1998) present two types of comparative analysis; the constant comparative method and theoretical comparisons. The constant comparative method was used throughout the analytic process and involved comparing incident to incident in data looking for similarities and differences to facilitate the development of concepts and the grouping of these under higher order categories (Ezzy 2002; Strauss & Corbin 1998). Data earned its way into the study when constant comparative analysis revealed repeated patterns in data (Chiovitti & Piran 2003). The technique involved not only comparing data against itself, but comparing against other data and finally against conceptualisations (Duchscher & Morgan 2004). Therefore though inductive strategies predominated, deductive processes were at work because the grounded theory approach simultaneously validates theory through the constant comparative method (Miller & Fredericks 1999; Morse & Field

1996). Comparative analysis was also essential to revealing the point of saturation when no new data was emerging that determined when data collection was to cease ('Grounded theory and constant comparative analysis.' 2004).

Theoretical comparisons, through using the literature and past experiences to stimulate analytic thinking, were not used as the properties and dimensions of categories became evident within data without the need to rely on this tool (Strauss & Corbin 1998). Additionally this researcher perceived that the theoretical comparisons technique was not congruent with Strauss and Corbin's (1998) expectation of objectivity. The researcher's past experiences were used as a means to enhance sensitivity to meanings in data but were not used as a means to look for specific concepts that did not emerge by themselves from data. The literature was used at the later stages of data collection and analysis to contextualise already developed concepts rather than being used as a means to find specific concepts that did not emerge by themselves from data. Avoidance of the theoretical comparisons procedure was believed to have assisted to allow 'emergence' of theory rather than forcing it from data. Analysis looked 'at' data rather than looking 'for' data (Robrecht 1995). The constant comparative method was a powerful tool that ensured the study findings accurately represented identified phenomena rather than being biased by the researcher's past experiences and the literature (Elliot & Lazenbatt 2005).

2.3.5.5. Open coding

The open coding process involved the data being closely examined and compared for similarities and differences though the constant comparative

method to inductively identify emerging concepts. This analytic technique required in-depth analysis to enable discernment of the range of potential meanings contained in the language of the text (Strauss & Corbin 1998). A concept was a labelled phenomenon that was an abstract representation of something in the data that the researcher interpreted as significant (Strauss & Corbin 1998). Labelling of concepts commenced at the beginning of the analytic process and continued until new data failed to identify new concepts. The labels were commonly reworded as the researcher tried to find the best name for a pattern that was coming out of data (Glaser 2002b).

There was one instance where the literature was used to assist to reword a label so that there was a more recognisable description for a concept that had already developed from this study's data; a decision that was substantiated by Strauss and Corbin (1998). Nonetheless the wording of all other concept labels came directly from the researcher's creative effort to find the best name for the patterns that came out of data. The process of labelling concepts and grouping these into categories reduced the data to be more manageable (Strauss & Corbin 1998). Identification of categories enabled additional development through further theoretical sampling, data collection and analysis to identify the specific properties and dimensions of each category. Strauss and Corbin (1998 p.117) clarified these by stating that 'whereas **properties** are the general or specific characteristics or attributes of a category, **dimensions** represent the location of a property along a continuum or range'.

2.3.5.6.   Axial coding

Axial coding is a complex process of putting the data that has been fragmented by the open coding process back together in new ways by making connections between categories and subcategories (Backman & Kyngas 1999; Strauss & Corbin 1998). During the axial coding process, some of the previously identified categories were renamed as subcategories. A category stands for a phenomenon whereas a subcategory answers questions about the phenomenon (Strauss & Corbin 1998). Strauss and Corbin (1998 p. 127) stated that:

> (w)hen analysts code axially, they look for answers to questions such as why or how come, where, when, how, and with what results, and in so doing they uncover relationships among categories.

During open coding phenomena were revealed and coded and there was no specific attempt to identify concepts as problems, conditions or processes (Strauss & Corbin 1998). Instead it was through the axial coding process of looking for answers to questions that the problem, conditions and process were able to be identified and related to each other. However, it is important to note that open and axial coding were not truly linear as they also occurred reciprocally (Strauss & Corbin 1998).

Strauss and Corbin (1998) provided the coding 'paradigm' which is an organisational scheme to assist the conceptual analysis of data into the causal and intervening conditions that are circumstances in which phenomena are embedded, the actions/interactions that are the responses (process) made to the problem and the consequences of these actions/interactions. The use of Strauss and Corbin's (1998) paradigm assisted to sort out relationships between concepts and categories. However, Strauss and Corbin's (1998) advice to avoid the rigid

use of this paradigm was taken. The study discovered the 'basic social problem' that was being experienced by participants. This is a term used by Glaser (1978) to denote the overriding problem that a cohort being studied have to deal with and which may not be known to them. The paradigm assisted to identify the 'basic social process' that was being used by participants to respond to the problem. This is also a term used by Glaser (1978) to distinguish a particular type of category that is processural, has two or more stages or phases and accounts for change over time. Strauss and Corbin (1998) do not use the terms 'basic social problem' and 'basic social process'. Rather these are Glaserian terminologies. However, use of these terminologies does not represent a divergence from the Straussian version of grounded theory. The terms were used to report this study's findings as they are well recognised by grounded theory researchers and are apt terms to distinguish the particular types of categories that were discovered.

Strauss and Corbin (1998) have provided the analytic tool called the 'conditional matrix' that is suggested to be a technique to stimulate thinking about the relationships between micro and macro conditions and consequences and their relationships with process. This researcher found this technique quite difficult to understand and was 'relieved' to find that the tool did not have to be used as these relationships emerged from data on their own. Therefore the study did not use the conditional matrix.

2.3.5.7. Selective coding

Selective coding was the process of building theory through integration and refinement (Strauss & Corbin 1998). It involved the identification of the 'core' category or major theme of the research from which theory emerged (Strauss & Corbin 1998). Analysis of this study's findings utilised selective coding to identify a core category and other major categories were related or integrated to the core category through explanatory statements of relationship, as suggested by Strauss and Corbin (1998). The core category was: central, with all other major categories related to it; appeared frequently in the data; and provided a logical and consistent explanation that evolved by relating the categories (Strauss & Corbin 1998 p.147). This procedure outlined a basic theoretical scheme.

The theory was then refined through removing excess codes and as appropriate, developing categories through further theoretical sampling, data collection and analysis until saturation occurred (Strauss & Corbin 1998). This development incorporated Strauss and Corbin's (1998) suggestion that it is important that the theory accounts for variation both within and between categories. Thus the potential for multiple 'realities' related to part-time nursing was accounted for in the developed theory. The refined theory was then validated by the strategies reported later in this chapter (section 2.3.6). These strategies and the actual writing of the report of the findings enabled further refinement of the theory. Therefore the selective coding stage of analysis continued until the report of the findings was finalised.

2.3.5.8. Computer assistance

Data analysis was a manual process using the sorting facilities of QRS NUD*IST Vivo (NVivo) computer software. The process was a manual one because computers are not capable of interpreting meaning in data and this was essential to the analysis process (Strauss & Corbin 1998). Richards (1999) and Fraser (1999) provided guidance for using this software. NVivo provided the tools to handle rich data records by coding and categorising. It would have been very difficult using highlighter pens to code and categorise the volume of hardcopy transcripts that emanated from this study. However, there is some debate regarding the use of computer software in grounded theory analysis because the approach requires the ability to see data as a whole and then to leave data behind (Goulding 1999).

Data collected from this study's large sample resulted in a sizeable volume of transcript data and NVivo provided a means to store transcripts and to generate a hardcopy Document Text Report of the intact transcriptions that included allocation of a number for each text segment. Text can be segmented using NVivo's sorting capabilities to enable all text related to a specific code to be sorted together as a coded text unit. Analysis made some use of this strategy. However, as the grounded theory approach requires the analyst to see data as a whole, segmentation of text was done in whole paragraphs to reduce the potential for loss of context. Additionally retrieval of coded text units within NVivo include text segment numbers. This permitted easy identification of segmented data within the intact hardcopy transcripts so that the context and sequence of participant responses could be easily verified. MacDonald and Schreiber (2001)

substantiated the value of this when they proposed that qualitative software can actually speed up and extend the analytic process as the researcher is able to move quickly from concept to raw data.

2.3.6. Validity

One criticism of qualitative research is that it lacks scientific rigour (Horsburgh 2003). A number of authors have highlighted that though grounded theory is being increasingly used by nurse researchers there are problems with how the methodology is being used (Becker 1993; Benoliel 1996; Elliot & Lazenbatt 2005; Wilson & Hutchinson 1996). Elliot and Lazenbatt (2005 p.49) provided five sets of criteria for assessing the quality of research: quantitative; qualitative; universal; original grounded theory; and Strauss and Corbin's grounded theory.

As Strauss and Corbin's (1998) version of grounded theory was used for the study it is appropriate that their criteria be met in the evaluation of the quality and validity of the study. Strauss and Corbin's (1998 p.268-271) criteria for evaluation included judging the 'research process' that was used for the study and ensuring 'empirical grounding of a study'. All research processes have been made explicit to enable the reader to evaluate the quality of the 'research process' (Smith & Biley 1997). A quality grounded theory study requires: use of memo writing; constant comparative analysis; a continuous cycle of theoretical sampling, data collection and analysis; identification of a core category; and development of a theory (Strauss & Corbin 1998). These vital elements have been included into this grounded theory study to ensure a high quality 'research process'.

The report of the study's findings that is provided in Chapters 3, 4 and 5 provide

the reader with the building blocks that led to discovery of the theory so that

empirical grounding of the study can be evaluated. The basic social problem, the

conditions that influence the problem and the basic social process have been

identified. All concepts have been systematically related to each other (Strauss &

Corbin 1998). Strauss and Corbin (1998 p.272) proposed that the theory should

stand the test of time and become part of discussions in professional groups.

Publication of the findings and testing of the theory in similar and other contexts

are required prior to evaluation of these criteria.

Researcher bias was avoided through the methods documented earlier and this

enhanced the study's validity (Chiovitti & Piran 2003). Decision making

processes have been documented to increase validity (Strauss & Corbin 1998).

The constant comparative method was used throughout the study in order to

constantly check for consistency of conceptualisations that emerged from data

(Smith & Biley 1997). This method provided a tool to correct inaccuracies in

conceptualisations and therefore provided an ongoing means to validate and

verify developing theory. The developed theory was taken back to participants to

gain 'member' verification and validation (Strauss & Corbin 1998). Member

verification and validation in the later stages of analysis is not strictly necessary

in a grounded theory study as there is an in-built verification and validation that

is embedded in the constant comparative method (Elliot & Lazenbatt 2005).

Additionally the developed theory was a conceptualisation of findings from a

large number of individuals that may have made it difficult to return the findings

for member checking (Horsburgh 2003). However, member checking of the developed theory was included into the later stages of the study. The theory was taken back to a proportion of participants to establish that it was 'recognisable' to their situation. Consistent with Glaser's (1992) suggestion, participants did not initially fully recognise the substantive theory that had been found by the study. It was only when the sub-categories, properties and dimensions were explained that the theory became recognisable. All discussed how their situations 'fit' the theory and they commonly spontaneously discussed other nurses' situations as they related to the theory. These conversations allowed the theory to come 'alive' and provided validation.

The process of validation and the actual writing of this report enabled further minor refinement to the theory. The writing of this report enabled a high-level comparative analysis, that formed part of the validation process, where raw data was compared to the developed substantive theory, as was suggested by Strauss and Corbin (1998). The coding process detailed earlier enhanced internal validity. The literature was reviewed at the later stages of analysis and was used as a comparison to contextualise findings and therefore provide validation of the findings. Participants own words have been used in the report of the findings to further enhance the validity of the developed theory (Backman & Kyngas 1999; Sarantakos 1993).

The developed substantive theory is relevant to the population from which it was derived and directly attempts to offer insight, enhance understanding and inform action; as suggested by Strauss and Corbin (1998). Strauss and Corbin (1998)

proposed that rather than determining generalisability, it is the explanatory and predictive ability of the developed theory that is the area to be critiqued. The developed theory is believed to be explanatory and predictive for the context of the study. However, further research would be necessary to truly determine whether the substantive theory developed in the context of this study is applicable to other contexts (Strauss & Corbin 1998). This study specified the conditions that pertained to the phenomenon to allow the generalisability of the theory to be empirically tested by further research in similar and other situations where the phenomenon occurs.

2.3.7. Ethical considerations

This study was supervised at an appropriate level as it was being conducted for award of a doctoral degree at Central Queensland University (CQU). Ethical clearance was obtained from the Human Research Ethics Committee of CQU. Access to potential participants was gained by application for ethical clearance from the ethics committees at the recruitment sites. Applications were successful before recruitment and data collection began. The study was explained to potential participants in an Information Sheet (Appendix A) and the researcher's contact details were provided to enable participants to access further information. Formal written informed consent (Appendix B) was obtained from all participants prior to commencement of data collection.

Anonymity and confidentiality have been addressed in a variety of ways during this study. Audio-tapes from focus group and individual interviews were transcribed by a research assistant who was regulated by ethical controls

regarding confidentiality and anonymity. To further support these two ethical considerations, the transcripts referred to individual participants by codes. As is the case when using focus groups, anonymity is not possible and it is impractical to guarantee participants absolute confidentiality because the researcher has no control over participants after they leave the sessions (Smith 1995). Assurance of confidentiality was given regarding the researcher's treatment of all data and those participating in focus groups were asked to maintain the confidentiality of discussions. One participant who was interviewed through email used an organisational rather than personal email address. This participant was warned that organisational information technicians could potentially access email messages. Though this potential was small, absolute confidentiality could not be guaranteed. Participant anonymity was assured in the reporting of study findings.

During the research, all data was stored securely in the researcher's home office. On completion of the study, all computer databases containing research related information will be copied onto disc and then erased from the hard drive of the researcher's personal computer. After the research is completed and the results reported, all data will be securely stored in a research locker in CQU and will remain there for a period of five years. This will include: audio-tapes; transcriptions; observational notes; demographic survey forms; consent forms; ethical clearance statements; lists of participants' names with associated identifying codes; discs containing computer records; and other miscellaneous data.

2.4. Conclusion

Strauss and Corbin's (1998) version has generally, rather than rigidly, been followed for this grounded theory study. The methods used to maintain objectivity and sensitivity and the use of the literature have been reported. The methods of theoretical sampling, data collection and analysis have been described. Explanation of how this study has addressed validity and ethical requirements has also been reported. The grounded theory approach and methods that have been reported in this chapter provided a structure for all research activities associated with the study. It was through the rigorous application of methods that this study was able to discover the theory of part-time nursing. The findings that led to this discovery are reported in the following three chapters.

Chapter 3
Basic social problem

3.1. Overview

The grounded theory approach has been used in this study to enable rich quality data to be collected and analysed. Chapters 3, 4 and 5 present the findings from analysis of these data. Chapter 3 focuses on reporting findings related to the basic social problem that has evolved through this study. Chapter 4 reports the 'conditions' influencing this problem and Chapter 5 presents the basic social process that was used to respond to the problem. The aim of Chapters 3, 4 and 5 is to lead the reader through the journey of discovery travelled by the researcher during this grounded theory study.

Throughout the report of the findings excerpts of raw data are used to support and substantiate the analysis and to ground emerging concepts in data. Within data excerpts, brackets have been used to identify the researcher's additions that provide clarity to participants' phraseology. Towards the end of this study's data collection and analysis the literature was used as data to broaden the richness of discovery. There was a limited volume of relevant literature that has been used in this report of the findings. Analytical conceptualisations are presented as abstract models and as an organisational strategy for the report these models are presented prior to the relevant sections of narrative text. This strategy will enable the reader to visualise the 'roadmaps' of the journey prior to undertaking it. Of course the researcher had not yet discovered these 'maps' when embarking on her journey. Instead the researcher used the framework of Strauss and Corbin's

(1998) grounded theory approach that was reported in Chapter 2 to navigate throughout the journey.

The latter part of Chapter 5 reports the substantive theory that developed from this journey of discovery. The data presented in Chapters 3, 4 and 5 will assist the reader to discover this substantive theory for themselves. Therefore the summative section of the report of the findings should merely be an affirmation of what the reader has already discovered.

This study initially aimed to discover the experiences of nursing while in part-time employment from participants perspectives. Therefore participants were asked to describe their nursing experiences. Analysis discovered both positive and problematic professional nursing experiences.

3.2. Positive experiences

The availability of part-time employment was a necessary strategy to retain nurses in the workforce. Data suggested that if the option of part-time employment was not available many would leave their employment:

> *I think that if they* [nurses] *could only work full-time most of the staff wouldn't be here. So if they* [management] *were to say 'Look we can't have part-time', then they would lose the majority of the staff.* (PT36)

In an era of acute nursing shortages, employment of part-time nurses was seen as beneficial to the provision of adequate nursing services.

Full-time nurses were described in data as being younger and more transient whereas part-time nurses were described as older and more settled because of

family responsibilities and ties to the community. For this reason, part-time nurses were proposed to provide workforce stability. Table 7 (section 2.3.3.1) identifies that the majority of participants had been employed within the one organisation for five or more years and a notable percentage of these for fifteen years or more. However, comparison of Tables 3 and 7 (section 2.3.3.1) suggest that participants have moved from one employer to another at some time during their nursing but data is not provided related to whether this occurred while employed part-time. Workforce stability provided by part-time nurses was suggested to be beneficial and cost-efficient to the workplace:

> *... I've been there for ten years so I haven't turned over... they haven't had to do all of that paper work and training all over again. Whereas with a lot of the full-time staff, they only stay three or six months and then they're turned over and you have to do the whole thing all over again.* (PT33)

The literature reported study findings that part-time nursing employment represented a retention strategy that enables more successful provision of nursing services and is a source of workforce stability (Edwards & Robinson 2004; Garbett 1996; Godfrey 1980a, 1980b). An estimate of $85 000 was presented in the literature as the cost of the loss of one Level 1 pay point 8 registered nurse (Queensland Nurses' Union 2002). Retention of nurses is therefore less expensive and disruptive than it is to replace them (Strachota *et al*. 2003). Jacobsen's (2000) Norwegian study indicated that when compared to full-timers, part-time employees may be a less stable workforce. However, Wetzel, Soloshy and Gallagher's (1990) quantitative study of Canadian full-time (n=296) and part-time (n=290) registered nurses found that 'part-time nurses had significantly greater organizational tenure than full-time nurses' (p. 82). Additionally Wetzel

et al. (1990) found that part-time nurses were commonly older with family

responsibilities and were more experienced than full-time nurses.

Data from the current study identified that frequently the most experienced

nurses in participants' workplaces were part-time nurses. Therefore part-time

nurses were essential to provision of an appropriate nursing skill mix:

> ... *My peers and I think we serve as very much the backbone* [of the
> unit]*. Generally the part-timers are the seniors, we've been around a
> long time and seen a lot of things... You can't read in a book what
> I've got in my head and you never will...* (PT58*)*

Both clients and novice healthcare professionals benefited from the employment

of experienced part-time nurses.

Employment of part-time nurses increased the actual number of nurses who

made up a workplace full-time equivalent (FTE) nursing staff allocation.

Consequently employment of part-time nurses brought a greater diversity of

experience and knowledge that benefited the workplace:

> ... *the more staff you have working for you the more input in some
> respects, like the diversity of interests, qualifications, specialty
> experience and areas of expertise*. (PT6)

This was especially beneficial when practice settings had a small FTE nursing

staff allocation. Larger numbers of employed nurses decreased conflict by adding

human diversity to the working environment:

> ... *they* [nursing staff] *have new people to talk to... So I think that
> helps too. Not everybody is getting on everybody's nerves all the
> time...* (PT57)

Willingness to work extra shifts when needed was cost effective to the workplace

as this limited the expense of using casual nurses or paying overtime. When

considering this issue participants suggested that it was beneficial to their

practice setting to have a part-time nurse who knew the area rather than a casual

nurse who didn't. It was also beneficial to the workplace when part-time nurses

were able to be rostered to fill in the gaps that existed around full-time nurses'

work schedules:

> *I really feel to be honest it's a benefit to have part-timers, particularly in a specialised field where we are... When we're short* [staffed], *we can get someone in and they don't know what they're doing or how they're doing it... Whereas, if we're short you can ask the part-timers. It's not costing overtime money and they know what they're doing.* (PT47)

Participants believed that in some ways they were more motivated than their full-

time colleagues. Examples of this motivation were evident in data. A common

example was their willingness to work extra shifts when they knew that there

were insufficient nurses or an inadequate skill mix that would impact on

provision of care. Another example was the use of personal time to do extra

activities that positively contributed to their own practice and/or their workplace.

Full-time employment was associated with less motivation to sacrifice personal

time for workplace needs.

Because they were working their preferred numbers of hours participants

believed that they were happier and more enthusiastic in the workplace:

> *... if people are allowed to work part-time... then you have staff who are going to be happier because things are working out better for them, so they're going to give more to their workplace.* (PT21)

> *Well I'm happier and more willing to do things. Not always take a harder workload, but maybe a difficult patient... and you might say 'Oh well, look I'll take them today. I'm only here today'...* (PT19)

Burke's (2004) quantitative study of Canadian full-time (n=382) and part-time (n=347) primarily registered nurses reported similar findings. Cheerfulness and optimism positively impacted upon the workplace and upon individual practice. This issue was found to regularly recur in data. This issue was exemplified through descriptions that contrasted participants' practice with that of some full-time nurses who were perceived as 'burnt out' and lacking enjoyment in their nursing practice:

> *... But I guess the benefits if you have people working part-time, if you're working the number of hours you want to work then you are happier and more contented and are happy to come to work... instead of being really tired and not performing to a level that is expected...* (PT65)

> *... You get more time to... recharge and bring that energy back into the workplace, which benefits colleagues as well. If people are down at the mouth and overworked and overtired it ramifies through the whole department.* (PT72)

> *... for me personally working part-time the benefits are that I'm refreshed, I'm not worn out, I'm not burnt out, I'm eager to get to work and to look after people* [clients] *and look after staff and so forth...* (PT33)

Part-time nurses' avoidance of burnout and enjoyment of their nursing was also found in nursing studies reported in the literature (Edwards & Robinson 2001, 2004; Godfrey 1980a). These issues were suggested by participants in the current study to benefit clients through the provision of a more caring attitude, greater patience levels and good-humour.

Part-time nursing was associated with reduced absenteeism. The literature also suggested that part-time employment is associated with reduced absenteeism (Edwards & Robinson 2004; Havlovic, Lau & Pinfield 2002; Queensland Health 2002; Rosendaal 2003). Attributing reasons found by the current study were that

part-time nurses were mentally and physically healthier than their full-time counterparts because of the reduced negative impact of work intensification and shift work. Additionally data explained that full-time nurses attempt to counteract the negative impact of these factors by regularly taking sick leave; often given the title of a '*mental health day*' in data. Participants considered that because they were employed in a part-time capacity, they were more motivated to work their rostered hours. A typical comment explained:

> *... there tends to be less sick leave altogether because you know you've only got a couple of days to work so sometimes, unless you're really crook, you'll go to work. And I think that you've got more time to recuperate if you are a bit sick because you've got the extra days off...* (PT14)

Analysis established that there were many positive experiences gained through part-time nursing. However, analysis also found that participants perceived that difficulties or 'costs' were associated. Grounded theory studies are based on the assumption that participants share a problem situation (Schreiber 2001). Therefore though these positive aspects were important, the study focussed exploration on participants' perceptions of their negative professional nursing experiences. Analysis of experiences of difficulties found that they were illustrative of a shared problem that was not being explicitly articulated. Rather this was discovered through gaining an understanding of the underlying meanings that these complex experiences had for participants. The remainder of this chapter reports the journey that led to the inductive discovery of the over arching basic social problem.

Description and explanation of the positive experiences that were associated with part-time nursing has been placed prior to explanation of the difficulties experienced to provide a more rounded view of the situation. However, analysis found that the 'positive experiences' were closely associated with a category that is reported in Chapter 5. Therefore though the initial textual report has been placed in this chapter, Chapter 5 will report how these experiences fit into the developed substantive theory.

3.3. Discovery of the basic social problem

From the very commencement of data collection this researcher continually interacted with data by asking 'What is going on here?', as suggested by Strauss and Corbin (1998). It became evident very early in the study that participants were experiencing a complex array of professional difficulties. The researcher progressively gained an understanding of the underlying meanings that each participant placed on their interaction with these phenomena. From this base of understanding it became increasingly apparent that identified phenomena represented the specific properties and dimensions of a higher order social problem that was shared by these participants but was not being explicitly articulated. Schreiber (2001) argued that the first goal of a grounded theorist is to understand the basic social problem from participants' perspectives. Therefore it was important to discover what had previously remained hidden.

Initially individual participants' stories were coded for emerging concepts leading to a plethora of codes. As these data were compared through the constant comparative analysis process repeated patterns and events within data were

identified. The methods described in Chapter 2 enabled the researcher to use a systematic approach to gain a conceptual understanding of data. The identification of explanatory properties and dimensions enabled discovery of participants' basic social problem. This discovery began as a hunch that was initiated through the interactional process that occurred between researcher and emergent data. The continuous cycle of theoretical sampling, data collection and analysis enabled the sub-categories and their properties and dimensions to be fully saturated so that the problem that was experienced was clearly evident.

The basic social problem that was identified through conceptualising data was that participants' experienced an 'inability to achieve personal optimal nursing potential'. This problem was found to have two sub-categories 'professional interaction difficulties' and 'professional development difficulties' that provided additional conceptual understanding of the problem. Each of these sub-categories had their own properties and dimensions that provided further explanation of the problem, and therefore enhanced understanding. The basic social problem has been discovered to be highly complex. However, the grounded theory approach to discovery has enabled this complex problem to be conceptualised so that it is more easily understood. Figures 1, 2 and 3 provide models that schematically identify the properties and dimensions of the problem. These models provide 'roadmaps' to assist the reader to navigate the narrative text throughout the remainder of this chapter.

3.4. Professional interaction difficulties

Effective professional interaction with all stakeholders within the workplace was perceived as essential to nursing practice. However, data identified that significant difficulties were experienced in achieving these goals. The following pages report the emergence of the sub-category 'professional interaction difficulties' that has been extrapolated from data and conceptualised through the analytical process. Figure 1 provides a schematic representation of the concepts that represent properties that are reported subordinate to this sub-category. The concepts placed subordinate to these denote the dimensions of each property.

Figure 1: Professional interaction difficulties
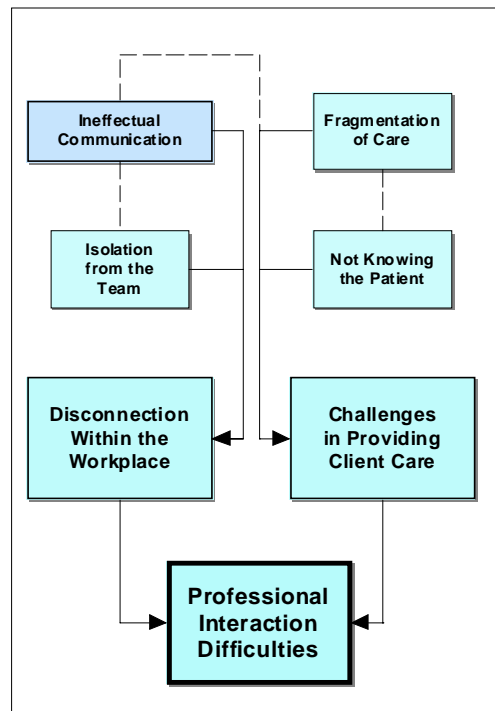
3.4.1. Disconnection within the workplace

Analysis identified that part-time nursing was associated with difficulties in maintaining and/or developing connections within the workplace. Data suggested

that these connections were important to professional nursing practice and that

disconnection within the workplace contributed to considerable professional

interaction difficulties.

3.4.1.1. Ineffectual communication

Significant data contributed to descriptions of communication difficulties. There

was a strong link established between communication difficulties and the periods

of time spent away from the workplace that were characteristic of part-time

employment. Participants perceived that ineffective communication processes

made it difficult for them to know what was happening in the workplace and

proposed that this lack of knowledge negatively impacted on many areas of their

nursing practice. Idioms such as '*behind the 8-ball*', '*missed the boat*', not

having their '*finger on the pulse*' and '*playing catch-up*' were regularly found in

data as descriptive of the outcomes of ineffective communication experiences.

One respondent described difficulties that many others experienced:

> *... you can miss out on communication within an organisation from it*
> [part-time employment], *and that's most probably the biggest*
> *drawback. You're often not present when... some communication*
> *comes out and by the time you're back into the building it's long*
> *gone or you've missed the boat or something. Or it's far too late for*
> *you to do anything about it. So from that point of view I think*
> *communication becomes a big issue with part-time work...* (PT73)

These idioms were also used to describe the outcomes of other difficulties; as

will be evident in forthcoming data excerpts.

Ineffective communication led participants to regularly suggest that they were

always the '*last to know*' of changes. A typical comment was:

> *... so sometimes changes do occur and I'm the last one to know. But it's reassuring because I sometimes find out that other people don't know, so I'm only the second last one to know...* (PT87)

It was often not until they were actually taken aside and told that they were doing things the wrong way that participants became aware of their lack of knowledge. Much data was dedicated to descriptions of feelings of incompetence because of an inability to know of changes. Godfrey's (1980a) North American based quantitative study into part-time nursing employment (n=7500) also found that inadequate communication of changes was a prominent problem. The majority of participants in the current study were very experienced nurses (see Table 3, section. 2.3.3.1) with many suggesting that they often worked as the nurse in-charge of the shift. However, analysis identified that an inability to know of changes negatively impacted on their professional self-confidence. Hagbaghery, Salsali and Ahmadi's (2004) qualitative study of Iranian nurses and two doctors (n=44) found that self-confidence is necessary to provide nurses with feelings of power and the ability that founds independent actions.

Analysis found that varied communication strategies were used in different practice settings with most using 'communication books' as the primary strategy for documented communication. Other common strategies included notice boards and email. These communication approaches were often over-populated with general notices that made it difficult and time consuming to find pertinent information. Even when information was available participants had difficulty accessing it because they didn't have time to do so. As one participant explained:

> *You don't know about changes, you're not informed about changes at all. You have to make a concerted effort on your own part when you arrive back at work to read things like the communications book, time permitting of course. And often that won't happen. And it won't*

be until you actually stumble across an event where it actually brings
it to the fore. Or you're doing something wrong and that's identified
to you... And often... I literally hit the floor running and I leave the
floor running so it's difficult to find out things... (PT58)

The most common communication strategy used in participants' practice settings

was verbal communication. There were many instances in data where

participants had been away for days and missed the verbal communication about

something that was important to them. Participants acknowledged that ineffectual

communication was a significant problem to their nursing practice and frequently

described strategies used to endeavour to keep updated. These included using

personal time during meal breaks to read communication books, notice boards

and emails and personal time outside the workplace was used to contact

colleagues such as their supervisor or peers to access and exchange information:

... So sometimes you do have to make a phone call from home to find
out what's happening, which is not good. (PT59)

The literature has identified that effective communication is important to

enabling professional nurses, irrespective of their differing practice contexts, to

interact and contribute in all facets of their practice (Jones & Cheek 2003;

Wareham 1996; Wicke, Coppin & Payne 2004). Tourish and Mulholland (1997),

in a quantitative study that examined the quality of communication between

British National Health Service nurses (n=61) and their managers, found that

full-time nurses were more satisfied with communication than part-time nurses.

These findings were suggested to be indicative of part-time nurses decreased

likelihood to be integrated and participate in the affairs of the organisation

(Tourish & Mulholland 1997). The current study's findings can not refute or

confirm these findings for the regional Queensland context as there was no comparison of full-time to part-time nurses. However, considerable communication difficulties were found to be experienced by part-time nurses. The literature supports the current study's findings by establishing that part-time nursing is closely associated with communication difficulties (Edwards & Robinson 2001, 2004; Garbett 1996; Godfrey 1980a; Grinspun 2002, 2003; Robinson *et al.* n.d; Wareham 1996; Wicke, Coppin & Payne 2004).

Full description of the magnitude of communication difficulties has been restricted by the limitations of this report. Nonetheless ineffective communication had wide reaching negative impacts on multiple areas of the experiences of part-time nursing. These will be explored further as the report progresses.

3.4.1.2. Isolation from the team

Analysis identified that ineffective communication often led to feelings of isolation from the healthcare team. Because part-time employment precluded them from keeping up with changes some participants felt that they had never been established members of the team:-

> *... So I always feel new all the time, even though I've been at the hospital for seven years, I still feel like I'm still new and not part of the team because the changes happen and it's very hard to catch up... with what's going on...* (PT85)

Being 'unknown' and not valued by other health professionals in their workplace was an issue that markedly influenced participants' ability to contribute as members of the team. As one respondent explained:

... because I worked full-time for a long time... and then when I became part-time I definitely felt not as well valued or my work wasn't as well recognised... and then there are staff changeovers, with doctors and nurses and because they don't know you I feel that they don't appreciate your input. Because with part-time [employment] *they just don't get to see you. I found that I'd be running the shift and the doctor would go to a more junior nurse rather than me to discuss a patient's care. And I suppose that is only because they work full-time and the doctor knows them but it is annoying.* (PT26)

In addition participants had difficulty knowing other staff members. As explained in the following excerpt, this difficulty impacted upon participants' ability to provide appropriate support to these professionals:

... The downside of part-time [employment] *though, especially when you're in a senior role, is it's easy to feel left out of the loop... And when you are in a senior role, your role is to provide education to other staff... and they aren't really sometimes familiar with you and you might not actually get to see them for another month before your shifts coincide again. So it's also very hard trying to remember where each and every individual is up to professionally; what their needs are for clinical development and education...* (PT83)

Feelings of isolation from the team were not confined to the professional arena. Social isolation from the team was also proposed in data. A typical comment was:

... you don't get invited to the social events in the unit and things like the girls had a weekend at... [an island resort] *and I was off and I could have gone but I wasn't invited. Was it because I'm... part-time and they don't know me as well... And things like peoples (sic) going away and they forget to ring you...* (PT33)

Contribution to team decision making processes was restricted. Part-time employment limited exposure to forums where participants could contribute to decision making processes related to client care and the practice setting in general. The general and nursing literature has also established that restricted contribution to decision making is associated with part-time employment

(Edwards & Robinson 2001; Grinspun 2002, 2003; Jacobsen 2000; Khalil & Davies 2000; Malone 1994; Thorsteinson 2003). An inability to contribute led to feelings of being undervalued and excluded; a finding that was substantiated by Robinson *et al.*'s (n.d) study of British registered nurses. Data from the current study also suggested that these factors potentially inhibited professional development:

> *Not being included or available for involvement in significant issues relevant to the unit impacts on me professionally as I believe that professional development can be enhanced from being involved in change discussions and processes. Involvement in change processes can develop and/or enhance teamwork and assist effective communication within the unit... Personally, being excluded makes me feel dissatisfied and not valued.* (PT11)

An inability to proactively contribute to the team resulted in participants suggesting that they were often passive recipients of others' decisions and they frequently felt that they were '*standing on the sidelines rather than being one of the players*'. Participants proposed that a professional nurse should effectively contribute as a member of the multidisciplinary healthcare team. Nevertheless part-time nursing resulted in isolation from that team.

3.4.2. Challenges in providing client care

Table 6 (section 2.3.3.1) identifies that the majority of participants in this study held positions as clinicians. Data identified that clinical nursing orthodoxy is based on provision of effective client care. Part-time nursing was associated with difficulties providing that effective care.

3.4.2.1. Fragmentation of care

Because participants worked in part-time employment they experienced difficulties in providing continuity of client care; a factor that was also reported in the literature (Edwards & Robinson 2004; Garbett 1996; Godfrey 1980a, 1980b; Grinspun 2002, 2003). Continuity of care has not been precisely defined in the literature (Sparbel & Anderson 2000a). However, participants in the current study perceived continuity of care from the perspective of an individual nurse's provision of direct client care and the contribution made by that individual to care planning and multidisciplinary continuity.

The difficulties in providing continuity of care were exacerbated when rostered shifts were disjointed rather than worked on consecutive days:

> *... because I've found that you do one shift, you have a few days off, you do two* [shifts]*, you have a longer stretch off. And you just don't seem to be having any continuity of care...* (PT79)

Clients were commonly unknown to participants or changes in client conditions and treatments were not known because they had been away from the workplace for days. Administrators in Godfrey's (1980b) North American study emphasised that these difficulties existed but believed that better shift scheduling and documentation could minimise the difficulties. Sparbel and Anderson (2000a), reporting findings from an integrated literature review of continuity of care, identified that communication is a key influencing factor.

Difficulties gaining sufficient client information to assist to provide seamless continuity of care were a problem for participants. Nursing handovers between

shifts were described as being brief and focussed on the current status of each

client rather than providing a history of events and a proposed long term plan of

care. Brief handovers were associated with the time constraints brought about by

minimal overlap between shifts. Ineffective communications associated with

nursing handovers were found to cause difficulties in providing optimal

continuing client care:

> *... and then there's times where you've got a unit full of new clients and you don't know them. And sometimes it's hard when you're going in there and you're thinking 'Well I've got handover happening and they're not really telling me from scratch. They're just telling me what's happened that shift'. So then it's up to you to actually go and read the charts and look to see and try to get an idea of what's been happening yourself.* (PT81)

Data suggested that finding the time to read client charts was challenging when

shifts commonly began at a busy pace; consistent with the suggestion by

Malone's (1994) British based editorial. A typical comment was:

> *... And there's too much paperwork to go through and you haven't got the time to go through it, so you're sort of like bluffing your way through some days.* (PT80)

Consideration of this issue led some participants to suggest that they were often

providing care that was not founded on an in-depth knowledge of the client's

history. Deficits in their knowledge about clients led to decreased confidence in

whether their care was consistent with the client's short and/or long term plan of

care. Difficulty in accessing client information was perceived as a barrier to the

provision of streamlined continuity of care. Ineffective communication of

changes in clinical procedures was also seen to be a barrier to the provision of

consistent care standards:

> *... and also consistency of care. Like things can change and I'll say 'God I didn't know that, I've been doing it the old way'. So when you*

don't know of changes it can be hard too to maintain a standard or consistency of care thing that contributes to continuity of care... (PT25)

Feelings of dissatisfaction with fragmentation of care were evident in data. Participants suggested that their time was consumed by management of imminent situations and trying to access client information leaving little time to actually contribute to the longer term planning, implementation and evaluation of client care. As one participant explained:

> *... if you work a late on Thursday and a night shift on Sunday and an early on Wednesday... if you're expected to be the team leader for those shifts I think you're disadvantaging everyone... you can be very dissatisfied because you feel like you haven't achieved anything. You spend your whole shift putting out fires* [dealing with problems] *or trying to catch up and then you go home and by the time you come back the patients have changed or the situation has changed and you have to go through the whole thing again rather than actually implementing anything that contributes to planning the care for the patient or being able to follow through.* (PT32)

Analysis found that some participants felt that they merely gave a level of care that got the client through the eight hour shift rather than actively contributing to the longer term plan of care:

> *... I guess you could look at it and say that I really go there and I give the care that gets myself and the patient through that shift. It's not sort of as proactive as I'd like it to be.... I just go there and sort of just do the basics that are going to get me through the shift.* (PT15)

Discontinuity of care was especially problematic when working in-charge of shifts:

> *I know that when I worked in...* [name of a town] *some Level 2s didn't take charge of the shift because they were only there for two days* [a week]. *They were Level 2s but they didn't do team leading at all because they felt they were only there two days and they didn't know the patients and they needed to know them if they were going to be in charge of the shift.* (PT17)

These issues were closely associated with the concept 'isolation from the team'. Not being present at doctors' rounds and multidisciplinary forums such as grand rounds and case conferences limited contribution to the long term care plans of clients. Inability to provide continuity of care was seen as difficult for both client and nurse. One participant noted:

> *... You find these problems and you might have them partially addressed and then you're off again and you wonder 'Well is anyone actually following through', so it makes it really hard.* (PT40)

Doherty and Doherty's (2005) qualitative study of British clients' (n=20) preferences for involvement in decision making substantiated these findings from the client's perspective. These authors reported that client disempowerment was related to poor communication between client and nursing staff and inadequate interdisciplinary team communication regarding client progress that was associated with a lack of nurses' continuity of care (Doherty & Doherty 2005).

Employment of part-time nurses was suggested to present problems for work units because the same nurses were not available each day. This was perceived by some participants to place a greater load on full-time nurses to provide continuity of care. Data identified that there was a need for successful systems of communication to enhance the potential for effective continuity of care:

> *... and I think that it* [part-time employment] *really does have an impact on that continuity of patient care. And I think that when you have part-timers on staff, that for the information swapping you need to have good systems in place. But if you have ever tried to phone the police after you got robbed the day before and there's a completely different crew on you know how bad their systems are. You could turn yourself in for doing the robbery and they'd let you go because they don't know anything about it because it was handled by a different crew. We have much better systems than that. We have systems in place to try to minimise that but I think it places an extra burden on the full-time staff and I think that we could be much better*

at passing on information so that the continuity of care is better,
especially when there are part-timers... (PT87)

Difficulties encountered by participants in achieving continuity of client care

may be similar to the difficulties full-time nurses experience when coming back

to work after holidays. A typical comment was:

> [Working part-time]... *is a bit like I guess when full-timers go on*
> *holidays and come back... and it's like 'Oh who is this person and*
> *what's going on'... you sort of come in at step 52 and you're thinking*
> *'So what happened in the other 51 steps before now'...* (PT21)

The comparison with full-time nurses returning from holidays was used

numerous times in data to explain experiences related to various other concepts.

3.4.2.2. Not knowing the patient

Fragmentation of care was closely associated with difficulties that existed in

developing effective therapeutic relationships with clients. Irurita's (1999)

grounded theory study that explored the adult patient's perspective of quality

nursing care in Western Australian hospital settings also found that a lack of

continuity of nurses was associated with difficulties in developing effective

nurse-patient relationships. A typical comment from the current study related to

this issue was:

> *... I think continuity of care within the ward is a big issue as well and*
> *I find it difficult to form relationships with patients. Because someone*
> *will say 'Oh I haven't seen you before' and you say 'No, I only do*
> *three shifts a week'. Or you've been working with them, especially if*
> *you've got someone who you admit... and they say 'Oh are you going*
> *to be working tomorrow' and you say 'Well no'. So I think that it*
> *impacts on your forming relationships.* (PT73)

Development of therapeutic relationships with both clients and their significant

others was necessary for provision of effective nursing care. Without successful

development of nurse-client relationships participants suggested that provision of care was more challenging and not as effective. The importance of the concept 'knowing the patient' to the quality of care provided has been highlighted in studies of nursing practice (Luker *et al.* 2000; McCabe 2004; Mok & Chiu 2004; Nordgren & Fridlund 2001; Radwin 1996; Shattell 2004; Thomas *et al.* 1995).

In the current study successfully knowing the patient was perceived to require time that was not available when significant periods were spent away from the workplace, as often occurred in part-time employment. Disjointed shifts were suggested to exacerbate the difficulty. The issues surrounding 'not knowing the patient' were proposed to negatively impact on both the clients and on the nurse. Participants' feelings of dissatisfaction were an outcome that emanated from an inability to develop effective nurse-client relationships that were believed to be an integral part of nursing practice.

3.4.3.   Professional interaction difficulties: summary

Data identified that part-time nursing was associated with experiences that negatively impacted on professional interactions. Part-time nursing led to 'disconnection within the workplace' and 'challenges in providing client care':

> *… it's easy to feel left out of the loop… you're not actually there during the regular office hour time when decisions are made. If you're not there for ward meetings it's very hard. You can read the minutes but then it's a reactive sort of thing, it's not proactive. You haven't actually been involved in the decision making process. Also staff don't really know you as well either, they possibly don't see you as a regular staff member…And also even just with continuity of care with patients. If you've got complicated cases and you've had the flow of the roster where you've had an extended period off… it's very hard to update on their events over that period of time.* (PT83)
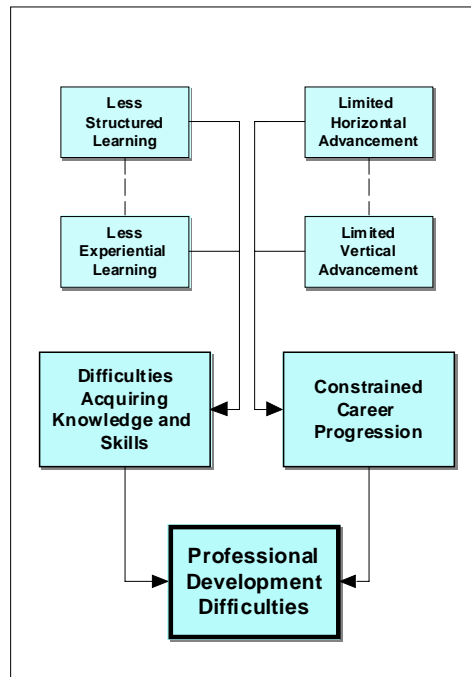
Saturation of the concepts that represented the properties and dimensions of this sub-category was achieved, as described in Chapter 2. This enabled a comprehensive understanding of the complex issues surrounding the sub-category 'professional interaction difficulties' (see Figure 1. section 2.4).

Analysis of data established that these were not the only professional difficulties experienced when nursing while in part-time employment. The following pages report further issues emerging from the data that formed the second sub-category that was developed through the analytic process. It should be noted that the professional interaction difficulties that have been reported in the previous pages considerably influenced the professional development difficulties that are reported in the following pages.

3.5. Professional development difficulties

Professional development was perceived by participants to involve acquisition of knowledge and skills and career progression. Analysis found that difficulties experienced in these spheres negatively influenced participants' professional nursing practice. The following pages report the emergence of the sub-category 'professional development difficulties' that has been extrapolated from data and conceptualised through the analytical process. Concepts that represent properties are reported subordinate to this sub-category and the concepts placed subordinate to these denote the dimensions of each property. Figure 2 provides a schematic representation of these concepts.

Figure 2   Professional development difficulties

Less Structured Learning

Limited Horizontal Advancement

Less Experiential Learning

Limited Vertical Advancement

Difficulties Acquiring Knowledge and Skills

Constrained Career Progression

Professional Development Difficulties

3.5.1.   Difficulties acquiring knowledge and skills

Participants proposed that contemporary nursing is practiced in an era of

continual change. A typical comment was:

> *... This professional field, especially nursing, has developed. And it develops rapidly. There's always new evidence to base your practice somewhere. So things change quite rapidly on the ward and you really can feel behind a lot with updates and there's* (sic) *so many areas to cover with nursing skills on the ward; whether it is a drug thing or a nursing intervention or a dressing. There's* (sic) *just so many areas to keep up with... so you really start to get behind the 8-ball...* (PT66)

Professional development through continual acquisition of knowledge and skills

was perceived as essential to practicing nursing. Jones and Cheek's (2003)

qualitative study of a diverse Australian registered and enrolled nurse sample

(n=38) also found that nursing requires lifelong learning to keep up to date with

changes affecting professional practice. However, the current study found that

part-time employment was associated with difficulties acquiring the knowledge and skills that enabled participants to remain up to date with changes and to progressively develop.

3.5.1.1. Less structured learning

Structured learning was seen as essential to development of professional nursing practice. Analysis found that personal and work time could be allocated to the pursuit of learning. Using personal time to increase structured learning was challenging for some participants, an issue that was especially important to those who used personal time to care for young children. The literature also points out that caring responsibilities can negatively influence access to structured learning opportunities (Barriball & While 1996; Tisdall 1999). Attitudinal variations were evident in data from the current study related to who was responsible for this learning. Some participants proposed that as professionals they were responsible for their own learning. Others perceived that their employing organisation should take primary responsibility. The following excerpt explained this:

> *... But most things* [educational forums] *that are on, yes we are encouraged to go or at least we are told that it's on anyway. And professional development is your own responsibility so if there's something on I want to go to I will pay to go and go in my own time. Some people won't though. Some people expect the organisation to do everything for them and do it in hospital time...* (PT50)

A review of the literature related to British continuing professional education in nursing was performed by Furze and Pearcey (1999) who also noted the wide spectrum of nurses' attitudes to learning. Nevertheless though there were variations in attitudes to learning most participants in the current study suggested that the responsibility should be shared between the individual and the organisation.

Accommodating for full-time nurses' educational needs was suggested to be ranked by some managers as more important than meeting part-time nurses' needs. Data proposed that full-time nurses were allocated work time to attend education sessions while part-time nurses were commonly expected to use their personal time. The suggested rationale for this inequity was based on attaining greater workplace value from judicious managerial allocation of limited resources. Therefore limited resources were dedicated to those who spent greater periods of time in the workplace:

> *... the people who work more shifts are the ones who get approved to go to different things* [attend educational forums]. *Which I guess in one sense is fair enough because they're there all the time but then it's like there should be a happy median. But of course that's in an ideal world isn't it?* (PT49)

> *... training and development are negligible when working in part-time positions... you certainly have to either take it on yourself or they say 'You're part-time so you can do it on your days off'. So basically you're extending your work life or your work hours over the week to include your training and development. Whereas the full-time staff will get work time to do that... I can't tell you of any paid education I've had probably in the last eight years. It has all been done in my own time...* (PT58)

Several participants proposed that although they were not given opportunities during working time to attend educational forums, they were asked to use their personal time to present workplace educational sessions to others.

Analysis found evidence that educational opportunities were potentially being offered based on a managerial obligation to meet accreditation requirements rather than a desire to provide opportunities that would meet individual nurses' needs. As one participant explained:

> *... do you want honest stuff, real honest stuff? I think that our NUM [Nurse Unit Manager] runs an in-service program here and I think it is designed to serve a purpose; to get the ticks in the right boxes for accreditation. I don't think it helps me but they don't care about that...* (PT87)

Mandatory training is one such managerial obligation. Annual mandatory training was often the only education that was accessed in work time and this was achieved far less regularly than annually. Mandatory training was also often undertaken in participants' personal time. Further indication of decision making related to allocation of resources for educational purposes was evident in data that described situations where there was an increased access to workplace educational opportunities after gaining promotion to Level 2 positions than were available when employed in a Level 1 role:

> *... But I'm slotted into different staff development and because you're a Level 2 I think that you have the added benefit because we tend to be sent to staff development workshops first. Much more so than when I was a Level 1...* (PT39)

Ineffective communication of planned educational sessions was a considerable barrier. A lack of knowledge of planned education sessions until it was too late was an issue for participants. By the time participants knew about these sessions they were either fully booked or the session was over. A typical comment was:

> *... I find that a lot of education sessions just don't fall on the days that I work because I'm only here those two days a week and you kind of get out of the loop. You don't hear what's going on; so something happens and you hear about it after the fact. So it's mainly the education thing which is a big drawback when you're working part-time.* (PT57)

Structured learning that contributed to professional development was perceived to come from a variety of forums. Using personal time or available work time to read nursing literature provided access to less structured learning. Workplace

self-directed learning packages were a good strategy. However, as already

reported, use of personal time was limited for participants with substantial other

life demands and data identified that there was limited work time available for

these pursuits:

> *... I know that everything is gearing towards self learning and stuff, but like for myself I don't have a computer at home so I can't get on the internet or anything and I have two small children so I can't drag them to the library so that I can use the internet there and I don't have time to do any reading at home so it's just impossible.* (PT57)

> *... I pick up articles and try to read them while I am at work and sometimes bring articles home to read... But it is difficult particularly when you're busy all the time at work and you don't get the opportunity to read and then you're busy all the time at home.* (PT53)

Formal education, such as postgraduate studies, was suggested as an excellent

means to access professional development. However, Table 13 (section 2.3.3.1)

identifies that most participants in this study were not studying towards post-

registration qualifications. Considerable allocation of personal time was believed

to be needed to pursue this level of learning. Formal education was presented as

a potential strategy for future use when other demanding life responsibilities

decreased. Davey and Robinson's (2002) longitudinal study of British registered

nurses (n=620) found that a significant percentage of female nurses with children

did not plan to undertake post registration tertiary education because of the

difficulty of combining paid employment, childcare and study.

Conference and workshop attendance was another forum that was found by the

current study to provide a means to gain structured learning. However, this was

expensive and participants experienced significant difficulties gaining financial

support from their workplace to attend. In a North American study of registered nurses' (n=134) motivations to professional development Dealy and Bass (1995) found that part-time nurses were much more likely to consider the expense of conferences to be a restraining factor to access than were full-time nurses. Data from the current study included descriptions of how fiscal support had been denied and instead scheduled days off had been given so that participants could attend these sessions in personal time. One participant provides an example typical of others' comments:

> *... I was prepared to do it* [go to a workshop] *on my days off if they paid for the course. But they said that they would give me days off so that I could do it. But I work part-time and I had all the days off anyway. So then I had to pay for it myself and financially I couldn't. So therefore I couldn't go.* (PT4)

Managerial support to attend education sessions was proposed to come through allocation of rostered days off which participants suggested merely fit into their usual work routine. Therefore participants believed that this support was no support at all. Attendance at conferences was also suggested to usually require travel away from their home town. This was often not feasible for those with other life responsibilities and demands; as was also suggested by Tisdall (1999).

Contemporary nursing staff shortages were posited as a notable barrier to being released from the practice setting to attend education sessions. This issue was perceived by some to impact on nurses irrespective of whether employed full-time or part-time:

> *... and whether you are a part-timer or a full-timer you don't get any down time for professional development away from the unit whatsoever.* (PT3)

Dealy and Bass (1995) found that equal percentages of both part-time and full-time nurses in their North American study rated this factor as the foremost restraint to access to structured learning opportunities. However, findings from the current study indicated that part-time nurses were less able to access structured learning in work time than full-time nurses. The literature has also substantiated that when compared to full-time nurses, part-time nurses do not receive equitable access to structured learning opportunities (Barriball & While 1996; Edwards & Robinson 2001, 2004; Garbett 1996; Lane 1998, 1999a, 1999b, 2000a, 2000b, 2004; Lane & Piercy 2003; Robinson *et al.* n.d).

In the current study workplace structured learning was commonly limited to those opportunities available in the practice setting; a remedy to the difficulty of being released from the practice setting that was also proposed by Dealy and Bass (1995). Informal education sessions in the practice setting were an avenue for knowledge acquisition that was potentially available during working hours. Being present at doctors' rounds and multidisciplinary forums such as grand rounds and case conferences were ideal opportunities to develop knowledge. Discussions among professional colleagues were also suggested as a strategy for learning. However, these opportunities were limited by part-time employment and the shift schedules worked:

> *... but the other issue is you never see the light of day and so you're never involved in medical rounds; you're always either on lates or on weekends so there's never any rounds. So you miss out on all that learning as well...* (PT30)

Whether within or outside the practice setting, planned education sessions were scheduled during 'business hours' and were not accessible to many participants;

a finding that is substantiated by Lane's (2004) study. A typical comment from the current study was:

> *... Because I've got no-one to look after the kids and all the professional development sessions are done during the day and I can't get to them during the day...* (PT12)

Participants' inability to personally attend educational sessions prompted them to come up with strategies that were currently used or could be used to learn from these sessions. Receiving a verbal summary or using the notes and handouts from those who attended educational sessions was presented as strategies that were currently used. More flexible scheduling of education presentation times was proposed as a strategy that could assist access to structured learning. Videotaping education sessions was suggested as a means to allow those who couldn't attend the actual presentation to access the same information as those who had. This potentially avoided the problem of gaining this learning second or third hand. One respondent explained:

> *I think that sometimes with in-services and stuff like that, you get them all second hand if you can't attend them. If there was some way like if someone did an in-service and it got videotaped so the videotapes were available for staff that don't work that day or can't make it to those sessions to be able to have a look at it.* (PT12)

Godfrey's (1980b) North American study found that most part-time nurses received the same staff development program as full-time nurses with some hospitals using videotape to assist to reduce the problems of cost and inaccessibility. However, though flexible scheduling and videotaping of educational sessions were strategies suggested by the current study's sample to assist with the difficulties, these were not currently available for participants.

One participant provided a summary of the difficulties associated with structured learning when she noted:

> *And if* they're [part-time nurses] *not getting the same educational opportunities as someone who is full-time what sort of percentage of their* [the organisation's] *workers is that? Are we not educating our staff? Do we not have competent people working in ...* [name of organisation]*? I'd be interested to know that. I know that people have to drop back to part-time when they start their families and there are a big percentage of those nurses. Are they the ones with past experience that gets them through? Or do they just have to bluff their way through. Good Lord I think that managers just don't care...*
> (PT66)

Analysis identified that structured learning was closely connected to the development of practical skills through experiential learning. Limited opportunities for release from the practice setting to pursue structured learning added to experiential learning's importance.

3.5.1.2. Less experiential learning

Learning by experience was very important to some participants as that was how they most successfully learned skills needed for their practice. A typical comment was:

> *... I learn better seeing and feeling and touching than reading it out of a book. I don't retain when I read it whereas if I saw and did it then I'd retain it... so that's why part-time* [employment] *is difficult.*
> (PT29)

Reduced exposure to experiential learning that was associated with working fewer hours markedly impacted on participants' professional development. Less time in the workplace was closely associated with less experiential learning. Analysis established that the opportunity to repeat skills was needed to develop confidence in performance. As one participant noted:

... it's very difficult to catch on to the actual area or even feel comfortable; to up-skill. Because it takes a long time to become very comfortable in an area. So when you're only working two days a week it's so disjointed, and you need repetition to become efficient. (PT53)

This issue was closely associated with diminished self-confidence. Decreased access to experiential learning was associated with extended timeframes to complete tasks. Participants perceived that without repetitive practice it was more difficult to develop a smooth routine for performing various skills. Repetition of some skills was limited when working in part-time employment because there was reduced potential that they would be present when certain situations occurred requiring the use of individual skills.

Difficulties up-skilling to a new area of practice was seen as problematic. Data identified that practice development was slower than was experienced by others who worked in full-time employment:

... I felt like I was dragging the chain for a lot longer. I started with another girl who worked full-time and she seemed to grasp and run with it and I just seemed to lag behind... (PT36)

... I started in a specialty area in a part-time capacity and I've always felt like I never had the solid body of knowledge and skills to fall back on. And I remember someone saying 'I've deskilled so much since I had a baby and went part-time'. And I thought 'You should try up-skilling from nowhere, it's hard'. And I think that people who work full-time don't appreciate that and they still expect that just because you've been there for six or seven years that you will know X,Y,Z. But you don't necessarily because you may not have ever been exposed to it because you're not there all the time... (PT32)

Part-time nurses potentially take longer to develop skills than their full-time counterparts. As seen in the previous excerpt, at times participants' part-time employment status was not considered by others. In these instances others'

expectations of the nurse's skill level was related to the chronological period employed in a specialty rather than the actual time spent in practice. Data identified that failure to acknowledge the part-time status of a nurse at times placed demands that participants felt unable to meet:

> *... I have been part-time for so many years ... that they lose sight of the fact that you are only there on a part-time basis. And you are expected to be quite senior... and I'm incredibly high up on the roster list* [in seniority] *but I don't feel comfortable to be there... and I feel there's this pressure on me... for example to co-ordinate the shift... and I don't feel happy with that at all...* (PT60)

Low activity times were used to practice skills by utilising equipment set aside for teaching purposes. This was perceived as a means to develop confidence as it provided a strategy to maintain or develop skills when opportunities for experiential learning were not readily available:

> *... and there's play time... and that's when you can go and play with things and get technology updates when you haven't come across something with patients... But you don't get any time to do the play time... there is little down time for part-timers...* (PT39)

Though simulated learning was perceived as one means to lessen the negative impact of reduced experiential learning, participants also commented that work intensity gave little opportunity for this type of learning to occur. Redeployment to other work areas when work activity was low was also an issue. The following excerpt explained why this was problematical:

> *... like the other day I came on* [to work] *and got told that I had to go to the Medical ward because we were quiet and had extra staff. And I said 'Why me'? And they said 'Well ...* [name of nurse] *can't go because she's senior on and we have gone in the past week'. And I felt like saying 'But I haven't gone during the week because I haven't worked and I did go the last time I worked'. And they are full-time so where is the fairness? And we had a really sick patient and I would really have loved to look after her because I needed that experience but I had to go...* (PT31)

Peer inequity related to redeployment processes potentially limited specialty experiential learning.

Part-time nursing was perceived as an obstacle to gaining access to both structured and experiential learning. These issues were found to be closely connected to the concepts discussed in the following pages of this report.

3.5.2. Constrained career progression

Participants in the current study proposed that all professional nurses should have the opportunity to progress their careers if they wanted to. However, participants perceived that part-time nursing presented a barrier to this progression.

3.5.2.1. Limited horizontal advancement

Performance of extra non-core responsibilities was proposed to provide opportunities for professional advancement. Data described both direct and indirect clinical and non-clinical activities that were periodically available. Described activities were wide ranging and included: preceptoring/mentoring student and graduate nurses; presenting or organising others to present educational sessions; developing self-directed learning packages; competency assessment of others' practical skills; marking written assessments; developing and updating policies, procedures and clinical pathways; quality activities; membership on committees; rostering staff work schedules; and other special project work.

An issue that recurred regularly in the data was that high levels of work intensity were a barrier to completing these activities in work time. The reduced hours spent in the workplace associated with part-time employment exacerbated the difficulty. Analysis identified that allocation of work time to accomplish extra activities seemed to be atypical rather than the norm. The correlation between the work requirements of the activity and the nurse's employment hours was not always used to guide managerial decisions related to allocation of extra responsibilities. As one participant noted:

> ... *that's your load* [of extra responsibilities] *and it makes no difference if you are part-time or full-time. You get the same load. If you're part-time you've got to pick it up when you're at home instead of being able to get the time to do it at work.* (PT54)

Even when work time was available there were difficulties trying to achieve non-clinical extra responsibilities within the work environment. A typical comment was:-

> ... *that's really hard to do here because we work with the ward clerk and you just cannot concentrate and the computer I use here is ancient so it's really difficult...* (PT14)

Data identified that where possible many extra responsibilities were accomplished in personal time:

> *I always take the roster home to do it because it's quieter at home and I can do it while the kids are at school.* (PT13)

> *I'm just doing the infection control package for our ward and so I just take home the papers and mark them which isn't a big job but I find that I don't have time to do that at work. And so it's better to take it home and have a quiet place to do it and it takes maybe 15 minutes for every paper so that's not a big deal.* (PT67)

Analysis found that nurse managers often allocated extra responsibilities based on a nurse's willingness to use personal time to accomplish the activities. The data surrounding this issue varied. Some participants did not object to doing these activities in their personal time while others claimed that they did not have personal time to allocate to the activities. Some refused to use personal time because they believed that they should be remunerated when doing activities that ultimately benefited the workplace. Some perceived that although it would be beneficial to expand their practice by accepting extra responsibilities, they were not willing to increase their workload while at work or take things home so that their home work commitment was increased. A disinterest in being allocated extra responsibilities commonly resulted from these factors. Other participants explained that they had been allocated certain activities that were secondary to their role and because there was no available work time these activities remained on-going and incomplete.

The opportunity to complete extra responsibilities while being paid to work from home was examined in data. This was perceived as a solution to gaining opportunities to advance professional practice by undertaking extra non-core responsibilities that could not be achieved while at work. The following excerpt explained:

> *But I would happily take on extra work if I was able to do it at home and be paid for it. I would happily take on updating the drug manuals, doing extra paperwork if I was paid for it and could do it at home. This would be good for me and good for the workplace. I think that we need to have the opportunity to take on extra responsibilities as this is a way to develop but why should you have to do it all in your own time.* (PT33)

Part-time employment was posited to be the rationale for not being offered the same opportunities for specific extra responsibilities that full-time nurses were given. One respondent suggested:

> *... I think that the attitude of Nurse Managers is not so good with regard to progression within the unit. I just feel that because I'm part-time sometimes that you get overlooked. When things come up that I could do and would be good for me to help me develop I just get overlooked. And I don't know whether I want to be looked at anyway to be honest but I do feel that maybe it's because I'm part-time that you get overlooked.* (PT29)

One of the specific responsibilities evident in data was a desire to preceptor/mentor student or graduate nurses. Participants believed that they were not offered these opportunities because they were employed part-time. The strategy of allocating two part-time nurses to each student or graduate rather than one full-time nurse was proposed. Participants suggested that this option was not considered by their managers. Edwards and Robinson's (2004) quantitative study of British full-time (n=262) and part-time (n=124) qualified nurses and their line managers (n=51) also found evidence that horizontal advancement opportunities were more restricted for part-time nurses than for their full-time colleagues.

Opportunities for horizontal advancement were suggested by participants in the current study to be rarely advertised. They were offered to interested nurses who were in the workplace at the time these responsibilities either became available or were being discussed:

> *Missed information and missed potential opportunities for project positions which are not always advertised but appointed to interested staff who are in the right place at the right time... if you're part-time you seem to miss out...* (PT78)

Even when the availability of extra responsibilities was communicated to staff within the practice setting the timeframes for expressions of interest were often

too brief. Participants suggested that because of their work hours they commonly did not see the communication until it was too late. Analysis identified that this was yet another example of how ineffective communication impacted negatively on participants.

3.5.2.2.   Limited vertical advancement

Participants perceived that promotional opportunities were significantly limited while employed in a part-time capacity. The international and Australian based literature provided substantial evidence that part-time employment was a barrier to promotion within nursing (Bailey & Hocking 1997; Brown & Jones 2004; Courtney *et al.* 2002; Edwards & Robinson 2001, 2004; Kemp 1994; Lane 1998, 1999a, 1999b, 2000a, 2000b, 2004; Lane & Piercy 2003; Marsland, Robinson & Murrells 1996; Queensland Nurses' Union 2001). However, Hill, Martinson, Ferris and Baker's (2004) on-line survey study related to part-time employment of North American women (n=6451) in the information technology industry found that it is possible for professionals to work part-time without loss of career opportunity.

The current study's identified limitations to horizontal advancement were seen as a considerable barrier to accessing vertical career advancement; a finding also suggested by Edwards and Robinson (2004). In the current study horizontal advancement opportunities were perceived to provide an avenue to develop knowledge and skills that were important to promotion:

> *… but I see that for staff part-time employment deters management from offering special project work, those extra responsibilities which would greatly assist with promotional opportunities*. (PT42)

The difficulties participants experienced acquiring structured and experiential learning, as previously reported, also negatively impacted on their ability to access promotional opportunities to a considerable degree.

Many participants proposed that they were not interested in promotion. Further probing by the researcher identified that there were varied rationale given for this disinterest. One rationale was that their current nursing role was what they desired and aspired to. These participants wanted to come to work and do a good job and then go home. In these cases promotion was associated with unwanted extra responsibilities that had the potential to disconnect them from the work that they were happy doing. Previous negative experiences related to promotion were another rationale given. As one participant illustrated:

> *... I initially applied to be a Level 2 when they first came out. I was unsuccessful even though I was more qualified than the ones who actually got the Level 2 positions. But I was told just prior to having the interview... 'Why are you putting yourself through this'... and she said 'You haven't got a chance of getting it. They're not putting on part-timers...'. And that threw me and I thought 'They can't discriminate'...* (PT38)

Data suggested that though attitudes may have changed in more recent times these participants were not interested in applying for higher level positions based on their past negative experiences.

Promotional opportunities were usually advertised as full-time positions and as such were perceived by participants as not accessible for those who wished to work in part-time employment:

> *There are very limited promotional opportunities for part-timers. Often Level 2 and certainly any positions above that require the employee to work in a full-time capacity.* (PT27)

This factor was also found by Lane's (1998) British study of qualified nurses. Data from the current study suggested that even Level 2 positions required nurses to work full-time or close to full-time hours. For this reason participants avoided applying for these promotions. However, other data proposed that it was possible to gain promotion to a Level 2 position while retaining part-time employment status. Some data recommended that many part-time nurses misguidedly do not apply for Level 2 positions because they believed that they could not apply for an advertised full-time position and then expect to work part-time:

> *... a few years ago we did have Level 2 positions and we couldn't fill them and we recruited part-timers to the positions because they were the only applicants... the positions are always advertised as full-time... and a lot of people are under the assumption that because they are part-time they can't apply for it... as if they don't have the right.* (PT33)

Examples were provided in data of part-time nurses who were promoted to Level 2 positions that had been advertised as full-time. As seen in the previous excerpt, part-time nurses were potentially more likely to access promotion to Level 2 positions when these positions couldn't be filled by full-time nurses. Analysis found that employment hours may be considered a more important factor than the nurse's ability to perform the role. Participants proposed that promotion should be based on an ability to perform a role rather than on what a nurse's employment status was. However, data identified that commonly this principle was not endorsed by employing healthcare facilities. A typical comment was:

> *... So you don't always get the best people for the job. I went to something at Community Health a couple of years ago and it was talking about staffing and these people were saying that they often have to look at the quality of the person they're getting be it full-time or part-time. The best person for the job isn't necessarily the one who works five days a week. But that doesn't seem to have filtered through to here* [participant's healthcare facility]... (PT50)

Examples were cited in much data of how participants or other nurses had gained

Level 2 positions that required full-time or close to full-time employment. After

gaining the position and working the expected hours for a period of time nurses

had later reduced their working hours while retaining their Level 2 position:

> *But most of the Level 2 positions are full-time and people who are*
> *doing them part-time have dropped back* [their employment hours] *or*
> *they got it four days a week and then dropped back to two or three or*
> *something.* (PT41)

Retention of their part-time employment status was perceived to be impossible if

wanting to gain promotion above a Level 2 position. However, there were a

number of participants who believed that this was possible and cited examples.

Unpublished 2001 nursing labour force data identified that between 18.5 and

25.1% of Queensland nurses in Level 3 and above positions worked part-time.

Table 6 (section 2.3.3.1) identifies that two participants in this study were

employed in Level 3 positions. Both worked thirty two hours per week. One of

these participants proposed that she had to 'fight' those in higher level positions

to get a reduced number of work hours and was having to successfully fulfil a

full-time role to justify her reduced hours. This participant explained that this

required the commitment of a lot of her personal time. The other participant

proposed that she was able to get these reduced hours because those in higher

levels perceived that it was cost effective to not have to pay for the accumulated

days off that full-time nurses received every month, as was required by the

relevant industrial awards.

The demands of those positions above Level 2 were described in data. These roles were proposed to be only available as full-time positions and commonly role responsibilities required dedication of more than full-time hours. As one participant explained:-

> ... *I've tended not to do it* [apply for positions above Level 2] ... *it's way too stressful. It's well beyond full-time work when you see what they do. It's not just that they work full-time, they're there for extra hours too...* (PT33)

Therefore participants perceived that they would not only have to increase their employment hours to full-time but they would actually have to work additional hours on top of that to meet the demands of these roles.

The potential for job sharing was suggested to be a means to access promotion opportunities while avoiding full-time employment hours. Job sharing has been proposed by the literature to be beneficial to both the employee and the employing organisation (Branine 2003; Hall 1993; Jackson 1991; Taylor 1997). The current study found that good communication and collaboration were believed to be necessary if the arrangement was to work. As higher level positions were so demanding two people sharing a role would prevent burnout:

> *Job sharing I think is a good idea... if you're both working in a collaborative way, definitely. Even the clinical education role, it's a demanding role and working full-time you can get burnt out. So if you had two people in the role, with that comes benefits in terms of more energy...* (PT31)

Participants also perceived that no one nurse is good at everything. Therefore a job shared position would allow the two nurses to divide role responsibilities according to their skills so that each contributed more effectively.

When probed only a few participants were knowledgeable about available organisational policies containing guidelines to support job sharing arrangements. However, these participants perceived that their healthcare facility would not support job sharing at higher level positions irrespective of the presence of wider organisational policies and associated guidelines. A submission by the Queensland Nurses' Union (2002) suggested that though Queensland Health, the public healthcare sector organisation that employs the majority of Queensland nurses, has policies that exist on paper to support family friendly initiatives this organisation failed to adequately promote these policies; a suggestion that was consistent with the findings from Skinner, Saunders and Duckett's (2004) qualitative study of employees (n=668) of Britain's National Health Service. Additionally the uptake of Queensland Health's policies was proposed in the literature to rely on employees' knowledge of entitlements and micro-level managements' willingness to adhere to policies (Queensland Nurses' Union 2002). Queensland's *Ministerial taskforce: Nursing recruitment & retention* (Queensland Health 1999) also found that nurses lacked understanding and awareness of these benefits. One example of a Queensland Health (2002, p. 2) document that provides guidance for 'making flexible work arrangements that meet the interests of both Queensland Health and its employees' is the *Flexible Work Arrangements Guide*. This document provides guidelines that would assist nurses to access promotional opportunities through strategies such as job sharing.

The current study found evidence of a willingness to change employment hours to full-time for a short period to temporarily act in a higher level position. Descriptions were available in data of enjoyment of higher level roles and

development of skills in these role responsibilities. Some participants proposed

that they would like to apply when higher level positions became available but

would not because they were not willing to increase their employment hours to

full-time permanently. As one participant explained:

> *The job I want will be advertised soon as a full-time Level 3 position and to the best of my knowledge that's what it will be. I have really liked the job when I've acted up in it and I would love to apply for it but I'm not willing to go full-time. We're* [the healthcare facility] *not family friendly at all. They just won't consider job sharing as an option. And yes, I could push my barrow about that but would it ultimately be worth it? No way. So you just don't apply...* (PT50)

The participants who acknowledged that wider organisational policies were

available to support their application to job share perceived that they would need

to use these policies to 'force' their healthcare agency to consider job sharing.

The negative consequences from this action were proposed to be unappealing.

There was the suggestion in some data that higher level positions should only be

available to those who worked in full-time or close to full-time employment. It

was suggested that roles could not be performed effectively by those working

lesser hours. This was especially seen to be the case for those positions above

Level 2. One participant who had experienced having a job shared nurse manager

role proposed that it did not always work:

> *... I think it is possible to have a part-time position at a higher level... but we had job sharing in our unit* [Nurse Manager position] *... and while it was great for both people who did it, I don't think it worked. I don't think there was enough communication between the two of them... from someone who was working under that situation it didn't work well...* (PT32)

There was also the perception in some data that part-time nurses' access to

promotion should depend on the position. While education, research and clinical

positions should be available in a part-time capacity, nurse unit manager positions should not.

Recent experiences of negative managerial attitudes towards part-time nurses considering promotion were described. These attitudes were suggested to be based on participants' part-time employment status rather than their ability to perform in the role:

> *... I feel like there's an assumption that your commitment to your job is less because you are part-time... I think it is much harder to progress because they* [managers] *don't think you're committed...* (PT29)

> *... because I feel at times a lot of people think because you're part-time you've got a part-time brain and I think that's a shame... And I don't think we're often taken very seriously... Occasionally you'll see an expression of interest for a position come up for a Level 3. And you say to someone who perhaps is a Level 3 that you'd really like to have a go... and they look at you and say 'But you're only part-time'.* (PT50)

Individual attitudes related to whether access to promotional opportunities was available were closely linked to perceptions of managerial/organisational attitudes towards this issue.

There was a preponderance of data indicating 'acceptance' that a desire to remain in part-time employment presented a barrier to pursuit of career advancement through promotion. This acceptance was founded on the belief that promotion was not associated with the option of working in part-time employment. There was notable reluctance to trade off part-time employment for access to promotional opportunities.

3.5.3. Professional development difficulties: summary

Analysis established that part-time nursing potentially led to difficulties

acquiring knowledge and skills and constrained career progression:

> *Like, you're not here* [in the workplace] *as often so you need to rely
> on your past experience to get you through. They* [the organisation]
> *don't give you any opportunity to get any education, like in-service,
> and so you have to do it in your own time which I don't mind
> particularly. And you get overlooked for that project type stuff which
> I do mind. And of course promotion is out of the question when
> you're part-time. I think that promotion needs to be addressed as a
> major issue because I don't think that people are working to their
> capacity... So I think to get the best service and to maximise
> outcomes for me and the other part-timers we should be able to get
> promoted. Because there's some absolutely shit hot quality people
> out there* [who work part-time] *who aren't working to their potential
> at some loss to them and to the organisation and to the consumers
> that come through.* (PT87)

Saturation of these concepts and their subordinate concepts provided conceptual

understanding to the sub-category 'professional development difficulties' (see

Figure 2, section 2.5).

When considering the concepts subordinate to this sub-category some data

proposed that rather than professionally developing, 'maintenance' was more

descriptive of many situations of part-time nursing:

> *I think that I've got to a stage that I'm definitely on maintenance at
> the moment. But I don't think I'm losing anything, because that's
> something I am fairly mindful of, not losing skills... So definitely not
> going forward but just sort of stagnating at the moment.* (PT82)

Maintenance was not perceived as an ideal situation to be in but was proposed to

be a result of the difficulties surrounding professional development. Participants

wanted to progress their nursing practice but part-time employment presented a

barrier to this development.

Analysis of data associated with the experience of professional development difficulties identified some suggested strategies to avoid these. Performance appraisal and planning processes were proposed to be an organisational obligation. However, the process was often not actively taken up in participants' work units or was not effectively utilised. Annual involvement in this process was posited as a forum for negotiation with supervisors to plan for opportunities that would facilitate professional development through acquisition of knowledge and skills and career advancement. Failure to have access to these negotiations was seen to significantly inhibit professional development. As one participant explained:

> *I believe the biggest downfall of the whole system is that career advancement and how you're progressing and whether or not you're getting your professional development and so forth comes from having a discussion with your supervisor. And we don't do that. We don't do our performance planning, we don't have time to sit down and have a half hour discussion about 'Well hey, ... I really need some education about XYZ and I would like to take on some extra responsibilities and I'm interested in acting up when a position becomes available'. You just don't have discussions like that.* (033)

Though performance appraisal and planning represented a vehicle to access training and to value performance the literature identified that part-time workers rarely received these reviews (Feldman & Doerpinghaus 1992; Sherer & Coakley 1999).
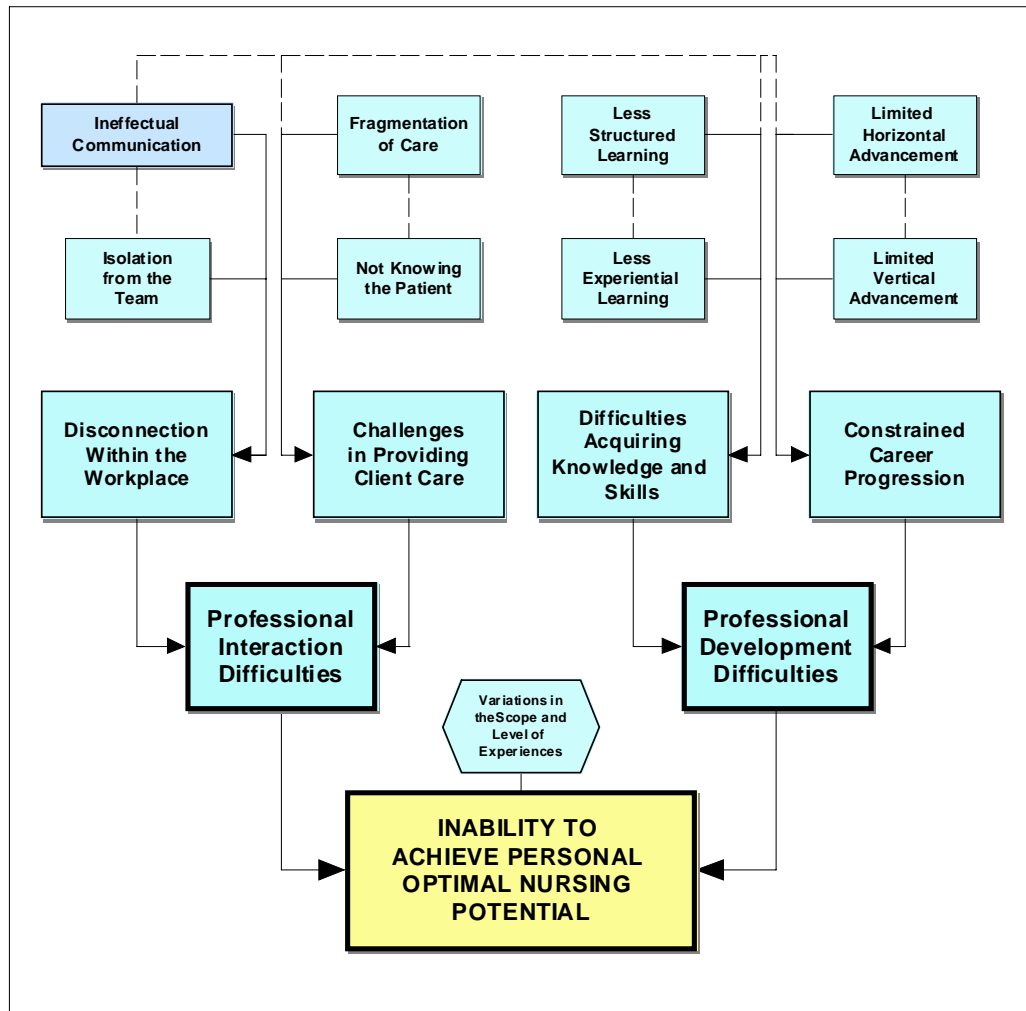
3.6.   Inability to achieve personal optimal nursing potential

Effective professional interaction with all stakeholders within the workplace was proposed to be essential to professional nursing. Additionally professional development through acquisition of knowledge and skills and career progression were believed to be vital elements of professional nursing. Analysis identified

that commonly these were implied in data rather than being outright statements. The researcher went back to a proportion of participants to validate these interpretations of meaning. These issues were explicitly presented by participants during this process, thereby validating the researcher's interpretations.

Figure 3:   Inability to achieve personal optimal nursing potential


The sub-categories 'professional interaction difficulties' and 'professional development difficulties' and their subordinate concepts progressively contributed to the discovery of the category 'inability to achieve personal optimal nursing potential'. Figure 3 provides a visual model of these concepts. This category was identified as the basic social problem that was experienced by

participants. Though participants did not openly articulate this problem the properties and dimensions of the problem were explicitly described and explained. Conceptualisation of these data through the grounded theory approach led to discovery of the overriding problem that had previously remained unknown.

As seen in Table 3 (section 2.3.3.1), the majority of this study's participants were experienced nurses. Data identified that many participants regularly worked as the nurse in-charge of the shift. Therefore it is reasonable to suggest that most participants were practicing nursing at an advanced level. Nevertheless the analytic process established that the experience of part-time nursing led to an inability to achieve their personal optimal nursing potential. Therefore irrespective of their level of nursing practice, attainment of personal optimal nursing potential was precluded.

Analysis of data that provided the properties and dimensions of the basic social problem identified participant heterogeneity in their experiences of the problem. Figure 4 provides a diagrammatic explanation of the issues that will be described in the following paragraph.

Figure 4:   Variations in the scope of difficulties and the level of effect
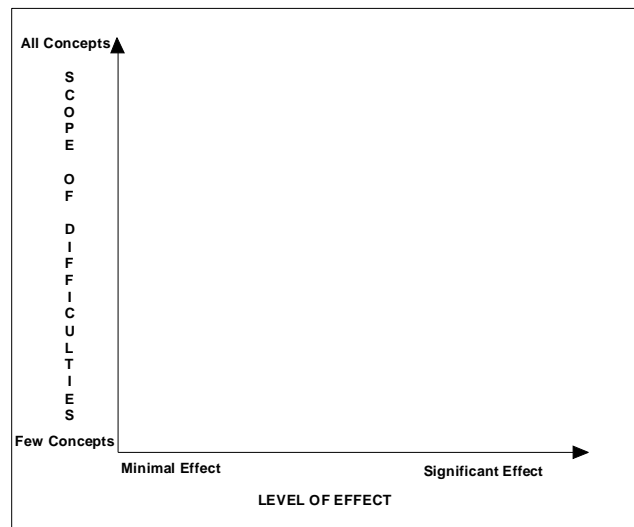
While some participants experienced professional difficulties that were coded to
all identified concepts, most did not experience every concept identified. Further
analysis identified that the level of perceived negative effect varied for each
individual. Analysis determined that each could be placed along a continuum
from minimal to significant effect. Therefore individual participants differed in
the scope (the number of concepts to which data was coded) of their difficulties
and the level (or degree) of effect. Nonetheless though differences in experiences
were evident in data, all participants shared the basic social problem because
identified concepts independently and collectively led to the problem.

Constant comparative analysis has enabled patterns to be identified in data.
Discovery of these patterns was deemed important as they allowed concepts to be
grounded in data. Saturation of each concept was achieved when no new
information was collected. The grounded theory approach has permitted the
complexity of 'variations' within this category to be fully extrapolated from data
and this has enhanced the explanatory power of the developed theory.

3.7. Conclusion

Chapter 3 has reported findings that led to the discovery of the basic social problem that was part-time nurses' 'inability to achieve personal optimal nursing potential'. The two sub-categories and their properties and dimensions that describe and explain the problem were well grounded in data. Saturation of these concepts and categories has been achieved through the grounded theory method described in Chapter 2. The previous pages of this chapter have reported the analytic conceptualisations of these findings and have provided excerpts from raw data to substantiate these conceptualisations. However, the analytic process of continually interacting with emergent data by persistently asking questions of the data established that discovery of the basic social problem was only part of the story.

There was a complex intermingling of events or 'conditions' that were influencing the problem. These provided explanation for why participants experienced the problem in different ways. These conditions were explored to enable the researcher to gain a greater understanding of their influence so that the explanatory power of the developed theory could be enhanced. Additionally it became obvious that participants were responding to the problem through various 'actions/interactions' that were representative of the basic social process.

The report of findings in Chapter 3 has already provided explanations of many of the conditions that influenced the problem and the basic social process that were participants' responses to the problem. These were so closely integrated with the problem that it was impossible to reduce this initial part of the report to exclude

these issues. Nonetheless the conditions and process were somewhat hidden in the narrative text of the report of the findings thus far. Chapters 4 and 5 aim to highlight these and further the report of the findings through exploration of the conditions and the basic social process to enable a more complete understanding of the situation of part-time nursing.

Chapter 4
Contextual conditions

4.1. Overview

This chapter continues to report the findings from this study. The analytic process enabled discovery of the basic social problem that was reported in Chapter 3. As data were collected to enable discovery of this problem it became apparent to the researcher that the problem did not stand alone. Instead there was a complex interplay between certain conditions that influenced the problem and the actions/interactions (process) that were occurring as a response to the problem. It was recognised that a complete understanding of the situation was not achievable until these issues had been discovered and were related to each other and to the basic social problem.

An opportunity to gain a preliminary understanding of the conditions and the actions/interactions surrounding this problem has been provided throughout the narrative text of the previous chapter. However, in Chapter 3 these factors were embedded in the report of the problem and as such were potentially hidden from the reader. This chapter uncovers the conditions that influence the problem. Conditions are reported under the categories; 'motivators to work part-time', 'employment hours', 'specialty factors', 'individual factors' and 'organisational factors'.

4.2. Discovery of the conditions

Conditions are divided into three groups; causal, intervening and contextual (Strauss & Corbin 1998). 'Causal' conditions are happenings that influenced the problem and 'intervening' conditions are those happenings that altered the impact of the causal conditions (Strauss & Corbin 1998). 'Contextual' conditions are the specific set of conditions that intersected to create the problem at a certain place and time (Strauss & Corbin 1998). Comparative analysis clearly identified that it was the interweaving of conditions that intersected to form 'contextual' conditions that ultimately created the basic social problem. The following pages report analysis findings using data to explore each relevant condition separately so that a comprehensive understanding can be gained.

4.3. Motivators to work part-time

Though anecdotal supposition was available, research based knowledge about nurses' motivations to work part-time was quite limited (Walsh 1999). Regional Queensland nurses' motivators to work part-time were unknown. The category 'employment hours' was found to be an important condition that had wide reaching influences on the basic social problem. Therefore gaining insight into participants' motivators to work part-time was necessary to understanding 'why' they were situated in part-time employment.

In many instances several motivators were associated with the decision to work part-time and these were frequently interrelated with varying degrees of personal priority given for each relevant motivator. The analytic process enabled the category 'motivators to work part-time' to be conceptually developed. Concepts

signifying properties are reported subordinate to the category and the concepts

placed subordinate to these properties specify the dimensions of each property.

Figure 5 provides a guiding model.

Figure 5:   Motivators to work part-time
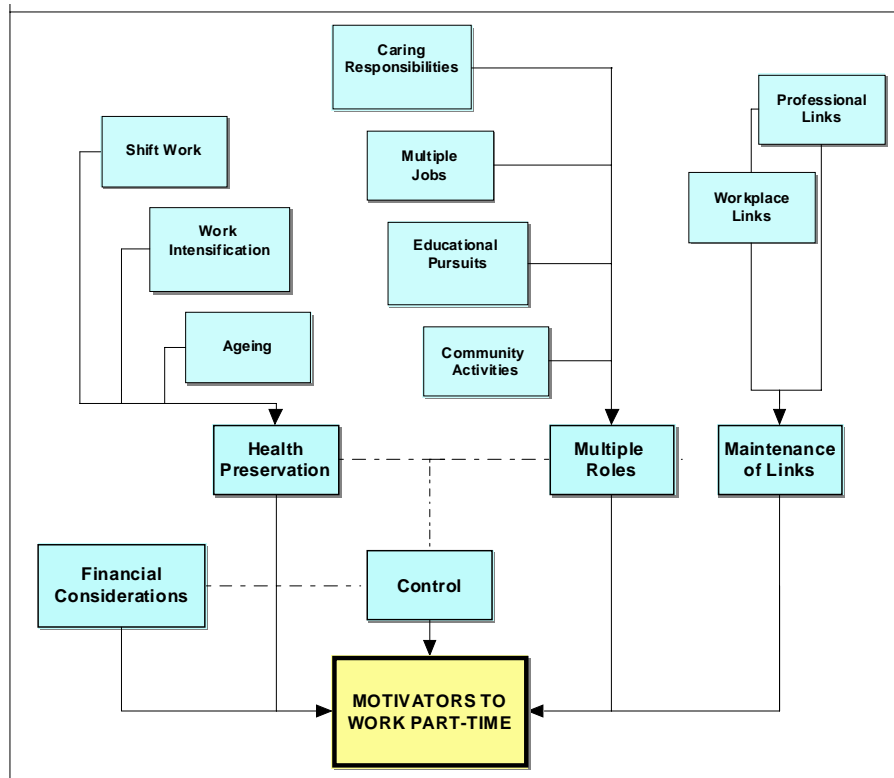
In an attempt to limit the volume of this report some concepts have been briefly

described. However, it should be noted that brevity of text is not reflective of the

weighting of concepts in data. As described in Chapter 2, the constant

comparative method ensured that data only earned its way into the study when

repeated patterns were found (Chiovitti & Piran 2003).

4.3.1.   Financial considerations

The financial benefits of employment are clear and are commonly assumed to be

a motivator to any employment. However, other primary motivators to part-time

employment were presented in data and financial factors were not spontaneously

mentioned at all in most cases. Nevertheless exploration identified that financial factors were an issue that had been given prior consideration. Consideration had been given to the financial repercussions of forfeited income that was linked to part-time employment. A typical response was:

> *And I think we also know that money is not that different between working 8 shifts* [a fortnight] *and full-time. You get two days off extra and you're only $100 out of pocket. I can live with $100 out of pocket if I can have those two extra days off a fortnight.* (PT54)

Data proposed that the potential financial shortfall could be limited by salary sacrificing, rostering to penalty rate shifts that are outside of standard business hours, and because of adjusted tax schedules. Godfrey (1980a) conducted a qualitative survey of the readership of North American based journal '*Nursing*' to explore nurses' (n=7500) opinions and experiences of part-time employment. The study also found that financial considerations were an issue for nurses who worked part-time however the deficits were able to be limited through adjusting work schedules and personal spending (Godfrey 1980a).

In the current study financial considerations influenced decisions related to how many hours participants were willing to work. Warren (2004), in a report that emanated from an examination of British household survey data, proposed that financial considerations were important to part-time employees' ability to successfully balance work and life. In the current study financial demands were perceived to be constant and transitory. Constant demands were met through contracted employment hours. Transitory financial demands were met by working in another job or by working hours in excess of contracted hours:

> *And I manage financially on part-time. I can always pick up extra shifts if I want it and I do when I need the money.* (PT16)

Financial considerations were associated with motivators to part-time

employment but were not commonly a primary motivator.

4.3.2. Health preservation

Shift work, work intensification and ageing and their impact upon participants

were major issues in data. The negative health ramifications of these issues were

found to independently and collectively be a motivator to part-time employment.

4.3.2.1. Shift work

Part-time employment was suggested to be more appealing than full-time

employment when work schedules included shift work:

> *... part-time, it doesn't make me sick, I can sleep more... if you're working 40 hours or more than 40 hours it's just too much physically, emotionally, you break down. The shift work, the night duty, you can't physically maintain that lifestyle for 40 hours in a week; I don't think it's possible without being sick...* (PT84)

Of primary concern was an inability to deal with the health effects of working

night shifts. Shift work was perceived as conflicting not merely with physical

health but with emotional and social or relationship wellbeing:

> *It* [shift work] *affects me physically, probably the lack of sleep, sleep depravation... It's very tiring and I can't cope emotionally.* (PT33)

> *... shift work is a social killer as far as your social life is concerned.* (PT18)

> *It was just very difficult working shift work and we were trying to have a child... and eventually our marriage broke up...* (PT3)

White and Keith's (1990) qualitative study of a random sample of married North

Americans (n=1668) that explored the effect of shift work on marital quality

found that shift work reduced marital quality and increased divorce potential.

Healthcare environments that provided twenty four hour nursing services through a three shift per day rostering schedule were of concern to participants; a concern shared by the International Council of Nurses (2000). In the current study rostering schedules that included regularly working all three shifts were perceived to negatively affect health:

> *... to work a late/early* [shifts] *and to come home and basically sometimes get only two or three hours sleep because your mind is racing from working the late. And then having to get up and do the early. The way you feel when you get home at four in the afternoon on the day after the late/early, that's not healthy...and then of course you have to front up for a night* [shift] *the next day...* (PT88)

There is a substantial literature related to the negative outcomes that nurses experience from working shift work (Brooks 2000; Fitzpatrick, While & Roberts 1999; Jamal & Baba 1992; Poissonnet & Véron 2000; Totterdell et al. 1995). British author Brooks (2000), in a meta-analysis of empirical studies related to flexible work arrangements, found that compulsion to work shifts that are not conducive to the individual such as night shifts and rotating shifts led to increased health problems. The Australian report titled *The patient profession: Time for action. Report on the inquiry into nursing* (Commonwealth of Australia 2002a) suggested that shift work is unattractive to many nurses and should no longer be accepted as an inevitability of working as a nurse. Wilson's (2002) literature review into shift work for healthcare personnel found that individual preference and control were important issues to those working shift work; the issue of control will be discussed later in this chapter (section 4.3.5). Part-time employment was perceived as an avenue to work less shift work than would be worked in full-time employment and therefore provided a means to enable better health.

4.3.2.2. Work intensification

Data regularly described high levels of work intensification and this was presented as a secondary motivator to work in part-time employment. The Australian report titled *The patient profession: Time for action. Report on the inquiry into nursing* (Commonwealth of Australia 2002a) proposed that nurses have to meet high levels of need, technology and fast admission and discharge flows. Hegney, Plank and Parker's (2003) quantitative/qualitative survey study of the workloads of registered and enrolled nurses and assistants in nursing (n=1477) identified that work intensification is an issue for contemporary Queensland nurses. Additionally, increasing nursing shortages have been linked in the literature with escalating nursing work intensity in Australia (Queensland Nurses' Union 2001, 2002; Wickett, McCutcheon & Long 2003).

Issues related to the technological intensification of their work environment were evident in some data. Contemporary nursing was commonly perceived as physically intense:

> *... the ward is at its most stressful as in its busiest or most demanding... in actual fact I find that I go home physically tired... I mean my feet sing from all the walking...* (PT21)

Intellectual intensification of nursing work was also of concern:

> *... I think that in the acute care situation, specifically where I am, it's more mental than physical and you often come home mentally wiped out after a shift.* (PT56)

Analysis identified that it was the combination of these factors that led to perceptions that nursing was practiced in a milieu of high work intensification.

Commonly the effects of work intensification were not confined to the work environment but pursued participants at home. Olofsson, Bengtsson and Brink's (2003) grounded theory study of Swedish nurses (n=4) experiences of work stress also found evidence that work related issues remained with nurses when they were at home. Participants in the current study perceived that this made nursing a '*threat*' to them as it could '*take over your life*'. These idioms were used a number of times in data related to this issue. Part-time employment was proposed to enable a reduction of the potential threat of nursing. An example of respondents' comments follows:

> *Well* [with part-time employment] *you can actually get work space out of your head. You have more time to focus on other areas of your life... so you're not... having all your days off and still having work stuff going through your head...* (PT5)

In an opinion paper presented by Hawksworth (1999), secretary of the Queensland Nurses' Union, there was the suggestion that work intensification motivated nurses to work part-time that then contributed to the level of work intensification through a decrease in the hours being worked that in turn led to more nurses choosing part-time employment. Therefore there was a vicious cycle occurring.

4.3.2.3. Ageing

The concept of ageing was not a singular concept in the data. Rather it was integrally connected to the 'shift work' and 'work intensification' concepts. Ageing was suggested to play a significant role in the negative health outcomes associated with shift work and work intensification:

> *You get tired... but I think it's worse when you get older.* (PT45)

The literature has also established that aging increases shift work intolerance (Brooks 2000; Poissonnet & Véron 2000). In the current study chronic work induced health factors and transition to retirement were also motivators to part-time employment that were associated with aging. Additionally the concept of ageing was perceived by many as a significant future motivator to part-time employment.

4.3.2.4.   'Health preservation': summary

Data related to the concept of 'health preservation' included a high frequency of the expressions such as '*burn/t out*', '*worn out*' and '*killer*'. These expressions were commonly used to describe negative reactions to shift work and work intensification. Also idioms such as '*breathing space*', '*refresh*' and '*recharging batteries*' were commonly used in data to identify how part-time employment positively assisted to offset these negative reactions. The following comment provided an example:

> *... for me personally, working part-time the benefits are that I've got some breathing space, so I'm refreshed, I'm not worn out, I'm not burnt out...* (PT33)

Analysis of all data identified that these concepts primarily motivated some participants to work in part-time employment while for others they provided a secondary motivator.

4.3.3.   Multiple roles

Participants described their many life roles as motivating them to work part-time. These multiple roles were considered to be important and a primary rationale for seeking part-time employment.

4.3.3.1. Caring responsibilities

As may be expected when considering the demographic platform of the participants in this study (see Tables 14 and 15, section 2.3.3.1), responsibility for dependants was the prime motivator found in data for the decision to work part-time. There is a plethora of general literature establishing that part-time employment is a means used to enable women to participate in the workforce while continuing to meet traditional domestic commitments (Hakim 1996a, 1996b, 1998; Newell 1992; Pocock 2003). The foci of caring motivations in the current study were related to dependant children as opposed to aged dependants; the rationale potentially submerged in the fact that no participant had aged dependants living with them. Full-time employment prior to having children was followed by part-time employment after the first child's birth. Changing to part-time employment after having children was perceived as a normal thing to do. There was the suggestion that societal 'norms' impacted on working time decisions:

> *...when I decided to drop from full-time to part-time it was like a chronological thing that people did. It's the norm, you get married and you have your first child and you drop* back [hours worked]. *So a natural progression I suppose.* (PT39)

Data, as in the following excerpt, established that it was family needs that impacted most on working time decisions:

> *It* [part-time employment] *suits me and my home situation. Everyone is happier at home if you work part-time because you're there... You are able to perform your role as wife/mother, which is predominantly what you want to do. But you still want to be able to work, and work productively. So you choose to work part-time.* (PT50)

Though nursing was important, it was not more important than the role of carer.

The following comment exemplified the wealth of data surrounding this issue:

> *You know it's funny, before I had children I was definitely quite career orientated... But it's funny since having the kids, things come at a cost, and I do find it hard to balance work and home. And so unfortunately it's work that's going to give because of the kids. They're always going to be the priority.* (PT26)

Household domestic work was presented as part of caring responsibilities. Division of household domestic work commonly followed traditional gendered distributions. This appeared to occur irrespective of division of responsibilities for paid work outside the home:

> *... for a period after having a family my husband was the home person for a while and I worked full-time... It was very difficult... he wasn't doing the roles that I normally take care of in the home. So therefore I was working full-time as well as holding down all the home jobs as well. So it was a stressful situation...* (PT6)

Suitable access to formal child care providers was seen as problematic and a source of significant stress for some participants. The Australian general and nursing based literature has also established that child care issues are a considerable concern to working parents (Commonwealth of Australia 2002a; Pocock 2003; Queensland Health 1999; Queensland Nurses' Union 2002; Thornthwaite 2002). The current study identified that shift work and inflexible rostering exacerbated the difficulties of accessing formal child care providers. Caring responsibilities were analysed to be the major motivator in data to part-time employment.

4.3.3.2.   Multiple jobs

Table 10 (section 2.3.3.1) identifies that a notable percentage of participants were employed in more than one job. International studies and opinion papers

exploring part-time nursing also established that a considerable percentage of part-time nurses in other countries are working in more than one job (Edwards & Robinson 2004; Garbett 1996; Grinspun 2003; RNAO 2003; Wetzel, Soloshy & Gallagher 1990). The literature provided several proposed rationales for this including that multiple jobs were used to give variety in nursing work and that the mutuality of benefits between employee and employer was incomplete (Edwards & Robinson 2004; RNAO 2003).

Some second employment positions in the current study were associated with family businesses and not related to nursing. Additional nursing positions were most commonly through casual employment. Responsibilities frequently differed to those performed in primary part-time positions and were described as complementary. Employment in more than one nursing job was deliberately sought to broaden exposure to diverse experiences that were not available in one role. The following represents a typical comment:

> *They* [the two jobs] *give you diversity. Actually they complement each other and probably the fact that you do the...* [other] *work makes you more aware of the evidence based practice, best practice and so then that translates into your clinical working environment.* (PT38)

Working in multiple jobs was not a common primary motivator in data. Rather multiple jobs were used to diversify nursing experiences or to supplement income. However, these jobs represented yet more roles that were included in participants' repertoire of roles.

4.3.3.3. Educational pursuits

Data suggested that part-time nursing provided some flexibility to enable

attendance at informal educational forums:

> *... like if you want to fit one or two workshops in a year you go to it basically in your own time, because you've got more days off* [than when working full-time]*... (PT04)*

Most participants were not currently studying towards post-registration

qualifications (see Table 13, section 2.3.3.1) and educational pursuits were not a

common motivator for part-time employment. However, data proposed that

studying towards post-registration qualifications would be very difficult if

working full-time. One participant noted:

> *... And when I was studying too it was certainly a benefit to be working part-time... I don't know if I could have done it if I worked full-time. It was certainly easier to do it working part-time. (PT14)*

The Queensland Nurses' Union (2001), in their submission to the senate inquiry

into nursing, suggested that this is a problem that many Queensland nurses face.

4.3.3.4. Community activities

Community activities were commonly discussed in the data. These activities

were wide ranging but frequently included socialising with friends, sporting

commitments and membership in various community clubs and organisations:

> *I play squash... and I also belong to organisations such as Toastmasters... as well as having joined the voluntary workforce in such roles as the school tuckshop roster... (PT78)*

Varying degrees of priority were placed on community activities. However,

analysis identified that community involvements were not a direct motivation to

work in part-time employment. Nevertheless there was significant evidence that

these formed yet another concept that contributed to participants' multiple roles and as such were associated with motivations to part-time employment.

4.3.3.5. 'Multiple roles': summary

Analysis of all data relating to these issues identified that although specific roles provided the explicit motivation to work part-time, it was the combination of multiple roles with associated accumulated demands that impacted on participants' working time decisions. Demands were significantly increased where multiple roles existed and this impacted considerably on decisions related to the hours that could be devoted to employment. A typical comment was:

> *I've got full-time life work and part-time employment and five years ago it was the other way around... The other day we were discussing if I should take on the role of secretary of the...* [sports] *club... And he* [husband] *said 'Well you've got a lot on but you could probably cope with it because you're not working a lot'. And I said 'Excuse me, not working much! Right, so I'll stop mowing the lawn, washing up, getting lunches ready, dropping...* [older child] *off at preschool, looking after...* [younger child]*, doing the* [business] *books for you, ironing your clothes, looking after your mother, doing her shopping twice a week, washing her clothes, and that is just a few of the things that I do. Did you say that I'm not working much?' But you know Lynn, I am now the secretary of the...* [sports] *club.* (PT33)

Grosswald (2003), when reporting findings from a North American workforce survey (n=3552), suggested that time spent in the workplace implies time away from other roles. There is a wealth of literature dealing with the three major models related to the work-life (or work-family) phenomenon: the 'compensation theory' that presumes that work and life are complementary; the 'spillover theory' that surmises that there is a transfer of negative or positive factors from one domain to the other; and the 'conflict theory' that posits that work and life compete for available resources (Greenhaus & Beutell 1985; Grosswald 2003; Jansen *et al.* 2003; Thomas & Ganster 1995). In the current study data associated

with multiple roles suggested that part-time employment enables work-life compensation to occur. Negative work-life and life-work spillover and conflict were associated with full-time employment. The following comment was typical:

> *... the benefits to me* [of part-time work] *is that because I get more time off I feel more settled in my home life. So of course that makes you more settled at work. You're not constantly stressed out; you're not bringing problems to and fro from work to home and visa versa. That's the biggest advantage to myself because I did find that I was becoming quite stressed out and you don't realise how stressed you actually are until you drop the days* [worked]. (PT52)

The potential for negative spillover or conflict strengthened motivations to work in part-time employment.

4.3.4. Maintenance of links

Analysis found that part-time employment was used at times to maintain links with the profession and the workplace.

4.3.4.1. Professional links

A desire to maintain nursing knowledge and skills was a motivator to part-time employment. When employed in other non-clinical nursing employment, maintenance of clinical nursing knowledge and skills was identified as a motivation that enabled professional credibility to be retained. Developing links with others in the profession was also a motivation found in data. The literature also provided some evidence that this was a motivator to part-time employment (Wetzel, Soloshy & Gallagher 1990).

4.3.4.2. Workplace links

Social and mental stimulation were proposed as secondary motivators to the decision to work part-time:

... I had six months off after both children and by the end... I was brain dead, like goo-goo-gaa-gaa... Whereas coming to work, yes it's great for me because I get to interact with other adults... and to keep the brain ticking over, to learn new skills... (PT57)

Social stimulation was associated with relationships with clients and with workplace friends and colleagues. The nursing literature has identified that mental stimulation and companionship are motivators to return to nursing on a part-time basis (Khalil & Davies 2000; Robinson *et al.* n.d). The literature also suggested that those who stay at home because of caring responsibilities have a declining accessibility to social networks (Barnett & Hyde 2001). Pocock's (2003) analysis of the relationship between work and care that was based on multiple data sources found that Australian communities have shifted from the traditional neighbourhood street to the workplace, providing a rationale for the declining accessibility to community based social networks.

4.3.5.   Control

'Control' has been identified to be a discernible motivator to work part-time that was evident in much data. The literature also identified that females in general and nurses more specifically choose to work part-time to gain 'control' (Brooks 2000; Godfrey 1980a; Kemp 1994; Pocock 2001b). Control was proposed as the perceived or real level of choice and influence that a nurse has in the decision making process affecting working time patterns (Brooks 2000).

Participants were motivated to work in a part-time capacity so that they could control the number of hours that they spent in the workplace. Part-time employment was used to control the dichotomising of available time by limiting the time spent in the workplace:

I definitely see it [part-time employment] *as more flexible for my personal life. I have more control over what I can do with my personal life if I'm part-time. I feel like if I was full-time then there would be five days a week that the choices of what I could do with my time outside work have been reduced, whereas at the moment it is only three days a week. Even if I get a bad roster..., then there's only three days that are ruined, not five out of my personal time. It's a control factor; it really is a control thing.* (PT29)

Analysis established that the 'control' motivation was a consequence of other motivators. Participants used part-time employment as a means to control imbalances so that a synergy could be potentially gained in relation to financial considerations, health related factors and the multiple roles that each participant performed. The literature suggested that those who have higher levels of stressors and demands may be more likely to seek control (Brooks 2000).

4.3.6. 'Motivators to work part-time': summary

Figure 5 (section 4.3) diagrammatically illustrates the concepts that formed the properties and dimensions of the category 'motivators to work part-time'. As only one participant was motivated to work part-time because a suitable full-time position was unavailable, this rationale was not included as it was unable to be grounded in data. Participants commonly perceived that their motivators would change over time. All participants were asked if they would increase their employment hours in the future. A future intention to permanently increase employment hours to full-time was rare. A typical comment was:

Probably as the kids get older I'll increase shifts, hopefully not to full-time. I have no desire to work full-time... you've put in a lot of time for kids... So when I've got them through I don't want to turn around and work full-time. I would like to have some time to myself. (PT18)

The findings of motivators to part-time employment enabled a rich understanding of the conditions that placed participants in the situation where they would

experience part-time nursing. These findings also identified that working time decisions are complex and commonly take into account many factors. Data established that if these motivators did not exist, most participants would be in full-time employment. Though not a 'causal' condition, 'motivators to work part-time' represented a condition that directly influenced 'employment hours' and contributed to the complex interweaving of this and the other conditions of 'specialty factors', 'individual factors' and 'organisational factors'.

Figure 6 is a model to provide the reader with a visual support to traverse the narrative report related to the other conditions identified by this study. The properties of these categories are placed subordinate to them and the dimensions of the properties are explained in the narrative text.

Figure 6: Contextual conditions
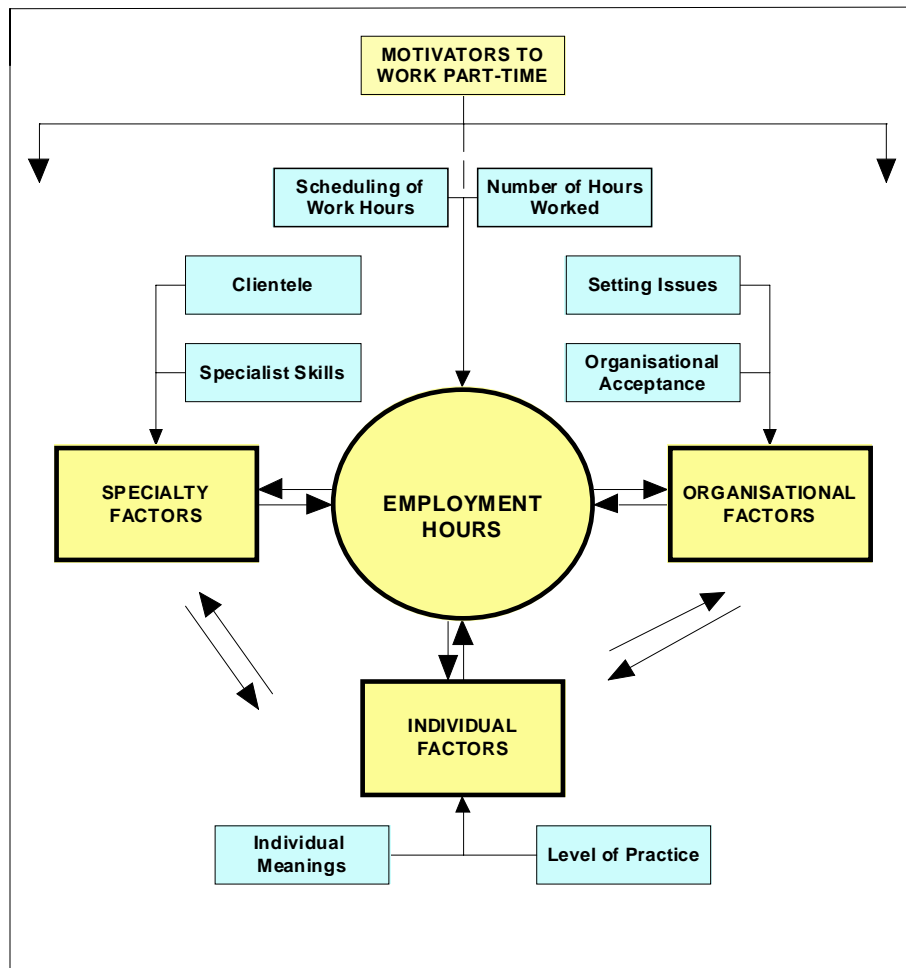
4.4. Employment hours

As already reported analysis found that decisions to work part-time were strongly and directly linked to the motivators that were reported in the previous section of this chapter. The condition 'employment hours' was analysed to be the chief 'causal' condition that influenced the basic social problem. This finding substantiated the necessity to gain a comprehensive understanding of the motivators to part-time employment.

4.4.1. Number of hours worked

Analysis clearly established that reducing employment hours to part-time was the foremost reason why the basic social problem was being experienced. Working part-time hours was found to have an extensive influence on all of the concepts identified in Chapter 3. However, Burke's (2004) quantitative study of Canadian full-time (n=382) and part-time (n=347) nurses found that when nurses' preferred number of work hours were congruent with their actual hours of employment, job satisfaction was higher and they were more likely to report greater psychological wellbeing. The current study found many positive outcomes emanating from part-time employment, as reported in the previous chapter. Based on Burke's (2004) findings this may be an outcome of participants' congruency of work hours.

Prior thought to the issue of employment hours was evident. Data described participants' experiences while working at their current numbers of work hours and those past experiences of employment at greater or fewer hours. Additionally observations of the experiences of others who were employed at greater or fewer work hours were found in data. These data explicitly identified the influence that working part-time had on professional nursing experiences. Participants were very willing to share what appeared to be well developed opinions about the number of employment hours that were perceived as functional for professional nursing practice and the number of hours that led to high levels of difficulties. Comparative analysis of data discovered that experiences differed depending upon how many hours per week were worked. Other general population studies have reported that experiences can differ based upon the number of hours that are

worked (Hakim 1998; Hom 1979; Rosendaal 2003). Rosendaal's (2003) quantitative study of part-time workers (n=1707) in the Netherlands, that included nurses in the study, found that the number of hours that were worked affected work experiences.

In the current study working close to full-time employment hours resulted in less professional difficulties. Larger numbers of hours spent in the workplace and associated smaller periods of time spent away from the workplace resulted in fewer difficulties and the difficulties that were encountered were experienced to a lesser level than was experienced by others. There was much similarity of experiences in data from those participants who were employed to work close to full-time hours. Additionally there was a clear delineation between data from those who worked these hours to data from those working lesser numbers of hours:

> *I don't think that I experience many difficulties working part-time. If it was less than four* [shifts per week] *it would be difficult by way of continuum of your nursing care of the patient. I work eight* [shifts per fortnight] and *that's not much less than full-time. But if I worked less, even one* [shift] *less, I would just feel on and off within the ward and I don't think you'd get a real feel for your care of your patient, your ongoing care.* (PT17)

Analysis established that eight hour shifts were the reference point for comments in data about shifts or days worked.

Smaller numbers of work hours were proposed to be associated with greater professional difficulties. When considering the issue of employment hours from the perspective of optimal professional nursing practice, data suggested that if at

146

all possible a nurse needed to work at least twenty hours per week with some

data describing a preference for a minimum of twenty four hours:

> *I did two* [shifts per week] *when I first came back initially but I found that too social. It's not enough. You've got to be here more to get in amongst things...* (PT51)

> *I think you have to work at least three days a week to keep up honestly. Having worked two days a week for a number of years and then having gone to five days a fortnight, that extra day even made a big difference. But I think if you really want to be an integral part of the workforce in your unit you have to do at least three days a week. That's my personal observation.* (PT50)

Data unanimously proposed that nurses who worked smaller numbers of hours

were more likely to experience considerable professional difficulties. Smaller

numbers of hours spent in the workplace and the associated large periods of time

spent away from the workplace were perceived to directly contribute to many

difficulties:

> *Part-time work if you only work one or two days a week... I think you're just so far removed that you just come to work, you work for that day and you go home and you might not come back for six or seven days... So I find that if you're only working one or two days a week I think that it is harder, much harder...* (PT65)

British researcher Hakim (1998), in her book related to social change and labour

restructuring, proposed that there is a need to define part-time work hours more

comprehensively than merely collectively grouping all as part-time employees.

Other studies reported in the literature substantiate this factor (Hom 1979;

Tansky, Gallagher & Wetzel 1997; Thorsteinson 2003). The findings from the

current study are consistent with those from the literature related to the need to

explore part-time nursing from the perspective of the actual hours that are

worked. Exploration of the influences that part-time employment as a collective

had on the basic social problem was advantageous. However, it was only when

that exploration was extended to a comparison of the number of actual hours worked that a comprehensive understanding of the situation was gained.

Variations in the experience of the basic social problem were very frequently directly related to the number of hours that were worked. Considerable similarities in experiences related to the basic social problem were found to exist among data from participants who worked similar numbers of hours. Also notable differences in experiences were found to occur when data emanated from participants who worked dissimilar numbers of work hours. These dimensions provided the basis for a good deal of explanation of the variations of experiences of the basic social problem.

The concept 'number of hours worked' strongly influenced the basic social problem. When the number of hours worked was close to full-time an 'intervening' influence affected the impact of the overall causal condition. However, when the number of hours worked was very small the impact was exacerbated. The condition 'motivators to work part-time' was found to markedly impact on decisions related to the number of hours that were able to be worked. These motivators influenced the number of hours worked that in turn influenced the basic social problem.

4.4.2. Scheduling of work hours

Analysis found that part-time employment was commonly linked to work schedules that were outside of routine business hours. Participants' motivators to work part-time were frequently an explanation for this. Shift workers were more

likely than others to experience the concepts reported in Chapter 3 of 'ineffectual communication' (section 3.4.1.1), 'isolation from the team' (section 3.4.1.2), 'less structured learning' (section 3.5.1.1) and 'limited horizontal advancement' (section 3.5.2.1). Data suggested that when work hours were scheduled outside of routine business hours the potential for difficulties were exacerbated:

> *... I don't think the fragmentation is any more difficult* [because of part-time employment] *because it's more about the shifts that you actually work. Some people who work full-time also work weekends and night duty and have days off in the middle of the week. So I don't think that fragmentation is a problem when you are working four* [shifts per week]. *Of course when you get down to probably three or two days a week, well especially two days a week you certainly don't get a lot of continuity at all and especially when you work your shifts out of hours.* (PT35)

Data proposed that benefits were available when work occurred during business hours. As one participant explained:

> *I understand why they* [managers] *encourage you to come in and do a day shift occasionally. Just to keep up to date with what's happening and be part of doctors' rounds... and get to know the people who work during the day and how things occur... to me that makes sense.* (PT36)

Brooks and Swailes (2002), reporting a quantitative study of British registered nurses (n=2987), provided support for the suggestion in the previous excerpt when they proposed that out of hours shifts can distance nurses from daytime experiences and development opportunities. A combination of working a smaller number of hours and work schedules that were primarily outside of routine business hours was found to be especially problematic in the current study.

When working time patterns included disjointed shift schedules more difficulties were experienced than when shifts were worked on consecutive days. Though the

scheduling of full-time nurses days off was constrained by industrial award

guidelines, this was not the case for those who worked in part-time employment.

Disjointed shift schedules provided greater challenges in providing client care:

> *... I guess sometimes continuity sometimes is a problem... it is always
> perhaps good to have someone there for a few shifts in a row... you
> know you can have someone part-time that* (sic) *may only do four or
> five shifts* [per fortnight] *but if they work them all together then you
> can get that continuity. But if they work them all separately then of
> course you can't...* (PT69)

'Employment hours' was identified as the major causal condition of the basic

social problem. However, analysis identified that this condition did not represent

the whole story. The condition 'motivators to work part-time' evidently

influenced this condition. Nevertheless there were other conditions that

interacted with participants' employment hours to ultimately determine the

influence on the basic social problem.

4.5. Specialty factors

Comparative analysis identified that the type of specialty in which nursing was

practised formed a condition that influenced the basic social problem. Jamal and

Baba's (1992) quantitative study of Canadian nurses' (n=1148) job stress, work

attitudes and behavioural intentions also found that specialty represented an

important variable. Participants in the current study worked in a wide variety of

specialties (see section 2.3.3.1) and these founded an explanation to some of the

variations identified in experiences of the problem.

4.5.1. Clientele

Data established that different specialties varied in their clients' typical lengths of stay. Irrespective of part-time employment, the concept 'challenges in providing client care' that was reported in Chapter 3 (section 3.4.2) was not experienced when nursing in a specialty where typical client lengths of stay were short-term, as occurred in specialties such as peri-operative and emergency. In these instances the expectations of both nurse and client was that relationships would be temporary. Also continuity of care could be achieved as the episode of care often took place during the one shift.

These difficulties were also not experienced when nursing in specialties where typical client lengths of stay were long-term, as occurred in specialties such as aged and residential care and renal nursing. In these specialties long periods of time were available to develop and cement nurse-client relationships and continuity of care was not an issue as client conditions did not usually change significantly.

Analysis identified that when the specialty provided for short- or long-term client lengths of stay an 'intervening' influence was evident. One participant's comments encapsulated the impact of client lengths of stay by describing the differing experiences of working in each of three areas within the maternity specialty:

> *I guess it* [issues concerning continuity of care and development of therapeutic relationships] *is probably different depending on the area that you work in. Like in the nursery* [neonatal special care nursery] *we have a rapport with the mums because they're* [babies are] *there long term. So you might see them for two days but when you come back in three days time after days off they're still there. Whereas it's*

probably not so much of an issue in labour ward because you only have the women there for a certain period of time. But out there [in the antenatal and postnatal ward] *the women are there for a few days so continuity of care is more of an issue because everything changes when you have days off.* (PT8)

This participant discussed the issues from the perspectives of three sub-specialties within the one specialty. Nevertheless analysis established that this issue was commonly associated with different specialties.

Some specialties, such as acute care, provide twenty four hour nursing services to clients that required participants to work a large percentage of their shifts outside routine business hours. Nursing in certain specialties, such as critical care, further increased the percentage of shifts worked outside routine business hours. The rationale was that similar staffing numbers were required throughout the twenty four hour care continuum. Clients in these specialties had high care needs that required very low nurse-client ratios. This situation was compared to other specialties that had reduced staffing out of business hours. The following represents a typical comment:

... I used to work in a critical care setting... I know the shifts would have been too difficult for me to maintain my family life. There is just too many nights and lates [shifts]. *So this area* [perioperative nursing] *has certainly been a Godsend in that respect... It's much more flexible and you work more day shifts by far because that's when we do our elective procedures so that's when we mostly work...* (PT52)

The difficulties of working scheduled hours outside routine business hours have already been reported. This issue was closely related to the concepts 'multiple roles' (section 4.3.3) and 'health preservation' (section 4.3.2) that were reported earlier in this chapter. The interweaving of these concepts founded a relationship

between nursing in certain specialties and a motivation to work fewer hours. The
difficulties associated with reducing the number of hours worked has also been
reported earlier in this chapter (section 4.4.1).

Challenges in providing client care were depicted in data as more important
in certain specialties, such as in mental health and paediatric nursing:

> *...Especially in mental health, nurses have to develop a trust with
> their patients and this can only be developed over time. Part-time*
> [employment] *definitely hinders this process particularly from
> the patient's perspective...* (PT42)

> *... like in Paeds* [paediatric] *you need to establish a rapport with
> kids... and that's really, really important in this area* [specialty]
> *because if they don't know and trust you you can't do anything, but
> listen to their screaming of course...* (PT70)

Specialties that cater for a more vulnerable clientele may magnify the experience
of 'challenges in providing client care'. Edwards and Robinson's (2004)
quantitative study of British line managers (n=51) and full-time (n=262) and
part-time (n=124) registered nurses found that part-time nursing in mental health
was most commonly associated with difficulties developing effective nurse-client
therapeutic relations. Malone's (1994) editorial suggested that psychiatric
inpatient units should be cautious in employing nurses who worked part-time.

4.5.2. Specialist skills

There is a plethora of literature highlighting the growing national and
international shortage of specialist nurses (Commonwealth of Australia 2002a,
2002b; Cowin & Jacobsson 2003a, 2003b; Creegan, Duffield & Forrester 2003;
Duffield & O'Brien-Pallas 2002, 2003). The current study found that acute
shortages of nurses in particular specialties increased managers' willingness to

employ nurses at whatever numbers of hours they were willing to work. Though Edwards and Robinson (2001) had presumed that this would be the case for the British Health Service context their analysis of part-time working across one Trust instead found higher concentrations of part-time nurses were found in departments where managers were sympathetic to part-time employment. Though the current study also found that understanding nurse managers increased accessibility to preferred employment hours, specialty nursing shortages also contributed considerably to gaining preferred numbers of work hours. Working in specialties with acute nursing shortages enabled greater access to smaller numbers of employment hours.

These shortages also increased accessibility to promotional opportunities, specifically to Level 2 positions. Data suggested that part-time nurses were more likely to be promoted to Level 2 positions when these positions couldn't be filled by full-time nurses. Specialty nurse shortages increased the likelihood of promotion as the availability of full-time nurses with specialist skills was limited. A typical comment was:

> *... a few years ago we did have Level 2 positions and we couldn't fill them and we recruited part-timers to the positions because they were the only applicants... Because there is a definite shortage of ICU* [intensive care unit] *nurses and especially when you are trying to get a job filled in regional areas...* (PT33)

Data included a limited number of accounts of attainment of temporary or permanent Level 2 positions while working smaller numbers of hours. Specialty nursing shortages were described in these data. In these circumstances nursing shortages had an 'intervening' influence on the basic social problem. This finding was closely associated with the following issue.

Data identified that certain specialties required greater specialist nursing knowledge and skill levels than may be required in other specialties. The specialty that nursing occurred in impacted on the level of difficulty experienced when up-skilling and/or maintaining skills. This was an issue that recurred regularly in data. A typical comment was:

> *... I had worked in a couple of areas* [specialties] *before I came to CCU* [Coronary Care Unit]. *But when I came here I really had a steep learning curve. You just need a much higher level of knowledge and practical skills to do cardiac nursing than I needed in those other areas...* (PT78)

The difficulties experienced were perceived to be greater the fewer number of hours that were worked.

The category 'specialty factors' represented a condition that had both 'causal' and 'intervening' influences. More importantly the condition made a notable contribution to the complex interweaving of conditions that ultimately determined the contextual conditions influencing the basic social problem.

4.6.   Individual factors

There was much evidence in data of the individual factors that influenced the basic social problem.

4.6.1.   Individual meanings

Comparative analysis of all data found variations in participants' perceptions of specific experiences. Some of the variations noted in the level of effect relating to the basic social problem were a natural phenomenon of human perception.

Benchmarking perceptions of experiences regularly occurred in data that made comparisons to nurses who worked differing numbers of work hours. The benchmark that was used at any given point markedly influenced perceptions of experiences of the basic social problem. The literature clearly highlights that the 'frame of reference' used by part-time employees influences perceptions of equity and affects job satisfaction (Armstrong-Stassen 1998; Barling & Gallagher 1996; Burke & Greenglass 2000; Eberhardt & Shani 1984; Feldman 1990; Tansky, Gallagher & Wetzel 1997; Thorsteinson 2003).

Individual attitudes influenced participants' experiences of difficulties. An example of many in data was when attitudes varied related to whether the workplace or the individual nurse should assume primary responsibility for the provision of learning opportunities. Irrespective of the number of hours worked, individuals who accepted primary responsibility for their own learning had fewer difficulties acquiring knowledge and skills. Participant's attitudes to phenomena were also analysed to be based on their individual prioritisation of importance. An example of many in data was when participants' described their current nursing role as what they wanted and perceived that promotion would lead them away from the work that they wanted to do. These data acknowledged that the potential for accessing opportunities for promotion were limited. However, this was not a perceived difficulty because these opportunities were not wanted. As one participant explained:

> *I'm not interested in promotion. Only because I'm happy doing Level 1 work. My priority is patient care and I just hate the paperwork that goes with the other Levels and...* (PT51)

Individual prioritisation of importance was also found to be closely related to the condition 'motivators to work part-time'.

Analysis identified that the meanings that individuals ascribed to their interactions with phenomena impacted on their perceptions and attitudes, including personal prioritisation, which in turn influenced their experiences of the basic social problem.

4.6.2. Level of practice

Level of practice was found through comparative analysis to have a considerable influence on experiences related to the concept 'difficulties acquiring knowledge and skills' that was reported in Chapter 3 (section 3.5.1). There was much data related to this issue. Being new to a specialty and/or having an undeveloped knowledge and skills base exacerbated the experience of difficulties. Whereas a well developed specialist knowledge and skills base had an 'intervening' influence. The following excerpt explained:

> ... *So I guess if you know the area* [specialty] *and you only work a couple of days a week then there is no negative sort of thing because you still know what you are doing and still know the area. Whereas I'm still sort of fresh meat, so it's very difficult to up-skill when you are working part-time...* (PT49)

Further comparative analysis found that fewer employment hours combined with limited levels of practice to exacerbate difficulties. Irrespective of employment hours, nursing at a high level of practice had an 'intervening' influence. A typical comment was:

> ... *I feel that the longer one has been working in the area* [specialty] *the more naturalised one becomes in their skills. So reducing one's hours has little effect on one's abilities.* (PT78)

Rosendaal (2003, p. 489) substantiates these findings when positing that the relationship between performance and hours of employment 'is probably influenced by experience, the familiarity with the work environment, personal capacities'.

Some data from the current study described strategies to increase the level of practice so that working a smaller number of hours was not such a difficulty:

> *Do you know that in discussions with the NUM* [Nurse Unit Manager] *she suggested to me that rather than trying to start here working two days a week that I work pretty much full-time to start off with, which I did. I worked four days a week for a month and it was definitely very advantageous to me. It was a good way to learn and I learned a lot in that short time. And as a matter of fact...* [name of another nurse] *has not done that and she has found it heaps more difficult...* (PT26)

Data substantiated the benefits of working a greater number of hours when new to a specialty.

Enrolled nurse participants proposed that they were less likely than registered nurses to experience vertical advancement difficulties because the level that they practised nursing was to a large extent predetermined by their nursing qualifications. These data suggested that though ability to horizontally advance existed, vertical advancement was, for the most part, limited by their qualification. It was suggested that enhancing the limited promotional opportunities for the enrolled nurse could only be achieved by becoming a registered nurse.

The condition 'individual factors' provided an important influence on the basic social problem and contributed considerably to the complex interweaving of

conditions. Data clearly identified that the condition was not static as individual

meanings and level of practice changed over time.

4.7. Organisational factors

 The category 'organisational factors' was analysed as a condition that provided a

direct influence upon the basic social problem and also made a significant

contribution to the interweaving of all identified conditions. This condition was

regularly found in data and has been analysed as very important to the situation

of part-time nursing.

4.7.1. Setting issues

Data identified that workplace settings varied in their ability to enable work

schedule flexibility. The following excerpt explained:

> ...*Can I talk about both areas* [settings] *that I've worked in lately?*
> *The first was much more difficult because of the shorter staffing ratio*
> [smaller number of nursing staff] *and the lack of senior staff most of*
> *the time. But when I went to the other area it was much easier*
> *because of a much bigger staffing pool and it allowed the in-charge*
> *Sister to be a lot more flexible with the shifts she gave you... so that*
> *was better to fit in with your family. But in my previous area that*
> *wasn't available because of staffing numbers. That's why I left that*
> *area.* (PT53)

Inflexibility in work schedules was a barrier to meeting other life demands that

commonly represented the motivators to work part-time. This finding was

substantiated by the British literature related to part-time nurses (Lane 1998;

Robinson *et al.* n.d). This issue was discussed in much data from the current

study and was also analysed to be closely related to the concept 'organisational

acceptance', the property that is reported next. Changing work settings or

reducing work hours were strategies used to gain more control in a situation of

inflexibility. These findings are consistent with those found by Robinson and colleagues' (n.d) longitudinal study of British registered nurses (n=620). In the current study changing work settings commonly led to situations where there was a need to develop further knowledge and skills in a new practice setting/specialty and therefore influenced the experience of difficulties acquiring knowledge and skills. As previously discussed in this chapter (section 4.4.1) reducing the number of hours worked contributed considerably to the experience of many difficulties.

Inflexible scheduling of workplace meetings and educational sessions was analysed to have a 'causal' influence on participants' ability to contribute to team decision making and in accessing structured learning. The scheduling of these forums was suggested to be restricted to routine business hours that were not always congruent with the time participants had available to attend.

Workplace settings where there were high levels of staff rotation or turnover were associated with experiences of being isolated from the team:

> *It's also hard to develop good working relationships with the medical staff because they rotate so quickly. Like the junior registrars in this unit are only in the place for twelve weeks and I've actually worked where I've never encountered a couple of them because their shifts haven't coincided with mine. And so it's very difficult to develop a good working relationship with other staff, medical and allied health, when they rotate so quickly in this unit and you don't work that much.* (PT33)

This issue was regularly found in data and had a 'causal' influence on the basic problem, especially when associated with smaller numbers of work hours.

4.7.2. Organisational acceptance

Data established that the organisational support that was provided to participants varied. Organisational support, or lack of support, directly influenced the basic social problem by impacting on many of the concepts identified in Chapter 3. Therefore this condition was analysed to have wide reaching influences on the basic social problem. There was much data proposing that nurse managers primarily and nurse educators as a secondary source were central to the issue of organisational support; a finding substantiated by Australian researchers Jones and Cheek (2003). Iranian researchers Hagbaghery and colleagues (2004) found that support from nursing management was a necessary prerequisite for the empowerment of nurses. Consistent with the grounded theory approach, these findings led this researcher to theoretically sample nurse managers and nurse educators.

Participants perceived that they were accepted in the workplace and data from the nurse manager and nurse educator cohort substantiated this. Participants acknowledged that their employing facilities and/or managers accepted their applications to work part-time and to further reduce their employment hours when the need arose. A typical comment was:

> *I have always found that the hospital has been very accommodating to me as a part-timer... if I ever have any difficulty or had wanted to cut back* [employment hours] *even further... which I have done over the years from time to time, it's never been a problem, they accept it. I've never been confronted with 'Oh well if you have to' kind of thing...* (PT32)

Acceptance of nurses who worked part-time was an issue that regularly recurred in data and the term '*accept/ed*' was frequently used. The attitudes of others in the workplace had changed over time and acceptance was presented as a

relatively recent happening. This factor may provide the rationale for why acceptance was very important to participants. Additionally until very recently healthcare facilities' executive and middle managers did not commonly accept the employment of those who desired smaller numbers of work hours. The rationale for this very recent change was embedded in current nursing shortages.

All nurse managers in this study were asked to provide the number of their overall nursing staff and the number of those who worked part-time. The percentages of nurses employed part-time varied widely from 25 to 83% of overall nursing staff. Differences in the levels of specialty nursing shortages were deemed to be the most significant factor leading to these variations. Analysis identified that the attitudes of individual managers also impacted upon these findings. Nonetheless the growing numbers of part-time nurses was proposed by participants to have contributed to their increased acceptance. Nurse managers recommended that nursing shortages, which were especially pronounced in some specialties, were affecting employment decisions. Commonly against their better judgement, nursing shortages had forced managers to employ nurses at fewer numbers of hours than they would have done prior to these shortages. Analysis identified that acceptance of part-time nurses, especially acceptance of those who prefer fewer work hours, was sometimes a reluctant situational outcome.

Though accepted, nurses who were employed in a part-time capacity were commonly not supported. Chapter 3 reported the difficulties experienced while nursing part-time. There was substantial evidence in participants' data that unsupportive attitudes and management by nurse managers primarily and nurse

educators either directly or indirectly had a 'causal' influence on participants' experiences of the basic social problem.

Data established that differences in individual nurse managers and nurse educators attitudes and management techniques contributed to wide variations in the support that participants gained. The following excerpt explained one participant's situation:

> ... I can't even remember the last in-service that I had, I don't know if I've had any. I seem to be missing all these opportunities for education... there's a real breakdown in communication here [participant's practice unit] whereas information gets sent out to other wards and they have a definite area and a definite system to go to, to find out what's available... even someone to speak to... With myself, we don't have these systems and I find it hard to pin my nurse manager down to discuss anything... (PT66)

This example demonstrated how variations in supportive strategies influenced experiences of difficulties.

In participants' data organisational support was closely associated with nurse managers' and nurse educators' attitudes towards those who practised part-time. Data from the nurse manager and nurse educator cohort proposed many benefits from employing part-time nurses. However, not all of these were beneficial to the part-time nurse. For example, these data proposed that the ability to roster part-time nurses to disjointed work schedules was advantageous. Findings from participants' data did not support this situation as professionally beneficial.

Data from the nurse manager and nurse educator cohort identified that in general their perceptions of nurses' motivators to part-time employment were consistent, though commonly narrower in range, with the findings from participants.

However, though they were able to provide the researcher with a variety of motivators, individual perceptions varied. One nurse manager noted:

> *Most part-timers work the amount of hours they need to match their financial commitments. Not many work more hours than they need to unless it would be for career progress. And because they have other commitments, family commitments and some of them wouldn't work if they didn't have to, I don't think most of them particularly want career progression...* (M17)

This data failed to acknowledge the heterogeneity of nurses' motivators to work part-time and their professional aspirations. Also data from this nurse manager later included issues surrounding promotional opportunities for nurses who worked part-time from the perspective that none wanted these opportunities; therefore it was not a difficulty that needed to be addressed. This represented one example of many in data identifying that attitudes were closely associated with the provision, or lack of provision, of support.

The nurse manager and nurse educator cohort were asked if they perceived any difficulties associated with employing part-time nurses. Difficulties in developing and assessing the knowledge and skills of these nurses were described in data. Continuity of client care difficulties were also perceived to negatively impact on their units. Issues surrounding communication of change were described and data proposed that an increased timeframe was needed to get the information to part-time nurses. Rostering for other life needs were perceived as difficult.

What became evident from analysis of data was that some situations were just accepted while others were addressed through a range of resourceful strategies. For example, management of nurses' roster requirements varied with some data

proposing that creative rostering was used to enable flexibility while other data explained:

> *... all nurses should be available for all shifts on all days of the week... and nurses need to make their own arrangements to enable this to occur...* (M5)

The inflexibility evidenced in the above excerpt could be seen as irrational management in an era of nursing shortages. However, Brooks and Swailes (2002) suggested that instead this may be driven by operational and professional requirements. Nevertheless this study identified that inflexibility of work schedules influenced the basic social problem via a number of routes.

Employment of part-time nurses increased the actual numbers of nursing staff in a workplace. This factor presented difficulties in many areas of management as additional resources had to be allocated. In an opinion paper British author Tisdall (1999) also suggested that managing part-time staff is more resource intensive than managing full-time staff. Data from the nurse manager and nurse educator cohort identified these situations as being accepted as a fact of life and something that had to be lived with. However, there was evidence in some data that these potential difficulties could be addressed by finding creative solutions. For example, data suggested that providing financial resources and organising the allocation of nurses to mandatory training and professional development was arduous when dealing with larger numbers of nurses. However, the following excerpt explained that this situation did not need to be seen as a difficulty:

> *... Yes there are more hours expended on mandatory training alone in order to meet that requirement than if there were less people... but because so many are part-time it also means you have the advantage of being able to roster them an additional four hours on top of their contracted hours or whatever in order to get the training done. And if you had less staff because they were all full-time I'm not sure that it*

would be any easier to get them to training and you'd probably have
to backfill them with a casual anyway. (M1)

The nurse manager and nurse educator data suggested that commonly the number of hours a nurse worked impacted upon decisions. An example is provided by a nurse educator who noted:

> *... but it depends on how much* (sic) *part-time hours someone is doing. If you've got someone working one or two days a week you will find that the NUM* [Nurse Unit Manager] *is very reluctant to let them go in paid time to any sort of educational session and that comes down to budgeting and I guess equity issues. But then if you really look at equity issues I think the part-timer is really entitled to as much training as the full-timer... they need to know what the full-timer needs to know. The full-timer's here day in day out and the full-timer actually probably has more access to impromptu education than the part-timer. So actually in reality the part-timer is the one that's* (sic) *missing out.* (M9)

This example also substantiated that perceptions impacted upon how a situation was addressed. Managers' concerns related to the additional overhead costs associated with the training and development of part-time nurses and their reluctance to allocate resources to this activity has also been identified in the literature (Edwards & Robinson 2001, 2004).

Data suggested that though educators organised educational sessions they were reliant on nurse managers to give nurses permission to attend. Some data from nurse educators accepted this situation as being out of their control. Other data established an ownership of the situation by developing alternative strategies to assist, such as the development of self-directed workbooks that could be completed at the individual nurse's own pace. These resourceful strategies provided for a more supportive environment. Instances in participants' data of supportive attitudes and management by nurse managers and nurse educators

were analysed to have a considerable 'intervening' influence on the difficulties experienced. Therefore resourceful strategies by this cohort were important.

Nurses at the level of nurse manager and nurse educator were generally perceived by participants to be the gatekeepers of promotional opportunities. Therefore this cohort was asked whether they believed that nurses who worked part-time were able to access promotional opportunities. Opportunities for promotion to Level 2 positions were suggested to be available. However, considerable variations were evident in data about the number of hours that a nurse needed to work to access promotion to this level. Most data proposed that full-time employment or close to full-time employment was recommended. Smaller numbers of employment hours were not commonly supported.

These data suggested that it would be rare to access positions above Level 2 while remaining in part-time employment. Interestingly most from this cohort proposed that they would like to work part-time instead of full-time. Burnout from excessive workloads was the rationale most frequently given. Nurse educators perceived that their positions could easily be job shared. Nurse managers suggested that job sharing could be an option but were wary of the implications of not having a full-time nurse performing their roles. Branine's (2003) large mixed methods study of British healthcare employees found that the majority of managers perceived that not all roles were suitable for job sharing. Branine (2003) denied that this belief was accurate as job sharing was suggested to be available in all roles somewhere in the National Health Service.

One nurse manager proposed that she was seriously considering applying to job share her role. This data proposed that significant opposition to the idea would come from those at executive level within her healthcare facility:

> ... I would like to be able to work part-time, and I think that just because I have a young family doesn't mean that I'm not good at my job... It just means that at this point in time it would be beneficial for me... And there are a number of hospitals in Brisbane now who have job sharing Level 3 positions and they were trialled and were evaluated and have been shown to be beneficial to the organisation... but even though it is in place in Brisbane I know I will have lots of opposition to it. They just don't want it here... (M10)

This substantiated findings from participants' data and the literature.

Comparative analysis of data from the nurse manager and nurse educator cohort identified wide ranging diversities in their attitudes and the techniques used to manage part-time nurses. As one nurse educator commented:

> ... I would like to see a bit more support for those people [part-time nurses] ... Every unit is different, every leadership style is different. You have your main leadership styles but boy are there some quirks there. I mean some are supportive to part-timers but some aren't that's for sure. (M9)

Some from the nurse manager and nurse educator cohort were employed in the same healthcare facilities. Variations were also evident in data that emanated from those in the same healthcare facility. Analysis could not identify a consistent approach in the management of part-time nurses. Rather variations were endemic.

Therefore this cohort was asked to describe the sources of information that they used to direct their management of part-time nurses. The industrial award's references to part-time nurses were described in all data. Past experiences of strategies that worked and those that didn't work in managing part-time nurses

were considered an important resource. Table 17 (section 2.3.3.1) identified that the majority of this cohort had ten years experience or more in their roles. Therefore past experiences were potentially a substantial resource. Experiences of being a parent or in part-time employment were also a resource. Demographic survey found that eleven (61%) of this cohort had experience working part-time. However, ten of the eleven had worked close to full-time employment hours rather than a smaller number of hours. Knowledge of organisational policies and guidelines was limited. Information related to rostering policies were found in data but knowledge of flexible work arrangements such as job sharing was meagre. The individual nurse was presented in limited data as a resource that could direct individualised management strategies. Legislative requirements, such as equal employment opportunity legislation, were not presented in data as a potential resource. Analysis failed to find a systematic use of resources to found management practices.

Findings indicated that nurses who worked part-time were 'accepted' in their workplaces. However, acceptance did not automatically translate to support. A wealth of data was gained from the nurse manager and nurse educator cohort. This assisted to enhance understanding related to this concept. A consistent approach to the management of part-time nurses was unavailable in these data. Supportive management strategies were unsystematic and an attitude of 'acceptance' of situations was commonly apparent. Creative solutions to address issues and enhance support were offered in data but these were not used by all. Analysis of participants' data has clearly established that an unsupportive

workplace has a 'causal' influence on the basic social problem. The reverse

situation has an 'intervening' influence. Therefore these issues were important.

The condition 'organisational factors' was analysed to directly influence the

basic social problem and provide significant explanation of variations in

experiences of difficulties. This condition was also found to have multiple

connections to the other conditions already identified in this report and as such

was an important contributor to the interweaving of conditions.

4.8.   Conclusion

The conditions influencing the problem experienced when nursing part-time have

been reported in the previous pages of this chapter. The identified conditions

have been grounded in a preponderance of data substantiating that participants in

this study interpreted them as influential to their experiences. The dilemma in the

writing of this report was to present the conditions in an uncomplicated way to

enhance understanding while simultaneously preserving the complex

interweaving of conditions that created individuals' 'contextual' conditions.

Multiple and diverse patterns of connectivity among and between conditions

were highly evident in the data. The interweaving of these conditions created

'contextual' conditions that have been demonstrated to lead to variations in part-

time nurses' experiences of the basic social problem. This is because specific sets

of conditions intersect to create the problem at certain places and times. It is

logical that all part-time nurses do not find themselves in exactly the same

circumstances. Therefore participants experienced variations in their experiences.

However, though the 'contextual' conditions differed for each individual and

changed as each individual moved throughout the trajectory of part-time

employment, all participants experienced an 'inability to achieve personal

optimal nursing potential' that was the basic social problem shared by all.

Chapter 5
Basic social process

5.1. Overview

The grounded theory approach enabled discovery of the problem that was experienced and the conditions that were influencing the problem. These were reported in Chapters 3 and 4. This chapter reports the process conceptually labelled as 'corrective juggling' that was used to respond to the problem. The category was central, related to all other categories, appeared frequently in data and provided a logical explanation to what was happening in data (Strauss & Corbin 1998). Therefore the category 'corrective juggling' met criteria that established that it was the core category of this study. The following pages report the three phases of 'corrective juggling'. Excerpts of raw data are used to substantiate that conceptualisations are grounded in data. Figure 7 provides a schematic visualisation of the concepts that are subordinate to this category.

The later part of this chapter reports the substantive theory that was developed by this study to explain the situation of part-time nursing. The categories that were reported in Chapters 3, 4 and in this chapter are related to each other to form theory. As suggested in the introduction to Chapter 3, it is hoped that the summative section of the report of the findings should merely be an affirmation to the reader of what has already been discovered.

Figure 7:   Corrective juggling
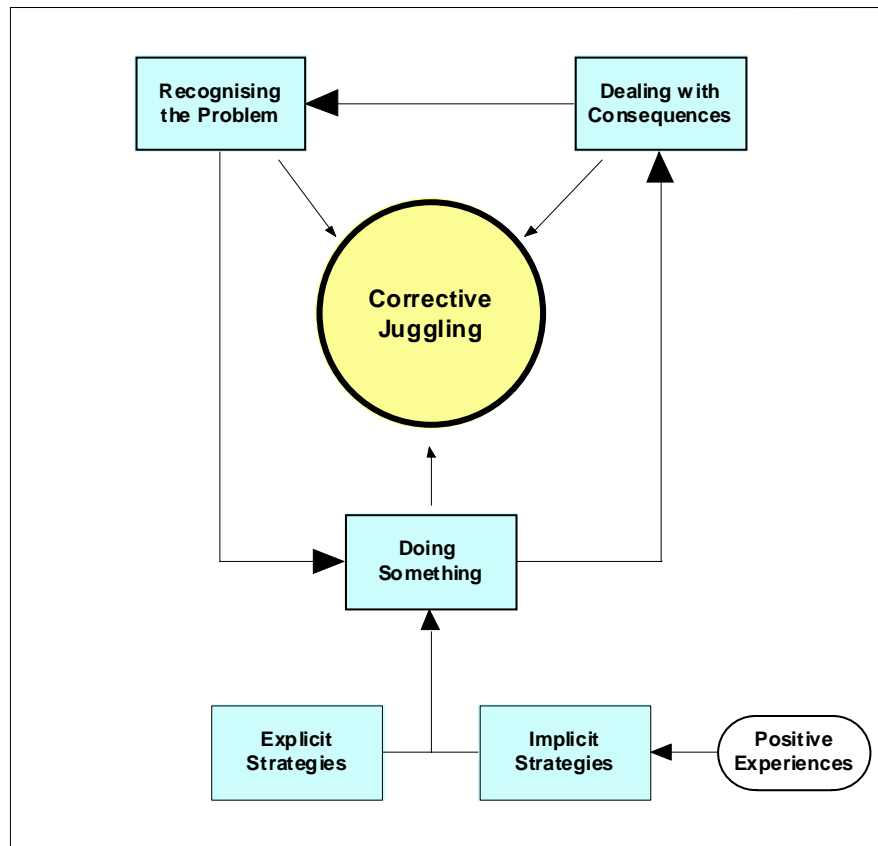
5.2.   Discovery of the basic social process

The identified problem that was occurring and the conditions that influenced this problem provided notable explanation of the situation of part-time nursing. Though multiple connections were evident between identified categories the situation of part-time nursing, as represented by analytic conceptualisations of the problem and conditions, was somewhat stagnant. However, inactivity was not found in raw data. Rather there was much evidence of actions/interactions. In the initial phases of the study these seemed to be uncoordinated events. However, exploration using the grounded theory techniques provided evidence that there were a series of orderly, coordinated, evolving sequences of actions/interactions that were occurring over time (Strauss & Corbin 1998). Analysis of the

actions/interactions found in data established that they were processural in nature, accounted for change over time, were conceptually labelled by gerunds (an 'ing' word) and the category was found to be the core category (Schreiber 2001, p. 75). When considering these factors it became apparent to this researcher that the category that had been discovered could be distinguished from other identified categories because it met the criteria for what Glaser (1992) termed a 'basic social process'.

5.3. Corrective juggling

'Corrective juggling' was used as a means to correct the professional practice imbalances that founded the basic social problem. The process involved making adjustments to the conditions that had a 'causal' influence on these imbalances. The underlying aim of the process was to gain a synergy and forward progression of professional practice. However, analysis has clearly established that while participants remained in part-time employment this was not fully achievable. Though correction was not achievable, limitation of the scope and level of difficulties was. These factors resulted in the process continuing across the trajectory of part-time employment.

The process was one of continually juggling conditions to try to correct the difficulties experienced when nursing part-time. As has already been explained the basic social process of 'corrective juggling' was closely related to all categories and has been identified as the core category of the study. Analysis found three main phases of 'corrective juggling'. These were 'recognising the problem', 'doing something' and 'dealing with the consequences'. Analysis

established that these phases occurred through a cyclic sequence that was the continual process of 'corrective juggling'.

5.3.1. Recognising the problem

An 'inability to achieve personal optimal nursing potential' was the problem shared by all participants in this study. However, this problem was not openly articulated. Analysis identified that while participants recognised and acknowledged the properties and dimensions of the problem, the overarching basic social problem had remained hidden. Recognition of the individual properties and dimensions of the problem formed the focus for the responsive actions/interactions that occurred. Therefore participants' recognition of specific difficulties provided an impetus for them to do something to respond to those particular difficulties. Because the problem had remained unrecognised these responses were consequently focussed reactions rather than being a broader response to the overarching problem itself.

5.3.2. Doing something

Recognition of these difficulties initiated the strategies that were used to respond to and shape the situation in which participants found themselves. A response to and shaping of a situation are characteristics of a process, as suggested by Strauss and Corbin (1998). Corrective juggling included wide ranging strategies that were used to endeavour to correct recognised difficulties. Analysis found that the conditions that have been reported in Chapter 4 were the vehicles for corrective juggling. The phase of 'doing something' included explicit and implicit strategies. While the explicit strategies were easily accessed and explored during

data collection and analysis, the implicit strategies required a far more discerning approach to extrapolate embedded strategies. Many corrective strategies have already been reported in the narrative text and data excerpts of Chapter 3. These and other illustrations from data are used to ground conceptualisations of the 'corrective juggling' process that are reported in the following pages.

5.3.2.1. Explicit strategies

Participants' use of corrective strategies often involved explicit changes to the 'causal' conditions. The most common corrective strategy used was that of increasing the number of hours that were worked. Rescheduling work hours to include routine business hours and/or to work shifts on consecutive days were also common corrective strategies. An example of a corrective strategy that included both increasing the number of hours worked and working those on consecutive days follows:

> *... I've increased my shifts from thirty two hours a fortnight to forty hours... and now I am going to do a forty hour week every other week. So forty hours a fortnight and just cram it into one week. Nothing to do with things being easier* [at home] *but just to find a bit of continuity at work. Because I've found that you do one shift, you have a few days off, you do two* [shifts], *you have a longer stretch off and you just don't seem to be having any continuity of care or keeping up to date with anything that might be going on...* (PT79)

At times making changes to the condition 'employment hours' was a planned temporary strategy. For example, short-term increases in work hours to full-time or close to full-time were a strategy to up-skill to a new specialty or to gain a temporary promotional opportunity.

Corrective strategies that were focussed on the condition 'employment hours' could logically be expected as this was identified as the chief 'causal' condition

of the difficulties experienced when nursing part-time. Additionally dimensions of this condition were identified as having an 'intervening' influence. Therefore changes to this condition to gain an 'intervening' influence represented an apt strategy to limit difficulties. Data clearly established that changes were continuously being made in relation to this condition. Hiscott's (1994) study of Canadian registered nurses (n=1056) also found high levels of changes in employment hours. However, though that study explored family status and age in relation to this phenomenon, Hiscott (1994) acknowledged that a limitation of the study was a failure to take into account specific job related problems and the implications on professional practice. Much data in the current study included experiences of nursing at current employment hours and past experiences at greater and fewer numbers of work hours. While this factor enhanced the depth of exploration into this condition, it also substantiated the condition's prominent relationship with the category 'corrective juggling'.

The condition 'specialty factors' provided a further vehicle for corrective strategies. One example of many in data follows. Some specialties catered for a clientele that enabled operational hours to be limited to routine business hours. These specialties were perceived to limit communication difficulties, feelings of isolation from the team and difficulties accessing structured learning. A typical comment was:

> *I used to work shift work in the acute section and I hated that. I hated the shift work but I also found it difficult to keep up with things when you never seemed to work during the day. Like, I was never there for meetings or education times and stuff. This is much better* [working routine business hours]. *I only work two days a week but when I do work I'm here when everyone else is here. So that is when everything happens and if it happens on the days that I work then I'm here for it. It's much better.* (PT86)

The important added advantages of this strategy were that it represented a means to avoid the negative health repercussions of shift work and permitted those with school aged children to better meet caring responsibilities.

The condition 'organisational factors' was not a vehicle used by participants for 'corrective juggling'. This condition was perceived to be out of participants' control. However, analysis identified evidence of corrective strategies being used by others in the workplace, such as nurse managers and nurse educators. The innovative strategies by nurse managers and nurse educators that were discussed in Chapter 4 (section 4.7.2) have been analysed to represent corrective strategies that enhanced the support provided to part-time nurses. Though these strategies provided an 'intervening' influence on the experiences of difficulties, participants were unable to control their use. Therefore they were adjacent to the corrective juggling process.

Approximately eight months post interview the researcher went back to participants to identify whether they had initiated 'corrective juggling' since initial interview. Difficulties contacting some participants led to questioning of fifty six study participants. As information about implicit corrective strategies was more difficult to collect, information collected was limited to explicit corrective strategies. Twenty nine (52%) of these participants had used explicit corrective strategies in the prior eight months. Permanent or temporary increase of employment hours and/or change of specialty were the most common corrective strategies used. Often the rationale given by participants for these

changes was to enhance learning and/or to gain temporary promotional opportunities.

Analysis established that it was rare for a corrective strategy to 'act' on one condition alone. Rather any corrective strategy involved actions/interactions with a number of conditions. For example, when the number of hours worked were increased this commonly required personal reprioritisation of the importance ('individual factors') of the motivators to work the original number of hours ('motivators to work part-time'). In this situation, though changes to the condition 'employment hours' were explicit in data, the other changes were of a more implicit nature.

5.3.2.2.   Implicit strategies

A sensitive approach to data collection and analysis enabled multiple implicit strategies to be identified. Implicit strategies commonly focussed on making changes to the condition 'individual factors'. Changes in perceptions and attitudes, including personal prioritisations, were frequently the means for these corrective strategies. An example provided in Chapter 3 (section 3.4.1.1) was the decision to use personal time during meal breaks to read communication books, notice boards or emails to try to correct the difficulties caused by ineffective communication.

Data included descriptions of many corrective strategies that could potentially provide 'intervening' influences but were not currently used. These creative ideas were implicit corrective strategies that were evidence of a proactive

approach to difficulties. Chapter 3 (section 3.5.1.1) reported the strategy of introducing greater flexibility of education session scheduling and the potential for videotaping these sessions. Chapter 3 (section 3.5.3) also reported the strategy of using performance appraisal and planning processes to decrease professional development difficulties.

More flexible work scheduling, such as ten hour night shifts, was presented as a potential corrective strategy that was used in some practice settings but was not common. An increase in the overlap between all shifts was associated with ten hour night shifts. This was perceived to enable an increased timeframe for verbal handovers and reading of client documentation that would assist the continuity of care difficulties that were reported in Chapter 3 (section 2.4.2.1). Additionally, increased shift overlap times were suggested to provide time to participate in short unit based educational sessions and to achieve extra responsibilities. As one participant explained:

> *... the organisation has seriously got to look at their rostering system.*
> *Throw out the eight hour night shift, it is antiquated, and get up to*
> *the ten hour night shift ... what we did in Melbourne was that*
> *afternoon shift came on at one o'clock, morning shift went to lunch*
> *after they had handed over. When morning shift came back they*
> *either did something that was their project or they went to the*
> *educational session that was a daily occurrence Monday to Friday.*
> *At the end of that they would come out onto the floor and the*
> *afternoon staff would then go and have the same education session*
> *and then come and take over after that to allow morning staff to go*
> *home.* (PT56)

These represented several examples of the many found in data of corrective strategies that had been conceived but commonly could not be utilised as their implementation was reliant on others within the organisation, such as nurse managers and nurse educators.

Job sharing was a potential corrective strategy in data reported in Chapter 3 (section 3.5.2.2) and Chapter 4 (section 4.7.2). The distinction between job sharing and part-time employment was commonly not recognised. Branine (2003) also found that British National Health Service employees' distinction between these two flexible work arrangements was limited. Nevertheless, situations where two nurses worked part-time and shared a full-time (or greater number of hours) work schedule were suggested to have many advantages. One participant who shared a seven day a week work schedule with another nurse explained:

> *... there's two of us that do the position and... between us we can swap our days if it's convenient and it's good to have that flexibility. And we work really well together... We certainly pass on information to each other but it actually means that we're doing it on our days off because we never work together... There's always information that we have to hand over so always one of us is on a day off and talking to the other one who is at work on the phone. But that's the way we manage it. I mean you could spend an hour writing out notes to each other but it's easier and a lot faster to pass a lot of things on verbally... So it means that we get some continuity in our role. Like the patients get continuity because we pass on things to each other so we know those little things that are good to know but that you don't necessarily want to write in their charts... And like* [name of a nurse] *always tells the patients that I will be on the next day so they feel they know you a bit even before you walk in the door and I do the same for her... And we know what's going on in the ward because if one of us knows something we both do... And if one of us attends an in-service or something we tell the other all about it... (PT75)*

These nurses had developed their own support system that was aimed at reducing multiple difficulties. The strategy of sharing a work schedule was explicit and therefore easily found in data. However, the other strategies were implicit corrective strategies that were not easily accessed during data collection or extrapolated during analysis. Other related data suggested that child caring could

be shared in such an arrangement. While one nurse worked the other would be responsible for caring for children. In this way many of the difficulties associated with meeting caring responsibilities while working would be resolved. A small data in the current study noted that requests to share a work schedule were denied. British healthcare employees in Branine's (2003) study who had experiences of job sharing also saw the ability to more successfully meet caring responsibilities as an important advantage.

An interesting implicit corrective strategy that was accessed during data collection was a description of a situation where a group of nurses who worked part-time used personal time to regularly meet together for morning tea while their preschool children played together. Data suggested that these were deliberately planned meetings to enhance learning by discussing nursing issues:

> *... A lot of the time I was keeping up* [developing knowledge] *through girlfriends... Like we used to get together for coffee and have a chat about work. It's amazing what you pick up from someone telling a story of something that happened to them. And from that you remember more than from someone probably standing up and giving a lecture about it. And you sit there saying 'So what did you do?'. So there have been many times that I could say having coffee and listening to my girlfriends have actually helped me at work when I come across something and think 'Wow, that person is having the same thing that* [name of a friend] *had happen with her patient'.*
> (PT79)

These nurses had recognised that limited learning opportunities were associated with part-time employment and they had responded through a purposeful and innovative corrective strategy.

Practicing with equipment during periods of low activity and making a concerted

effort to be exposed to new skills were other examples of implicit strategies

found in data. A typical comment was:

> *I try to make myself updated because I realise that it is a problem when you work part-time. So if someone is doing something that I haven't seen I'll make a point of making time to go to see it being done, even if I have to bust a gut to do my own work first so that I have that extra time. And if I get the chance to I'll ask if I can do it myself with somebody standing next to me. So I do try to do things like that. And I ask lots of questions all the time and make sure that I'm not just having a chat in breaks* [meal breaks]. *I'm always picking peoples' minds so that I can learn more...* (PT18)

Analysis identified that there were times that participants seemingly called a halt

to the continual process of corrective juggling. This was closely associated in

data with the situation identified in Chapter 3 (section 3.5.3) of 'maintenance'.

Data acknowledged that though professional difficulties were experienced, at

times they were tolerated because the motivators to work part-time were

considered a priority that would be endangered by any corrective strategy.

Therefore there was a willingness to tolerate professional deficits. Often this

situation was presented as temporary. Participants suggested that when other life

demands reduced they would reinitiate corrective strategies. One participant

explained:

> *... and it is very hard* [a lot of professional difficulties] *working part-time but at the moment I do it for my kids and they are the priority. And I have tried going up in shifts* [number of hours worked] *but it just doesn't work* [at home]. *So at the moment I just tolerate it being hard because I can't do anything about it... But when the kids get older I will increase my shifts...* (PT25)

Initially this researcher considered that situations such as the one described in the

previous data excerpt were examples where a response was not being made to the

difficulties experienced and as such did not represent a corrective strategy. However, further analysis identified that the decision to tolerate the situation required a change in the perceptions and attitudes that characterised 'individual meanings'. Tolerance of the situation provided a somewhat 'intervening' influence. Therefore the decision represented a very important implicit corrective strategy. Data also alluded to the fact that corrective juggling did not come to a stop until corrective strategies were reinitiated. Instead there was a continual process of recognising the difficulties that were experienced, choosing not to do anything and then dealing with the consequences of that decision. Therefore 'corrective juggling' continued even in this period of seeming halt to the process.

The positive experiences that were reported in Chapter 3 (section 3.2) have been closely associated with experiences of difficulties in much data. Analysis has identified that commonly the positive experiences were presented as a 'justification' for continuing to work in part-time employment. It seemed the message participants were conveying was that irrespective of the associated difficulties there were positive professional outcomes associated with part-time employment that justified continuing to pursue this work arrangement. This factor has been analysed to be illustrative of an implicit corrective strategy as there was evidence of a greater tolerance of the difficulties when the positive experiences were perceived as important.

5.3.3. Dealing with the consequences

'Corrective juggling' has been analysed as a dynamic process that aimed to correct the difficulties experienced. Data identified that there were always consequences from these actions/interactions. The consequences of corrective strategies were either a limiting of the scope and/or level of difficulties experienced or the difficulties remained unchanged. Data identified that these consequences fed back to the conditions. An example of this was provided in Chapter 3 (section 3.5.2.2). When the difficulty of 'limited vertical advancement' was recognised one corrective strategy was to attempt to gain promotion while retaining part-time status. Commonly the consequences of this corrective strategy were that promotion remained inaccessible. This fed back to the condition 'individual factors'. A personal reprioritisation of the importance of promotion was made and was often expressed as an attitude of disinterest and/or acceptance.

Analysis found that diminished professional self-confidence was an issue that many participants discussed, mentioned or alluded to. The issue recurred regularly in data establishing that it was an important consequence that participants had to deal with. When the difficulties illustrative of 'an inability to achieve personal optimal nursing potential' continued to exist even after corrective strategies were used, this consequence fed back to the condition 'individual factors'. Participants experienced a diminished self-confidence in their nursing practice. This was analysed to be professionally debilitating, promoting uncertainty and hesitancy in nursing practices. A comment that was typical of many was:

... and when you work part-time well, you're not in the place as often to see things, like with patients, and to know about changes. And I started to loose my confidence a little bit in my ability to do things because I didn't feel that I was up to speed. (PT26)

Diminished professional self-confidence was also associated with lowered self-esteem that commonly led to self-devaluation. Data identified wide differences in the levels of lowered self-esteem that occurred. One respondent commented:

I think sometimes as part-timers you think perhaps you're not, in terms of opportunities like professional development, that perhaps you feel you're not worthy. Because you're not here as much as full-timers and can't contribute as much as they can so maybe they are more worthy of these opportunities ... (PT31)

When the consequences of corrective strategies were not favourable, unconstructive changes to the conditions were commonly seen to occur. As the previous examples have shown, disinterest, acceptance, diminished professional self-confidence and lowered self-esteem were unconstructive outcomes of 'dealing with the consequences'.

Analysis established that commonly corrective strategies were associated with consequences that led to an ultimate reversal of the strategy. For example, the corrective strategy of increasing the number of hours worked was frequently associated in data with a later reduction of these hours. This researcher consistently asked the question 'What is happening here?' This questioning of data exposed the connectivity that was occurring between multiple categories. When the numbers of work hours was increased as a corrective strategy, the motivators for the decision to work those original hours had to be reprioritised. An increase in work hours had an 'intervening' influence on the basic social problem. However, time re-established the importance of the initial motivators.

This was especially the case when the strategy used had achieved the goal of limiting the difficulties that were the impetus for the corrective strategy. With these difficulties no longer of such magnitude and the importance of the original motivators re-established as a priority, the strategy was reversed by reducing the number of hours worked. The difficulties then returned.

Extrapolating the issues from data identified complex, dynamic relationships between categories. However, these complex relationships were logical which enhanced understanding. The following excerpt provided some explanation to the issue of consequences:

> *Sometimes I think I'd like to work more hours purely from a professional point of view. I'd like to be more in touch and more up to date. But that's just not possible. I've increased my shifts* [number of hours worked] *a couple of times over the years and to do that I had to sacrifice my family. It gets very frustrating because you can't be good at everything, you can't give 100% to everything. Either you are a fantastic nurse and a shoddy mother or you're an okay mother and a terrible nurse. And sometimes you just feel 'Well hell I'm bad at everything because I'm not doing anything properly'. But you still do continually try to work out ways to fix things so that you become more the fantastic nurse. But it is always important to make sure that at the same time you are not becoming the shoddy mother.* (PT32)

5.3.4. 'Corrective juggling': summary

Analysis clearly identified that corrective juggling was a continual, dynamic process. Analysis also established the complexity of the process. Individual participants recognised specific difficulties and used both explicit and implicit corrective strategies to provide a focussed response. The strategies used to respond to difficulties aimed to be corrective but while part-time employment was retained there was a mere limiting of the scope and level of the problem. For

this reason 'corrective juggling' continued across the trajectory of part-time employment.

5.4. The substantive theory

Chapters 3 and 4 and the previous pages of this chapter have reported the findings emanating from this grounded theory study. Concepts were progressively and inductively developed from data and these were then grouped under higher order sub-categories and categories. These were saturated and relationships between categories have been clearly established. These then provided the building blocks that have founded the development of this study's substantive theory. Figures 1 through to 7 provided visual representations of these building blocks. Figure 8 uses the contribution of Figures 1 through to 7 to present a visual model illustrative of the developed substantive theory.

Figure 8: Theory of part-time nursing
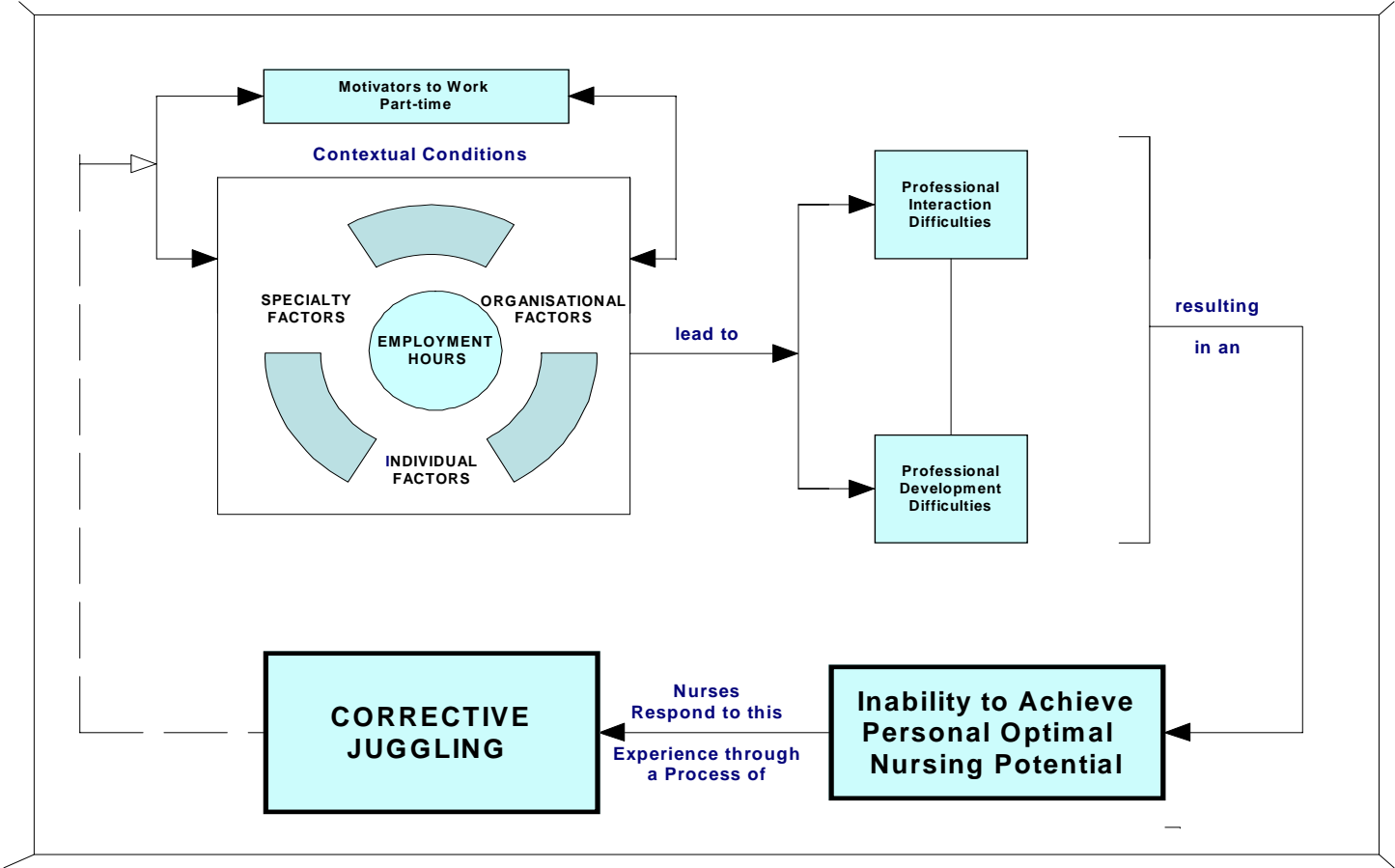
The substantive theory that has been developed to explain the situation of part-time nursing is as follows:

> The interweaving of the motivators to work part-time, employment hours, specialty, individual and organisational factors form contextual conditions that lead to professional interaction and/or development difficulties resulting in an inability to achieve personal optimal nursing potential. Nurses respond to this experience through a process of corrective juggling.

The developed substantive theory is very dynamic in nature. There is a continual motion occurring that animates the theory. It is principally relevant to part-time nursing because part-time 'employment hours' is the chief 'causal' condition influencing nurses' 'inability to achieve personal optimal nursing potential'. This substantive theory is applicable to regional Queensland part-time nurses and remains applicable across the trajectory of their part-time employment. The theory accounts for and is explanatory of wide variations in experiences, conditions and responses. The grounded theory approach has enabled a very complex situation to be conceptualised to offer insight, enhance understanding and provide a valuable guide to action (Strauss & Corbin 1998).

5.5. Conclusion

This chapter has reported the process of corrective juggling that participants used to respond to the problem that is experienced with part-time nursing. Examples were provided from data to ground conceptualisations. Saturation of the concepts has been achieved. The process of corrective juggling has been identified as the basic social process and has met the criteria that established that it was the core category of the study.

The summative section of this chapter reported the integration of conceptualisations related to the problem that was experienced when nursing part-time (reported in Chapter 3), the conditions that influenced the problem (reported in Chapter 4) and the process that was used to respond to the problem (reported earlier in this chapter). This integration enabled development of a substantive theory of part-time nursing that has been reported in this chapter. This concludes the report of the findings that have emanated from this study. The findings reported in Chapters 3, 4 and 5 are discussed in the Chapter 6 to contextualise findings and to highlight how this theory extends previous knowledge.

Chapter 6
Discussion

6.1. Overview

The aim of this study was to discover and describe phenomena and develop theory that explains the 'realities' of part-time nursing in regional Queensland. Chapters 3, 4 and 5 reported findings that enabled a theory of part-time nursing to be developed for the regional Queensland context. This chapter provides discussion of this theory that draws on the study findings and other directly relevant literature and theories. The chapter begins by briefly drawing upon the literature to 'situate' the current study and discussion of the problem experienced by regional Queensland part-time nurses follows. The contextual conditions that influenced the problem are then examined prior to discussion of the basic social process that was used to respond to the problem.

6.2. Situating the study

In the early 1980s a review of the literature by North American authors Rotchford and Roberts (1982) identified that potential variations between part-time and full-time workers had been neglected in organisational research. Consequently Rotchford and Roberts (1982) suggested that part-time workers were 'missing persons' in organisational research. This suggestion inspired researchers to learn more about part-time workers and the nature of part-time employment (Barling & Gallagher 1996). Much of the research that has been conducted since Rotchford and Roberts' (1982) 'missing persons' suggestion has focussed upon the attitudinal and/or behavioural differences between full-time

and part-time workers (Barling & Gallagher 1996). However, a number of authors in the more recent literature argue that part-time workers are a heterogenous group and to assume that all are alike is an overly simplistic approach (Armstrong-Stassen *et al.* 1998; Barling & Gallagher 1996; Hakim 1998; Thorsteinson 2003; Walsh 1999).

In Australia most part-time workers are segregated into the lower skilled occupations such as the service industries (de Ruyter & Burgess 2000). As proposed in Chapter 1 (section 1.1) only a small percentage of part-time workers come from the professions (ABS 2001). Lee, MacDermid and Buck (2000) proposed that no studies had comprehensively examined the actual experiences of professionals and managers working part-time and the perceptions of others in their specific work contexts. Review of recent available literature suggested that this is still the case.

The nursing profession, with its predominantly female workforce consisting of many who work part-time, has provided international researchers with a ready cohort to explore part-time employment from a single gender dominated occupation and/or professional perspective (Lane 2000a). There has been comparison between full-time and part-time nurses' work attitudes, such as commitment and job satisfaction, and the outcomes of congruent/incongruent employment hours and/or schedules have been investigated and reported in the literature (Armstrong-Stassen *et al.* 1998; Burke 2004; Havlovic, Lau & Pinfield 2002; Wetzel, Soloshy & Gallagher 1990). Interestingly most of the studies investigating part-time nursing employment were conducted by researchers who

were affiliated with schools of business rather than nursing (Armstrong-Stassen *et al.* 1998; Burke 2004; Edwards & Robinson 2001, 2004; Havlovic, Lau & Pinfield 2002; Lane 1998, 1999a, 1999b, 2000a, 2000b, 2004; Lane & Piercy 2003; Wetzel, Soloshy & Gallagher 1990). The 'business' orientations of these researchers were evident in the focus of their studies. The reports of these studies were published in the non-nursing literature; a factor that suggests that these researchers did not specifically aim to contribute to nursing knowledge.

Two nursing studies were conducted by the Canadian Registered Nurses' Association of Ontario (RNAO 2003) and Swedish researcher Kapborg (Kapborg 2000). These were primarily quantitative studies to discover registered nurses' experiences and attitudes to part-time employment. Kapborg's (2000) study did not differentiate between part-time and casual employment. Even though the majority of part-time nurses in the Canadian study preferred part-time employment, both studies focussed on the experience of being 'forced' into part-time and casual employment rather than the actual experiences of 'nursing' while in part-time employment.

Emanating from a larger longitudinal nursing study, Robinson, Marsland, Murrells, Tingle and Smith (n.d) reported on questionnaire data collected from British registered nurses (n=620) who between four and eight years after graduation took a break from employment for maternity leave and/or to care for children. This report focuses on issues related to nurses' combination of work and family rather than investigating part-time employment specifically. However, the report provides a description of the experiences of part-time

nursing and a small number of strategies that could assist to limit difficulties are presented.

Godfrey (1980a; 1980b) and Garbett (1996) reported findings related to the experiences of working part-time that were gained from a survey of the readerships of the North American based nursing journal '*Nursing*' (n=4125 full-time and 3375 part-time nurses) (Godfrey 1980a, 1980b) and British based nursing journal '*Nursing Times*' (n=193 nurses) (Garbett 1996). Both reports failed to differentiate between the experiences of part-time and casual nurses. These studies identified many professional difficulties experienced when nursing in part-time and casual employment. However, the reports of these studies were brief and there was minimal description provided of the difficulties or explanation of the influencing conditions. The responses that nurses made to the difficulties were not reported.

The current study explored the phenomenon of part-time nursing by investigating from a 'nursing' perspective. The study comprehensively examined the actual experiences of professional nurses working in part-time employment and included the perceptions of others in the specific work contexts. As has already been identified this viewpoint has been missing in studies of part-time professionals (Lee, MacDermid & Buck 2000). Rather than limiting explorations to a comparison between full-time and part-time, the current study explored variations among part-time nurses. There were no studies in the available literature that explored regional Queensland part-time nursing. Therefore the current study provided a unique insight into part-time nursing that has not

previously been revealed. Findings enabled development of a theory of part-time nursing for the regional Queensland context. This theory provides a more comprehensive understanding and explanation of the phenomenon of part-time nursing than has previously been provided. As there were no existing theories developed to provide a framework for understanding the phenomenon of part-time nursing, this theory represents a significant contribution to knowledge.

6.3. Basic social problem

This discussion commences by arguing that part-time nurses' experiences of the basic social problem conflict with individual constructs of professional identity. Issues surrounding the professional interaction and development difficulties experienced are discussed. This section concludes by discussing the identified lack of awareness of the problem.

6.3.1. Professional identity

The current study established that effective professional interaction with clients and all other stakeholders within the workplace and professional development through acquisition of knowledge, skills and career progression were essential to nursing. These factors are proposed to represent philosophies of nursing that founded individuals' 'professional identity'. The theoretical perspective of symbolic interactionism provided a basis for enhancing the understanding of these findings. From this perspective professional identity develops through a process of self-creation in which social interaction and self-reflection are basic processes (Fagermoen 1997). Individual constructs of nursing have been learned, shared and transmitted through participation in the nursing profession and have

combined with self-reflection to form a professional identity that is closely

linked with personal identity (Gregg & Magilvy 2001; Ohlen & Segesten 1998).

Though effective professional interaction and development were valued as

important contributors to the construct of professional identity, the current study

found that there were considerable difficulties achieving these goals when

nursing part-time. This led to an inability to achieve personal optimal nursing

potential that was found to be the basic social problem experienced by regional

Queensland part-time nurses in the current study. A negative relationship

developed between what was perceived should occur and what actually occurred

in practice. Therefore a conflict arose between individual constructs of

professional identity and actual experiences of part-time nursing. Consequently

nursing experiences that conflicted with professional identity constructs were

perceived as difficulties.

6.3.2. Professional interaction difficulties

Ineffective communication was found to be a considerable difficulty for regional

Queensland part-time nurses. Verbal communication was the most common

communication strategy used in practice settings to inform nurses of changes and

other relevant organisational information. The primary strategy for documented

communications of organisational information was the 'communication book'.

Madsen's (2000) study of nursing in one regional Queensland hospital between

1930 and 1950 found that aside from the commonly used word of mouth

instructions, the 'day book' was a significant source of information for nurses.

Comparison of Madsen's (2000) findings and the findings from the current study

establishes that little has changed over time. Nurses continue to function within a predominantly oral culture (O'Connell 2000). Historical communication strategies continue to provide organisational information to contemporary regional Queensland nurses.

However, the current study found that these strategies were not effective in meeting the information needs of part-time nurses. The report emanating from the *Ministerial Taskforce: Nursing Recruitment and Retention* (Queensland Health 1999, p. 40) identified that within Queensland '(c)ommunication to nurses (particularly beyond the South East corner) was perceived as problematic'. This report provided an illustration of nurses' communication difficulties by highlighting nurses' knowledge deficit of family friendly policies (Queensland Health 1999). Though this finding related to nurses in general it is consistent with the current study's findings that part-time nurses were not knowledgeable about organisational policies. The report proposed that a communication strategy be developed to assist to improve communication and to raise awareness of the importance of communication (Queensland Health 1999). However, communication remains a significant difficulty for regional Queensland part-time nurses. Therefore it is suggested that healthcare organisations need to be reminded of the importance of communication and consider more effective ways to communicate so that part-time nurses who may be away from the workplace for extended timeframes are able to successfully gain essential workplace information.

Experiences of professional interaction difficulties also included difficulties in provision of continuity of care. There is a plethora of literature related to continuity of care (Sparbel & Anderson 2000b). A smaller volume of literature identifies that this is negatively associated with part-time nursing (Edwards & Robinson 2004; Garbett 1996; Godfrey 1980a, 1980b; Grinspun 2002, 2003). Sparbel and Anderson's (2000a) integrated literature review of conceptual issues related to continuity of care concluded that continuity may be strongly affected by a variety of communication and system factors. Administrators in Godfrey's (1980b) North American study of part-time nursing emphasised that though there were difficulties experienced by part-time nurses in provision of continuity of care, better shift scheduling and documentation could minimise these difficulties. The need for better documentation to enhance continuity of care was not a key finding from the current study.

Rather than experiencing difficulties with substandard documentation, the current study found that there was insufficient time to access client documentation leading to a greater reliance on verbal nursing handovers. Further, the verbal handover between shifts was ineffective for accessing sufficiently comprehensive client information to allow seamless provision of care. Nursing handovers have traditionally been nurse to nurse verbal exchanges that occur in a setting away from clients (Hopkinson 2002; Kerr 2002; Sexton *et al.* 2004). The handover should play an important role in the provision of continuity of care through transfer of essential client information between nurses at shift changes (Kerr 2002; Lally 1999). However, contrary to the desires of part-time nurses in the current study this transfer of information is not expected to be achieved

through an extensive verbal handover. Instead verbal handover is meant to be an adjunct to comprehensive documentation.

Sexton and colleagues' (2004) study of handovers (n=23) conducted in one New South Wales medical ward found that only 5.9% of the handover content involved communications that could not be recorded in existing documentation sources. Sexton and colleagues (2004) proposed that by ensuring that only essential information was included in handovers more time could be spent in direct client care. The current study's findings suggested that limitations on the time available for nurses to access client documentation contributed to the resultant increased dependency on the verbal nursing handover. It may be presumed that a more streamlined and efficient use of verbal handover time would allow more time for access to client documentation. However, whether essential client information is gained through verbal or documented communications was not the chief issue in the findings gained through the current study. Instead time constraints brought about through minimal overlap between shifts led to limited time to access client information. It is suggested that short shift overlaps do not allow sufficient time for access to either verbal handover or documented client information when a comprehensive information base is sought.

Part-time nursing is associated with larger periods of time spent away from the workplace than full-time nurses' experience. Therefore access to a greater volume of client information is commonly needed than would occur if nurses had worked in the previous days. Additionally, in this situation forming successful

nurse-client relationships was found to require more time. The current study

clearly identified that an inability to access adequate client information through

verbal handover, client documentation and time spent with the client was closely

associated with challenges in provision of client care. Disruptions to continuity

of care and the development of therapeutic relationships potentially impact on

client outcomes through decreased effectiveness and efficiency of nursing

services. In a background of contemporary healthcare resource constraint and the

ever increasing requirement for high quality care, sub-optimal effectiveness and

efficiency of nursing care is not an acceptable situation.

Lawrence and Corwin (2003), who used the literature to examine issues

surrounding part-time professional work, proposed that organisational work

structures consist of patterns of interaction rituals. Findings from the current

study suggested that within regional Queensland healthcare organisations'

interactions commonly involved traditional communication strategies such as

high levels of face-to-face verbal communications that primarily occurred during

routine business hours. These interaction rituals were associated with part-time

nurses' disconnection within the workplace and challenges in providing client

care that provided the foundation to the experience of professional interaction

difficulties. Therefore it is suggested that part-time nursing has an incongruent

relationship with the interaction rituals of contemporary regional Queensland

healthcare organisations.

This suggestion is consistent with Lawrence and Corwin's (2003) argument that

the interaction rituals of local work contexts influence the acceptance or

marginalisation of part-time professional workers. Organisational assumptions about the relationship between working time and the professional employee may be challenged by the potential for missed participation that is associated with part-time employment (Lawrence & Corwin 2003). Lawrence and Corwin (2003) suggested that organisational assumptions related to professionals and working time are a basis for many key interaction rituals. Findings from the current study indicate that regional Queensland healthcare organisational assumptions may be based on professional nurses working long hours. The historical nursing workforce has been a 'young' full-time workforce and nurses left nursing when they married and/or had children (Duffield & O'Brien-Pallas 2002). Though these historical characteristics are not reflective of the contemporary nursing workforce they may provide a rationale for the present organisational assumptions. Interestingly part-time employment and associated provisions were only inserted into relevant Queensland nursing industrial awards as recently as 1984 (Queensland Nurses' Union 2004).

Marginalisation of professionals was posited by Lawrence and Corwin (2003) to be more likely when the interaction rituals of a local work context are violated; as can occur when part-time employment reduces the time a professional is available to an employing organisation. Therefore part-time nurses potentially violate the interaction rituals of regional Queensland healthcare organisations because these professionals are not available for the high levels of face-to-face interactions that organisations may assume are characteristic of a professional nurse.

The current study established that part-time nurses undertook many central organisational duties, such as being the nurse in-charge of the shift. Based on these factors the current study's sample were 'core' employees (Jenkins 2004). Tilly's (1992) qualitative study of North American managers, union officials and workers (n=82) in retail and insurance industries was used to make a distinction between 'secondary' and 'retention' part-time workers. This distinction provides a means to differentiate 'core' versus 'marginal' workers. Secondary part-time jobs, that were identified as 'bad' jobs, are characterised by low skills and compensation and offer few promotional opportunities (Tilly 1992). In contrast retention part-time jobs, which were identified as 'good' jobs, are characterised by high levels of skill and responsibility, compensation similar to full-time positions (pro-rated) and offer promotional opportunities (Tilly 1992). Retention part-time jobs are seen as a means to retain or attract valued workers who do not want to work full-time while secondary part-time jobs are used as a means to restrict costs and enhance temporal flexibility (Walsh 1999).

When a comparison of these criteria is made with the nursing jobs that part-time nurses in the current study held, these primarily fit into Tilly's (1992) conception of the 'good' retention part-time job. As such, part-time nurses can be seen as 'core' workers. However, there was much evidence that regional Queensland part-time nurses had been disconnected from the workplace and were also restricted in their access to promotion. Based on these findings it is suggested that though part-time nursing positions may represent retention jobs, the experience of these difficulties are marginalising part-time nurses. This

marginalisation or 'ghetto-izing' of part-time nurses is a barrier to utilising their full productive potential (Bailey & Hocking 1997).

Hakim (1998), who has widely published a viewpoint of women's orientations to work that emanated from analysis of a variety of British quantitative census and other occupational data, posited that part-time employment is an option for those who prioritise domestic commitments over their career. Part-time employment is proposed to be secondary to other life activities such as domestic responsibilities (Hakim 1998). Hakim (1998) argued that permanent part-time employment does not require the same commitment to the employment career as full-time jobs because women, who are the predominant gender in part-time employment, work part-time as they are family rather than career orientated. Hakim's (1996a; 1996b; 1998) 'preference theory' polarises women's priorities to either their domestic responsibilities or their career. From this perspective it may be surmised that because part-time employment is secondary to other life activities, full integration as 'core' workers would not be desired.

This theory is rejected by the current study's findings that indicated that nurses chose part-time employment in an attempt to balance two 'priorities'; their nursing role and their personal life activities such as family responsibilities. Hakim (1996a) did not see two equal priorities to be an option and relegated women who did this to the caricature of 'drifters'. Rather than being 'drifters' the current study's findings indicated that part-time nurses were very focussed towards achieving the best possible in both their personal life and nursing

activities. However, organisational rituals were a barrier to achievement of these goals.

6.3.3. Professional development difficulties

Nursing is a female dominated profession (AIHW 2003b). We could assume that a feminine organisational culture would be hegemonic, that occupational norms would favour women and that female gendered discrimination would not occur (Adams 1995). However, the findings from the current study negate the validity of these assumptions. These findings suggest that to achieve professional development values such as full-time employment and 'presenteeism' needed to be enacted. This is consistent with the findings from Branine's (2003) large mixed method study of human resource managers (n=96) and heads of departments, part-time employees and job sharers (n=42% to 56% response rate from 55 NHS trusts) that investigated the use of part-time employment and job sharing in Britain's National Health Service (NHS). The current study found that considerable difficulties were experienced in gaining access to professional development opportunities. These findings indicated that part-time nurses, who are predominantly female and choose their employment hours because their construct of feminine identity value a work-family balance, were being inequitably treated. Because this discrimination was not directly based on gender, 'disparate impact' may have been occurring (England 1998).

In Australia *The Sex Discrimination Act 1984* prohibits direct and indirect discrimination on the grounds of gender, marital status and pregnancy (HREOC 2004). In a conference presentation paper Australian Sex Discrimination

Commissioner Halliday (1998) proposed that when part-time employees have restricted access to promotional or staff development opportunities this situation may constitute indirect discrimination because it is women who are chiefly concentrated in part-time employment. Discrimination on the grounds of family responsibilities can only be deemed unlawful in Australia when there has been dismissal from employment (Halliday 1998). However, the disparate impact of women being more likely than men to bear the primary responsibility for family work may lead to indirect discrimination. Halliday (1998, p. 4 of 6) stated:

> Anti-discrimination laws state that *unlawful* indirect discrimination occurs where a condition, requirement or practice is imposed that has the effect of disadvantaging a group of people in relation to the other, and this is "not reasonable in the circumstances of the case". It is impossible to state definitively what would be reasonable or unreasonable in any particular case as circumstances will be unique to individual cases. The notion of reasonableness cannot therefore be discussed other than in general terms, because the individual circumstances of each case will determine the degree of reasonableness.

Organisational practices that rigidly adhered to conducting meetings and educational sessions in routine business hours were commonly inequitable for part-time nurses in the current study. Workplace support for full-time nurses and non-support for part-time nurses to attend educational sessions in work time and at organisational expense was inequitable. Promotional opportunities that were only available through full-time employment represented further inequities for part-time nurses. The current study's findings suggested that while some sub-ordinate facilities within a wider healthcare organisation supported part-time employment (or reduced employment hours through job sharing) at higher level positions others did not. Additionally policies and guidelines available at the macro-level (encompassing the entire organisation) of organisations were commonly not utilised at the meso– (facility) and micro– (work unit) levels to

support promotion of part-time nurses. These findings were consistent with Branine's (2003) findings from Britain's National Health Service.

Some may question whether a decision to refuse part-time employment for higher level positions is 'reasonable' when there were guidelines to support these strategies within a wider healthcare organisation. Also it would not seem 'reasonable' to refuse part-time employment for higher level positions when these employment strategies were permitted in similar positions in other facilities within the same wider healthcare organisation. As 'reasonableness' is a form of defence to indirect sex discrimination (Halliday 1998), it seems possible a respondent employer may not be able to defend these decisions as reasonable. This stance may well be seen as a polemic by healthcare organisations. Equal employment opportunity and anti-discrimination legislation at Australian federal and state levels directs healthcare organisations to prohibit gendered discrimination.

Lane (1998; 1999a; 1999b; 2000a; 2000b; 2004; Lane & Piercy 2003) published prolifically from her qualitative pilot study of qualified nurses (n=10-12x3 focus groups) and nurse managers (n=7) that then led to a quantitative survey of qualified nurses (n=643) from Britain's National Health Service. Lane (op cit) found that British part-time nurses experienced similar professional development disadvantages to those identified through the current study and proposed that these inequalities represented indirect gendered discrimination.

Australian authors Brown and Jones (2004) conducted a quantitative survey of New South Wales registered nurses (n=383) to investigate the influence of human capital variables on promotion. They found that males were significantly more likely than females to be in higher level nursing positions (Brown & Jones 2004). The study found that working with no breaks from full-time nursing was a significant predictor of promotion (Brown & Jones 2004). Part-time nursing was considered a 'career break'. Though their study did not find evidence of direct sex discrimination affecting career progression in nursing, Brown and Jones (2004) acknowledged that as women are considerably more likely than men to take career breaks for family reasons female nurses were disadvantaged when considering access to promotion.

Structured and experiential learning and horizontal career advancement opportunities represent a series of building blocks that provide preparedness that is necessary in order to have any prospect of achieving promotion. Part-time nurses' diminished access to these opportunities provides a pre-existing barrier that impedes access to promotional opportunities. Less time spent in the workplace was closely associated in the current study's findings with fewer opportunities for experiential learning. Though this factor was not directly associated with inequitable management, the findings established that limited access to structured learning opportunities added to the importance of experiential learning.

The current study's findings of inequities in the provision of access to structured learning, horizontal and vertical advancement opportunities may be logically

largely associated with indirect gendered discrimination. However, though gendered discrimination may contribute to the experience of professional development difficulties, there was no evidence from the current study that part-time nurses had considered this factor. Instead they attributed the inequities that they experienced to other factors.

The report from the *National Review of Nursing Education 2002* (Commonwealth of Australia 2002b) established that supportive workplace cultures that account for professional and personal needs and aspirations are essential. A recurring theme in data collected by this review was that nurses wanted: to have their professional skills and knowledge recognised; to have time to 'care' for their patients; to be supported in professional development; to have some control over their workplaces; family friendly workplaces; and safe environments and better remuneration (Commonwealth of Australia 2002b, p. 180). Most of these findings are consistent with the findings from the current study. Therefore it is fair to suggest that irrespective of employment status Australian nurses have similar needs and expectations. However, though part-time nurses' needs and expectations may be similar to those of full-time nurses, the current study's findings clearly identified that part-time nurses perceived that they are considerably further behind in the struggle to meet their goals than full-time nurses.

Access to structured learning and horizontal and vertical advancement opportunities represent a means to enact lifelong learning that is an essential prerequisite to effective professional nursing practice (Jones & Cheek 2003). The

findings provided substantial evidence that if part-time nurses wanted these

opportunities they needed to devote personal time in addition to their normal

working hours. Therefore working time was not restricted to the boundaries of

part-time nurses' actual employment hours. Instead these boundaries were

commonly elastic and working time encroached on personal time. Lawrence and

Corwin (2003) proposed that for many part-time professionals 'the distinction

between work and home times is highly ambiguous' (p. 928). Though part-time

nurses choose their reduced employment hours so that they are able to fulfil other

life demands, organisational practices (rituals) necessitate a decision between the

situation of non-progression of professional practice or devotion of personal time

to ensure that a level of progression continues.

However, because of their other demanding life activities many part-time nurses

in the current study were unable to devote the amount of personal time needed.

Their choices concerning allocation of personal time were constrained by these

life demands leaving them in the situation of non-progression or 'maintenance'; a

situation that was established to be less than ideal. Consideration needs to be

made of what percentages of nurses are in this situation and what this

unacceptable situation means for organisations. The following data excerpt

gained from Chapter 3 (end of section 3.5.1.1) is a stimulus for this deliberation:

> *And if they're* [part-time nurses] *not getting the same educational*
> *opportunities as someone who is full-time what sort of percentage of*
> *their* [the organisation's] *workers is that? Are we not educating our*
> *staff? Do we not have competent people working in ...* [name of
> organisation]*? I'd be interested to know that. I know that people have*
> *to drop back to part-time when they start their families and there are*
> *a big percentage of those nurses. Are they the ones with past*
> *experience that gets them through? Or do they just have to bluff their*
> *way through. Good Lord I think that managers just don't care...*
> (PT66)

Regional Queensland healthcare organisational assumptions about professional nursing and working time are not consistent with part-time nursing. There was much evidence in the findings that suggested when resources were limited a higher workplace value was placed on full-time nurses who were perceived as able to make a greater organisational contribution in return for professional development opportunities and support. The validity of this assumption must be questioned if, as the current study found, part-time nurses represent a more stable and experienced workforce than full-time nurses commonly represent.

It would appear that organisational perceptions of 'contribution' are equated to time spent in the workplace. Therefore organisational assumptions and interaction rituals may significantly impact on professional development. Consequently evaluation of the work structures surrounding the practice of nursing is required. Work structures that rigidly adhere to traditional interaction rituals requiring high levels of face-to-face communication are not conducive to part-time nursing. These work structures are not enabling part-time nurses to meet personal professional aspirations or to successfully contribute to organisational goals.

6.3.4. Lack of awareness of the problem

The professional interaction and development difficulties experienced by regional Queensland part-time nurses in the current study resulted in an inability to achieve personal optimal nursing potential. This situation was not consistent with individual constructs of professional identity. A conflict between

professional identity and actual experiences of part-time nursing was leading individual part-time nurses to encounter professional difficulties.

This problem was faced by all part-time nurses in the current study, therefore the problem is not merely a personal one but is shared. The scope of this problem may be extensive as part-time nurses potentially constitute a considerable percentage of the overall nursing workforce. Additionally the problem does not sit purely in the domain of part-time nurses. Organisations aim to achieve to their optimal potential and optimising organisational performance requires successful use of all of an organisation's resources including employees, the most important asset. If part-time nurses are unable to achieve to their potential they are also unable to optimise their contribution to their employing organisations. Therefore when even one employee is not achieving their optimal potential the organisation can not achieve its best. The percentage of part-time nurses in Queensland is increasing (AIHW 2003b). Based on developing patterns and the findings from the current study it is fair to suggest that Queensland healthcare is heavily reliant on a part-time nursing workforce. Consequently the problem that is experienced by part-time nurses is not merely a personal one or a problem shared only by part-time nurses but it is shared by the organisation. This makes the problem of upmost importance to contemporary healthcare.

Though the basic social problem was shared by all part-time nurses in the current study, they only recognised the individual properties and dimensions of the problem. Therefore the overarching problem of an 'inability to achieve personal optimal nursing potential' remained hidden. The validation procedure of taking

the developed theory back to those who participated in the study substantiated that though the theory was quite recognisable, there had been an unawareness of what was actually happening in the situation of part-time nursing. This researcher, who has practiced as a nurse in part-time employment in regional Queensland for more than twenty years, was very surprised through the discovery of the substantive theory. Certainly it was highly recognisable to her situation but she had not been consciously aware of the overarching problem that existed, of many of the corrective strategies she had also used or of the cyclic and continual nature of these strategies until the theory was developed. Findings of a meagre base of knowledge in the literature may also indicate a diminished awareness that a problem exists.

The lack of awareness of the problem associated with part-time nursing is almost certainly the rationale for why this situation is not being effectively addressed. Therefore the theory of part-time nursing that has been developed is of considerable importance to part-time nurses, the nursing profession and to healthcare organisations alike. The concepts reported in Chapter 3 were illustrative of the professional interaction and development difficulties associated with part-time nursing. However, overall these were not strictly new findings. Earlier literature provided brief descriptions of the concepts but no available literature has included all of these concepts in one report. The grounded theory approach used by the current study has provided an invaluable means to access a deeper conceptual understanding of the difficulties faced by part-time nurses. Additionally this approach enabled discovery of the basic social problem that represents a new finding that has not been reported in previous available studies.

This finding has important implications for part-time nurses, nursing practice, organisational knowledge, theory and future research.

As the reader will have noted, the discussion in the previous pages posed similar difficulties to those experienced when writing Chapter 3 (as reported in section 3.7). Because the conditions influencing the experience of part-time nursing were so closely integrated with these experiences it has been impractical to fully separate the discussion of the problem from these conditions. Chapter 4 reported the contextual conditions that influenced the basic social problem experienced by regional Queensland part-time nurses in the current study. The following pages discuss those findings and expand on the conditions introduced in the previous pages.

6.4. Contextual conditions

Initially there is a brief use of the literature to position the current study's exploration of contextual conditions. The conditions 'motivators to work part-time', 'employment hours', 'specialty factors', 'individual factors' and 'organisational factors' are discussed.

6.4.1. The literature substantiates exploration into conditions

In answer to Rotchford and Roberts (1982) suggestion that part-time workers were 'missing persons' Feldman (1990), another North American, used the literature to develop hypotheses that founded a 'causal model' of part-time work. This model in turn provided a theoretical framework for understanding the impact of part-time work on employees' attitudes and behaviours. In this model

different types of part-time work arrangements, demographic variables and work context factors were proposed to influence the experiences of part-time employees (Feldman 1990). Feldman (1990) concluded that more research was needed to investigate the influence of demographic factors on decisions to work part-time and the impact that these factors had on job outcomes. The causal model of part-time work provided by Feldman (1990) and the conclusion that more research is needed substantiates the current study's exploration into the conditions surrounding the phenomenon of part-time nursing. Feldman's (1990) causal model encourages researchers to be aware of different part-time work arrangements and to focus on the motivators to part-time work and the work context factors that may affect experiences of part-time work.

Feldman joined with Doerpinghaus (1992) to conduct a mixed methods study that included part-time nurses (n=153), salespeople (n=452) and university students (n=102). This study attempted to measure how employees in various part-time categories reacted to six key work context factors; pay, fringe benefits, type of work, relationship with co-workers and clients, supervision and scheduling flexibility (Feldman & Doerpinghaus 1992, p. 62). The findings from this study established that part-time workers are a heterogeneous group (Feldman & Doerpinghaus 1992). The experiences of permanent part-time employees were found to not only differ from full-time employees but to vary from temporary part-time and casual employees. These finding assisted to substantiate the current study's investigation into the situation of part-time nursing as a phenomenon that may differ from full-time and casual nursing.

A part-time employee's type of work was found through Feldman and Doerpinghaus' (1992) study to influence their experiences and because of this factor the experiences of nurses at times differed from other part-time employees. Feldman and Doerpinghaus' (1992) study did not differentiate between the various work contexts that nurses practice in. However, the current study found that nurses practice in a wide variety of specialties and Feldman and Doerpinghaus' (1992) findings substantiated further exploration into these.

6.4.2. Motivators to work part-time

The category of 'motivators to work part-time' has been reported in Chapter 4 (section 4.3). The current study found that the prime motivator to work part-time was caring responsibilities. There is a plethora of general literature establishing that part-time employment is a means to enable women to participate in the workforce while continuing to meet traditional domestic commitments (Hakim 1996a, 1996b, 1998; Newell 1992; Pocock 2003). The Australian traditional family model includes one partner in full-time paid employment outside the home and one partner in full-time non-paid employment within the home (Russell & Bowman 2000). Review of the Australian literature identifies that though this situation has changed as women increasingly enter the workforce, egalitarian households are not the norm and most women have retained chief accountability for the caring responsibilities and household domestic work that comprise family work (Russell & Bowman 2000; Thornthwaite 2002). It is therefore unsurprising that caring responsibilities were the chief motivator to part-time work that was found by the current study.

Review of international and national literature substantiated that the current study's findings of 'financial considerations', 'multiple roles' and 'health preservation' had similarities to those found in some general population studies that investigated motivators to part-time employment (ACTU 2000; Russell & Bowman 2000; Thornthwaite 2002). This confirms that there is a greater complexity to motivators to work part-time than the narrow focus of caring responsibilities that is supported by much of the literature. However, though the current study's findings showed similarities to those from studies involving general populations of part-time workers, they do not directly replicate those findings.

Walsh (1999) conducted a quantitative study Australian financial institution employees (n=1182) and submitted that part-time workforce heterogeneity has been underplayed. Higgins, Duxbury and Johnson's (2000) Canadian study included an exploration via interview of a sample (n=45) of career (professional and managerial) and earner (technical, clerical, administrative, retail and production) women's motivations to work part-time. Higgins and colleague's (2000) findings identified that motivations for part-time work varied considerably for these two groups. These findings give some basis for the suggestion that nurses' motivators to part-time work may potentially be more comparable to other career women rather than to the general population.

As stated in Chapter 1 (section 1.1) professional part-time workers represent a small sub-group within the overall Australian part-time workforce. It is reasonable to suggest that heterogeneity exists within this subgroup; especially

when considering a regional geographic population. Findings from the current study established that factors that are particular to contemporary professional nursing practice were contributing to regional Queensland nurses' motivators to part-time work. Therefore a review of the literature was undertaken to discover whether regional Queensland part-time nurses' motivations were similar to those across the profession. However, this review identified a dearth of relevant studies.

Kapborg's (2000) quantitative study of Swedish nurses (n=96) found that when motivators to work part-time were not voluntary, experiences of part-time nursing were influenced by the forced part-time status. Involuntary motivations to part-time employment were not consistent with the current study's findings. The Registered Nurses Association of Ontario's (2003) study of registered nurses (n=2029) found that the reasons nurses worked part-time or casual were: no full-time employment available; family and caring reasons; workload issues; and further study. Therefore a percentage of these nurses were also involuntarily motivated to part-time or casual employment.

Strachota, Normandin, O'Brien, Clary and Krukow's (2003) North American quantitative study that investigated why registered nurses (n=84) leave or change employment status to casual employment found that shift work was the most common reason. Other health related reasons, lack of managerial support, dissatisfaction with remuneration and personal reasons such as caring responsibilities were other reported motivations (Strachota *et al.* 2003). Though Strachota and colleagues' (2003) findings have some similarities to the findings

from the current study this study addressed the North American context and did not explore motivators to part-time work.

Lane's (1999a; 2000a) study of British qualified nurses found that part-time employment was sought after as a means to fulfil caring responsibilities when nurses returned to work after maternity leave. Khalil and Davies' (2000) qualitative study that also investigated British nurses' (n=5) experiences when returning to part-time work after childbirth somewhat extended exploration of motivators to this working time decision when they found that all were motivated to return to work for the mental stimulation and social interaction that work provided.

Kemp (1994) conducted a longitudinal study of the experiences of British graduate nurses (n=45) who no longer work full-time. Thirty four participants in the study had experience of part-time work. Kemp (1994) found that motivators for part-time employment were complex and while most were associated with child rearing other factors included: predictability and control of hours of work; avoidance of unsocial hours of work; relief from stress; and freedom to pursue personal goals including further study (p. 379).

Review of the available literature has led to the suggestion that though findings from the current study share some similarities to those emanating from the general part-time worker population they are more closely aligned to those from other professional or career part-time workers. The current study has identified that factors associated with nursing work contributed considerably to nurses'

motivators to work part-time. This factor provides a reasonable basis for the suggestion that the current study's findings of motivators to work part-time differ somewhat from those of the non-nursing wider part-time population; including other professional and career workers.

There is a dearth of literature available related to nurses' motivations to work in part-time employment. A meagre volume of nursing studies have identified motivators that have similarities to the findings from the current study. However, these studies investigated international, rather than Australian, nurses' motivators and reports describing motivators were brief. Additionally some international contexts were leading to involuntary decisions to work part-time that were not consistent with the current study's findings. Findings from the current study enabled an exhaustive description and explanation of the voluntary motivators to work part-time. These findings account for variations between nurses and provide an understanding of the complexity of factors that contribute to part-time working decisions. Most importantly the current study addresses the Australian context where a notable gap in knowledge existed.

The current study's findings provide substantial new knowledge that contributes to understanding nurses' motivators to work part-time. As part-time employment hours were the chief condition influencing the experiences of part-time nurses, the findings of motivators to work part-time enable greater understanding of how nurses come to the situation of part-time nursing. This has important implications for nursing practice, organisational knowledge and future research.

6.4.3. Employment hours

Decreasing employment hours to part-time was the foremost reason why regional Queensland part-time nurses in the current study experienced the professional interaction and development difficulties that resulted in their inability to achieve personal optimal nursing potential. Part-time employment was found to be commonly linked to work schedules that were outside routine business hours. This factor negatively influenced both professional interaction and development experiences. Brooks and Swailes (2002) quantitative study of British registered nurses (n=2987) also found that out of hours shifts can distance nurses from daytime experiences and development opportunities. 'Daytime' was the predominant timeframe in which professional interactions occurred in the current study. Disjointed shift schedules were also associated with part-time working hours and this presented challenges to the provision of client care. However, the findings indicated that even when a smaller number of hours were worked, shifts scheduled on consecutive days enhanced the potential to provide continuity of care and to develop effective nurse-client relationships.

Rotchford and Roberts (1982) concluded their review of the literature by questioning if the number of hours worked influenced the situation of part-time employment. The current study discovered that experiences of part-time nursing varied significantly depending on the number of hours that were worked. Hom's (1979) quantitative study of part-time employees (n=10,003) of a large retail sales organisation was one of the first to examine the effect of the number of hours worked. Findings led Hom (1979) to suggest that part-time work can be defined in terms of peripherality with fewer employment hours increasing

peripheralisation. In a critique of the literature related to part-time employment Barling and Gallagher (1996) used Hom's (1979) findings to base their proposal that part-time employment is not a consistent concept. Rather these authors proposed that variations in the number of hours worked lead to greater differences amongst part-time employees than is seen in the differences between full-time and part-time employees (Barling & Gallagher 1996).

Hakim (1998) proposed that there was a need to define part-time working hours more comprehensively than merely collectively grouping all as part-time employees. Hakim (1998) split part-time hours into three subdivisions that formed a decreasing continuum and labelled each accordingly. These labels included reduced hours (30-36 hours/week), half-time (11-30 hours/week) and marginal hours (1-10 hours/week) (Hakim 1998). The findings from the current study related to the number of hours worked could easily contribute to the development of three sub-divisions of work hours not dissimilar to those of Hakim (1998).

Rotchford and Roberts (1982) asked if there was a minimum 'cut-off point' involved in the relationship between work experiences and the number of hours worked. The current study found that from the perspective of effective professional nursing practice, a nurse needed to work at least twenty hours per week with some data describing a preference for a minimum of twenty four hours. Rosendaal's (2003) quantitative study of part-time workers (n=1707 including nurses) in the Netherlands also found that the number of hours that were worked affected work experiences. Rosendaal (2003) found that working

less than 19 hours per week was commonly associated with 'higher' levels of performance. However, working less than 19 hours per week did not lead to higher levels of performance when jobs were less structured, knowledge dependent and required intensive communication with clients and other stakeholders over periods of time (Rosendaal 2003); as occurs in nursing work. These findings assist to substantiate the current study's findings that twenty hours of work per week is necessary for effective professional nursing practice. For the situation of part-time nursing this is a new finding that has not previously been reported.

Katz and Kahn (1978) have used the theoretical framework of 'partial inclusion' to assist to differentiate between full-time and part-time employees' job related attitudes and behaviours. The partial inclusion theory suggests that people are involved in multiple social systems and involvement in each system is on a partial basis (Katz & Kahn 1978). When this theory is used in the employment situation it may be suggested that part-time employees are less included in organisational social systems than full-time employees because they devote less of their time and 'inclusion' decreases as the amount of time devoted to employment decreases (Barling & Gallagher 1996; Eberhardt & Shani 1984).

This suggestion at first appears quite relevant to the situation of part-time nursing as the current study found that fewer numbers of work hours were associated with lesser inclusion. However, Katz and Kahn (1978) proposed that partial inclusion can be modified by the 'priority of commitment' and the 'potency of involvement'. Partial inclusion does not take into account that although

employees have other life commitments the importance of work relative to those commitments may vary between individuals and change over time (Barling & Gallagher 1996). Additionally partial inclusion does not account for psychological involvement with an organisation (Barling & Gallagher 1996). The current study found that part-time nurses prioritised both their nursing and other life roles, wanting to contribute, and many dedicated much personal time to work pursuits, provided workforce stability, had lower levels of absenteeism and were commonly happier, more enthusiastic and motivated in the workplace than full-time nurses.

When the partial inclusion theory is considered specifically from a 'time available to the organisation perspective' it is consistent with the current study's findings of organisational assumptions and the experiences of part-time nurses. However, when partial inclusion is considered from part-time nurses' prioritising and involvement the theory loses some applicability for part-time nurses in regional Queensland. This suggestion was supported by Tansky, Gallagher and Wetzel's (1997) quantitative study of Canadian part-time retail workers (n=203) and hospital staff (n=245) that found a lack of support for using the partial inclusion theory to explain findings. These researchers proposed that organisations should not stereotype employees by assuming that fewer work hours equate to less positive attitudes related to the organisation (Tansky, Gallagher & Wetzel 1997).

The findings from the current study substantiate findings from earlier studies that the number of hours worked is an important condition to the experience of part-

time employment. Though employment hours were the chief 'causal' factor influencing the basic social problem it was not the only condition influencing nursing experiences. This finding is substantiated by the fact that partial inclusion is not only related to the number of hours that are worked but can be modified by various other factors (Katz & Kahn 1978). It is also consistent with Rosendaal's (2003, p. 484) finding that '(c)ertain aspects of the job and the job environment can enhance or weaken the effect of the amount of working time on the outcome'. Additionally Jenkins' (2004) qualitative case study of British managers (n=19) and part-time female employees (n=63) in a variety of industries also found that hours of employment were not a sufficient basis on which to understand part-time work.

6.4.4. Specialty factors

Chapter 4 (section 4.5) reported the specialty factors that influenced the experiences of part-time nursing. Different specialties were associated with varying types of clientele and these variations influenced experiences. The available literature provides brief comment, rather than comprehensive exploration, to substantiate this factor (Edwards & Robinson 2001; Malone 1994). Therefore the findings related to this concept represent new knowledge that has important implications for nursing practice, organisational knowledge and future research.

Variations in the skills required to work in different specialties were found to influence experiences of part-time nursing. Though this represents a new finding it may be reflective of the findings from other studies that different 'types' of

work influence the experiences of part-time employees (Feldman & Doerpinghaus 1992; Higgins, Duxbury & Johnson 2000; Rosendaal 2003). Duffield and O'Brien-Pallas (2002), in a paper comparing Canadian and Australian nursing workforce characteristics, suggested that it was problematic to expect highly specialised nurses to function at a similar level outside their area of specialisation. This suggestion acknowledges that differing skills are required for each specialty and that these skills are not completely transferable between specialties. The current study found that greater or lesser levels of skills are associated with different specialties. That this factor influences experiences of part-time nursing represents an important new finding.

The association of certain specialties with varying degrees of shift work was an important finding. There is a plethora of literature linking shift work to negative health outcomes for nurses (Brooks 2000; Fitzpatrick, While & Roberts 1999; Jamal & Baba 1992; Poissonnet & Véron 2000; Totterdell et al. 1995). The current study found that shift work represented a motivator to part-time employment and was also a rationale for nurses moving away from or to a specialty. The finding that some specialties, such as critical care, are associated with greater levels of shift work is important when considering the specialities that are experiencing acute nursing shortages (AIHW 2003b). Jamal and Baba's (1992) quantitative study that explored the association of shift work and specialty with Canadian nurses (n=1148) job stress, work attitudes and behavioural intentions found that though specialty practice represented an important variable, shift work was more important. Therefore the current study's finding that type of practice specialty influences the levels of shift work is significant.

There is a plethora of literature highlighting the growing national and international shortage of specialist nurses (Commonwealth of Australia 2002a, 2002b; Cowin & Jacobsson 2003a, 2003b; Creegan, Duffield & Forrester 2003; Duffield & O'Brien-Pallas 2002, 2003). The *National Review of Nursing Education: Discussion Paper* (Commonwealth of Australia 2001) reported that although there are nursing shortages across Queensland, regional and rural Queensland have acute shortages. Queensland Health, Queensland's public sector healthcare organisation, has predicted that the demand for nurses over the next decade will increase by 30% which is a considerable increase (Commonwealth of Australia 2002a).

Nursing shortages contribute to increasing workloads (Duffield & O'Brien-Pallas 2003). The current study found that work intensification was a motivator to part-time employment. The increasing number of nurses working part-time means more nurses are needed to provide the same level of nursing services (Commonwealth of Australia 2002a). Therefore the increasing number of part-time nurses are contributing to current nursing shortages. Creegan, Duffield and Forrester (2003), in a paper that overviewed nursing workforce casualisation, substantiated this by suggesting that though nursing shortages have come and gone the current difference to past situations is the large number of nurses working in part-time and casual employment. Nursing shortages contribute to increasing levels of part-time employment and in turn this factor contributes to nursing shortages. Additionally the current study findings established that specialty nursing shortages increase accessibility to part-time employment,

especially to lesser work hours. Though discussion earlier in this chapter has argued that part-time nursing is associated with diminished access to promotional opportunities, findings established that specialty nursing shortages can at times increase part-time nurses' access to Level 2 promotional opportunities. These complex situations have important implications to nursing practice, organisational knowledge and further research.

6.4.5. Individual factors

Though the current study did not directly explore the differences between part-time and full-time nurses, part-time nurses in the study commonly compared these two employment statuses when discussing their experiences. Issues surrounding the situation for part-time nursing were commonly compared or 'benchmarked' with nurses who worked different numbers of hours or with part-time nurses' own past experiences of working fewer or more hours. These comparisons of experiences influenced individual perceptions of the level and scope of difficulties that were experienced.

A theoretical framework that has been used to understand similarities and differences between full-time and part-time employees is the 'frame of reference' theory (Armstrong-Stassen 1998; Barling & Gallagher 1996; Burke & Greenglass 2000; Eberhardt & Shani 1984; Feldman 1990; Tansky, Gallagher & Wetzel 1997; Thorsteinson 2003). This theory posits that individuals' perceptions of their experiences are based on their comparisons with another self-selected group (Barling & Gallagher 1996; Feldman 1990; Tansky, Gallagher & Wetzel 1997). The current study's findings established that the

frame of reference theory is not only pertinent for understanding similarities and differences between full-time and part-time nurses but is relevant for understanding similarities and differences 'amongst' part-time nurses. The theory is most relevant in its application to understanding the 'meaning' part-time nurses attribute to their experiences. Though the frame of reference that was used varied dependant on the issue being discussed, experiences related to access to professional development opportunities were nearly always compared to the experiences of full-time nurses.

There was much evidence in the current study that part-time nurses perceived that they were being inequitably treated when compared to full-time nurses. Tansky, Gallagher and Wetzel's (1997) Canadian study found that part-time employees' perceptions of their equality relative to full-time workers highly influenced their satisfaction with their job which in turn influenced their organisational commitment. Tansky and colleagues (1997) findings are notable when considered alongside the wealth of perceived inequities that were found by the current study. An understanding that part-time nurses' frame of reference for professional development issues is full-time nurses is important for those who manage part-time nurses. If managers want their decisions to be perceived as equitable they must ensure that these decisions are based on similar criteria for both full-time and part-time nurses.

In many instances expectations of inequities led to a 'self-selection' process where part-time nurses made a self-determined choice not to apply for professional development opportunities. Blumer (1969, p. 17) stated that '(i)n

most situations in which people act toward one another they have in advance a firm understanding of how to act and of how other people will act'. These shared pre-established meanings of what is expected guides the behaviour of individuals (Blumer 1969). This may be important to understanding why part-time nurses in the current study would not apply for professional development opportunities when they perceived that managerial attitudes were unsupportive. A pre-established understanding of how managers would act guided part-time nurses' own actions.

Of relevance is the earlier discussion of Lawrence and Corwin's (2003) proposal related to organisational assumptions of professionals and their working time and how these assumptions become the basis for many key organisational rituals. The current study's findings indicated that part-time nurses themselves may also have assumptions that certain positions can not be performed in diminished working time (section 3.5.2.2). Therefore assumptions that may be influenced by pre-established shared meanings guide nurses' behaviour. Another finding was that part-time nurses' attitudes were often based on their individual 'prioritisation of importance' (section 4.6.1). It is suggested that this finding is relevant to Katz and Kahn's (1978) proposal that partial inclusion can be modified by 'priority of commitment'.

A nurse's 'level of practice' was found to have a considerable influence on experiences of part-time nursing (section 4.6.2). Rosendaal's (2003, p. 489) findings that the relationship between performance and hours of employment 'is probably influenced by experience, the familiarity with the work environment,

[and] personal capacities' substantiates these findings. However, the level of

practice influence over part-time nursing experiences appears to represent a

'catch 22' situation. The Queensland Nursing Council (1998, p. 8) proposed that:

> (n)ursing practice occurs at any point along a continuum from
> beginning to advanced. Movement along the continuum may occur in
> any direction. On-going advancement occurs with continuing
> education, experience and competence development. Alternatively, if
> a nurse practices in a new context or returns to practice after an
> absence, that practice may move towards the beginning point on the
> continuum.

The current study found that part-time nurses experienced difficulty accessing

continuing education, experience and competence development. It would

therefore seem that part-time nurses with higher levels of practice may be largely

reliant on knowledge and skills gained while in previous full-time employment

or through prolonged periods of time spent in a specialty. However, as identified

by the Queensland Nursing Council (1998) if these nurses change practice

contexts (or specialties) they move towards the beginning level on the continuum

of practice. Therefore the 'intervening' influence of their higher levels of practice

is lost and their experiences of difficulties are exacerbated. Consequently part-

time nurses may be somewhat 'trapped' in the specialty where they have

developed higher levels of practice. This factor can be linked to the earlier

discussion that specialty skills are not completely transferable between

specialties. However, as discussed in Chapter 4 (section 4.3.3.2) nurses wanted

diversity in their practice and this was the rationale for many seeking other

nursing employment or changing specialties.

Individual factors provide a condition that influences experiences of part-time nursing. This discussion identified that individual factors are commonly closely associated with organisational factors.

6.4.6. Organisational factors

This chapter has established that many of the organisational practices (rituals) impacting on part-time nurses in regional Queensland may not have changed over time. This is interesting when one considers that contemporary Australian healthcare environments are in a state of continual change (Commonwealth of Australia 2002b; Jones & Cheek 2003). However, even in the midst of these changes organisational basic assumptions about professionals and working time may remain traditional. Chapter 4 (section 4.7.1) reported that inflexibility of some practice settings' work schedules, meetings and education sessions negatively influenced part-time nurses' experiences. Part-time nurses reduced the hours they worked or changed settings when inflexible work schedules were not congruent with other life demands; as was also found by Robinson and colleagues (n.d). These factors are important. Therefore organisations need to understand the possible implications of workplace inflexibility.

The findings indicated that in order to effectively contribute, nurses must be readily available to participate in face-to-face forums with other members of the multidisciplinary team at times that are pre-established by the organisation. In addition, in order to access structured learning, horizontal and vertical advancement opportunities in nursing, expectations were that a nurse would have high levels of availability to the organisation. Jenkins' (2004) British study found

that organisational cultures that valued long working hours were least supportive of the relationship between part-time employment and career development.

Irrespective of what organisational assumptions about professional nursing and working times may be, the reality is that there are increasing numbers of nurses working in part-time employment. Though it is difficult to establish actual percentages of part-time nurses due to deficiencies in nursing labour force data, findings from the nurse manager cohort of the current study identified that 25%—83% of their overall nursing staff were part-time nurses. Therefore in some work contexts in regional Queensland a large majority of the nursing staff are part-time. In these situations the irrationality of assumptions and rituals that are based on nurses' high levels of organisational availability appear obvious. Nonetheless the outcome of these assumptions and rituals is that part-time nurses experience professional interaction and development difficulties that result in an inability to achieve personal optimal nursing potential. This finding has considerable implications for nursing practice and organisational knowledge.

Part-time nurses in the current study were 'accepted'. However, organisational practices limited their ability to access client and organisational information, contribute to client and organisational decision making, and to access structured learning and horizontal and vertical advancement opportunities. Therefore regional Queensland part-time nurses in the current study were practicing in a situation where they were surrounded by both a glass ceiling and glass walls. Their constructs of professional identity established that they needed to reach beyond their confines to be effective professional nurses but their part-time

employment and unsupportive organisational practices ensured that the barriers remained firmly in place whilst they continued to work part-time.

Bailey and Hocking (1997) conducted a predominantly quantitative survey of Level 1 and 2 registered nurses (n=263) in a public metropolitan teaching hospital in Western Australia. The impetus and focus for the study was a hospital policy that excluded access to the Level 2 role for nurses working less than thirty hours per week. The majority of the sample supported the principle that Level 2 positions should be available for those working less than thirty hours per week (Bailey & Hocking 1997). This study found that: human resource management practices were not being used to explore ways to enable nurses to perform the role while working part-time; organisational schedules, such as meetings and education sessions, were not designed for nurses who work part-time; and management attitudes were that part-time employment was associated with less commitment (Bailey & Hocking 1997). Consistent with Bailey and Hocking's (1997) findings, the current study found that organisational practices did not support integration of part-time nurses and solutions to this situation was not being explored in any systematic way.

The issue of 'commitment' did not emerge as a key finding from data in the current study. Considerable heterogeneity was found in part-time nurses' attitudes and aspirations. However, there was much evidence that the nursing role was seen as very important and there was a desire to perform the role effectively. Managers' failure to acknowledge the heterogeneity of part-time nurses' professional aspirations and motivators potentially led to inaccurate

managerial perceptions; such as the belief that all part-time nurses lacked career advancement aspirations. Therefore the assumptions and expectations of part-time nurses and their managers may not be consistent.

As discussed previously, Lawrence and Corwin (2003) argue that professional part-time employment potentially disrupts assumptions related to the relationship between professionals and their working time. These Canadian authors have developed a theory of part-time professional work that is based on the local work context factors of the strength of 'group boundaries', 'demands for conformity' and the 'level of stratification' that exist (Lawrence & Corwin 2003). These factors are proposed to affect the level of acceptance or marginalisation by co-workers and managers (Lawrence & Corwin 2003).

Interestingly the current study found that organisational acceptance of part-time nurses did not nullify their potential to be marginalised. Therefore initially the current study's findings appeared to be contrary to Lawrence and Corwin's (2003) thinking that acceptance is synonymous with inclusion. Further scrutiny identified that the current study's findings related to 'acceptance' were steeped in a historical background where there had been significant resistance to part-time employment for nurses. Therefore the more recent situation of diminished resistance was perceived as acceptance. However, acceptance was not automatically linked to the support that was needed and a lack of support was associated with the marginalisation of part-time nurses.

Irrespective of the two differing understandings of acceptance, Lawrence and Corwin's (2003) theory of part-time professional work is examined further. The current study suggested that effective nursing practice required high levels of face-to-face interactions. The decreased participation by part-time nurses in key interactions potentially negatively impacted on others' perceptions of whether these nurses should be given group membership. Examples of strong 'group boundaries' that excluded membership for part-time nurses in the current study were when other health professionals collaborated with more junior full-time nurses rather than the part-time nurse who was in-charge of the shift and when part-time nurses were not invited to group social functions (section 3.4.1.2).

Findings established that there were strong 'demands for conformity' (Lawrence & Corwin 2003). Examples of these conformity pressures were rigid work schedules, organisational opposition to promotion for part-time nurses and inflexible scheduling of meetings and educational sessions (sections 4.7.1 and 3.5.2.2). There was evidence that part-time nurses were expected to conform to traditional organisational practices rather than organisations changing their practices to integrate part-time nurses. Lawrence and Corwin's (2003) third factor of 'stratification' is pertinent as a very traditional hierarchical structure remains in regional Queensland nursing.

Lawrence and Corwin (2003) posited that marginalisation is more likely when strong group boundaries and pressures for conformity exist and there is a high degree of stratification. The discussion in the preceding paragraphs has established that Lawrence and Corwin's (2003) theory of professional part-time

work is applicable to the situation of part-time nursing. Therefore this theory enables enhanced understanding of the current study's findings and adds weight to the finding that 'organisational factors' are a condition that influences part-time nurses' inability to achieve personal optimal nursing potential.

Lee, MacDermid and Buck (2000), who conducted a qualitative study including over 350 interviews generated from a sample from wide ranging Canadian and North American industries, examined variations in organisational responses to the part-time employment of managers and professionals. The study found that differences in organisational responses to part-time employment could be represented by the terms 'accommodation', 'elaboration' and 'transformation' (Lee, MacDermid & Buck 2000). Comparison of Lee and colleagues' (2000) findings with the findings from the current study identified that regional Queensland healthcare organisations may commonly respond to part-time nursing through 'accommodation'.

In 'accommodation' responses there is a reluctance to support part-time employment and the rationale for accepting these employment arrangements is to retain valued employees (Lee, MacDermid & Buck 2000). A very narrow range of jobs is perceived to be 'do-able' through part-time employment and there is likely to be a marginalising effect on the part-time worker's career (Lee, MacDermid & Buck 2000). In these organisations there is no development of new routines to adapt to part-time employment and the status quo is maintained (Lee, MacDermid & Buck 2000). Therefore it is suggested that 'accommodation' may be a more accurate term to describe organisational responses to part-time

nurses than the current study's finding of 'acceptance'. Lee and colleagues (2000) found that an organisation that responds through the second option of 'elaboration' investigates part-time employment and responds by developing new routines while retaining the basic status quo in relation to work structuring and careers. The current study found some evidence of innovative strategies that were used by nurse managers and nurse educators that responded to part-time nurses' needs without changing other work rituals. Therefore it is fair to say that at times regional Queensland healthcare organisations respond to part-time nursing through Lee and colleagues (2000) paradigm of 'elaboration'.

There was no evidence from the current study of a 'transformation' response by part-time nurses' employing healthcare organisations. 'Transformation' responses were found by Lee and colleagues (2000) to be associated with a greater willingness to accept non-routine behaviour, movement away from the status quo and a highly supportive continuous reorganisation of work and career paths to adapt to changing workforce issues such as part-time working. Lee and colleagues (2000) deny that their paradigms represent a continuum from less desirable to more desirable. However, the current study's findings suggested that an organisational response of 'accommodation' was undesirable and supportive reorganisation of work practices and career paths to adapt to part-time nursing was desired.

The current study's findings established nurse managers and nurse educators as the source from which organisational support for part-time nurses should come. Nurse managers and nurse educators operate at the middle level of the nursing

hierarchical structure and are the connection between the macro/meso-levels (organisation/facility) and the micro-level (work unit) of healthcare organisational structure in regional Queensland (Clinton & Scheiwe 1995). These nurses are responsible for the human resource management of Level 1 and 2 nurses who work at the micro-level of organisations and for ensuring the quality of services at this level (Clinton & Scheiwe 1995). Therefore part-time nurses' experiences of professional difficulties are human resource management and quality issues that are relevant to nurse managers and nurse educators.

Inequitable human resource management practices were commonly attributed to inadequate support from nurse managers primarily and nurse educators as a secondary source. The *Report on the Inquiry into Nursing* (Commonwealth of Australia 2002a) noted that Australian nurses require much greater support from management. Nurse managers and nurse educators hold the base of power for those working at the micro-levels of healthcare organisations; where part-time nurses in the current study were positioned. However, this 'power' was commonly not used to provide the support that was needed to limit the problem associated with part-time nursing. Nevertheless unsupportive managerial practices may be reflective of the situation in which managers find themselves.

As part-time nurses were unaware of the overarching problem that they were experiencing it is fair to suggest that managers share this unawareness. Wider macro-level organisational policies and guidelines that potentially provide supportive frameworks for the management of part-time nurses had commonly not filtered down to this group (section 4.7.2). Additionally it would be difficult

to believe that managers are aware that their inequitable decisions relating to part-time nurses' access to professional development may be putting them at risk of breaching antidiscrimination and equal employment opportunity legislation. Also the dearth of nursing literature related to part-time nursing has impeded access to knowledge that may support managerial strategies. Therefore a situation of 'unawareness' may be a rationale for the diminished managerial support provided to part-time nurses.

The findings indicated that in many ways the needs of part-time nurses and their employing organisation may be incongruent. For example, an organisational need for cost-containment sits uncomfortably beside the part-time nurses need for fiscal support to access educational opportunities; especially when considering the cost in relation to their reduced service hours. There was evidence that nurse managers deliberated on these two incongruous needs in their decision making related to allocation of structured learning opportunities for part-time nurses (section 4.7.2). Therefore managers may be contending with incongruent demands. Tourish and Hargie (1998), who conducted a study of communication within Britain's National Health Service, proposed that '(t)he management role is thus fraught with inherent ambiguity, and may on occasion feel like an attempt to juggle with concrete blocks' (p. 69).

Conway and Briner (2002) proposed that though the 'partial inclusion' and 'frame of reference' theories have been used to explain differences in attitudes and behaviours across work status these theories are able to be manipulated to explain any empirical findings. As such, these authors proposed that these

theories did not provide a framework for understanding the experience of part-time work. Conway and Briner (2002) conducted a quantitative study of part-time employees in the banking sector (n=1608) and the supermarket industry (n=366) to determine the usefulness of the psychological contract as a theoretical framework for understanding part-time work. The findings from Conway and Briner's (2002) study established that the psychological contract was a useful framework for understanding banking employees but was not useful for supermarket employees. They concluded that further research is required to validate the use of this theoretical framework.

There is the potential that inconsistencies in the expectations of part-time nurses and their managers in the current study represented psychological contracts that were not shared by both. A psychological contract is a set of reciprocal expectations and assumptions that are shared by an individual employee and the employing organisation about what each will give to and receive from the other (Cavanagh 1996; Maguire 2002; Skinner, Saunders & Duckett 2004). In most instances the current study findings suggested that the 'organisation' was represented by the nurse manager. These contracts contain both transactional and relational aspects. The transactional aspects refer to the extrinsic, static and observable parts of the contract such as the hours that are to be worked and the remuneration for those hours whereas the relational aspects of the contract are broad qualitative aspects encompassing areas such as trust and commitment, equal opportunity and organisational involvement (Maguire 2002; Rousseau 1990; Skinner, Saunders & Duckett 2004).

As many aspects of the psychological contract are broad conceptualisations that are individually constructed there is the potential that the expectations and assumptions of the employee and the organisation may not be congruent. For example, findings from the current study suggested that part-time nurses perceived that their access to professional development should be similar to full-time nurses. Commonly this did not appear to be the expectation of nurse managers.

Incongruent expectations and assumptions potentially led to breaches of the psychological contract. Breaches of the relational aspects of a psychological contract can have serious long-term consequences (Cavanagh 1996). Therefore it would seem appropriate that managers and part-time nurses communicate more closely with each other about their expectations and assumptions so that psychological contracts are developed from shared and accurate understandings. If this occurred expectations and assumptions that were incongruent could potentially be negotiated to the satisfaction of both parties. Guest and Conway's (2002) British qualitative (n=80 managers and staff)/quantitative (n=1306 senior managers) study of organisations found that a more explicit psychological contract comes from an extensive and effective communication process. These findings further substantiate the current study's findings that improved communication between organisations and part-time nurses is needed.

The previous pages have discussed the contextual conditions that influenced part-time nurses' experiences of the basic social problem. Relevant theories, previous studies and literature have enhanced the understanding of the conditions

discovered through this study. No available previous studies have specifically explored the conditions that influence part-time nursing. Therefore the contextual conditions found by the current study represent new knowledge that has important implications for nursing practice, organisational knowledge, general and nursing theory and future research. Chapter 5 (section 5.3.2) reported that these conditions were the vehicles for part-time nurses' responses to their professional difficulties. The following pages discuss the findings related to the basic social process discovered by the current study.

6.5. Basic social process

The discussion presented in this chapter has argued that traditional, unsupportive and inequitable practices are limiting the ability of part-time nurses to successfully achieve their personal optimal nursing potential. However, Hakim (1996b) posited that women are self-determining authors and agents of their own lives; a concept that may be transferred to males as well. From this perspective it could be suggested that the professional difficulties associated with part-time employment are merely a reflection of self-determined preferences. Certainly part-time nurses in the current study voluntarily chose to work part-time. However, the professional difficulties associated with their decisions were not disregarded as unimportant. These difficulties were not accepted as a self-determined consequence of their decision to work part-time. There was much evidence that part-time nurses were responding to these difficulties.

The basic social process that was discovered through the current study was 'corrective juggling'. This process was used to respond to the professional

interaction and development difficulties that were experienced. As discussed earlier in this chapter, a conflict arose when individual constructs of professional identity were inconsistent with actual experiences of nursing. Corrective juggling was used to adapt and adjust to the challenges associated with this conflict. Therefore corrective juggling is a coping strategy.

However as an extension to other coping theories, 'coping' in this situation was not aimed at adjusting or adapting to psychological or physical stressors. Rather corrective juggling was focussed on the 'stressors' to professional identity. The aim was to correct discrepancies between professional identity and actual nursing experiences. Corrective juggling further extends current coping theories as it does not merely aim to achieve a balance or equilibrium. Instead corrective juggling aims to achieve a balance and to progress nursing practice. The findings clearly identified that 'maintenance' was not perceived as an ideal situation (section 3.5.3). Rather continual professional development was sought after. Part-time nurses did not want to experience professional difficulties that were leading to their inability to achieve personal optimal nursing potential. They desired to be 'core' workers who were able to effectively practice nursing and contribute to other organisational functions.

Lawrence and Corwin's (2003) theory of professional part-time work has been discussed earlier in this chapter. Leading on from this theoretical position these authors suggested that if part-time professionals do not want to be marginalised they have two alternatives; 'compliance with existing rituals, and the innovation of new rituals' (Lawrence & Corwin 2003, p. 936). The corrective strategies

found in the current study encompass both of these alternatives. Temporary or permanent increases in the number of hours worked and use of personal time for work related pursuits were examples of corrective strategies that were compliant with existing regional Queensland healthcare organisations' rituals. Rather than challenging existing organisational rituals or social structures these corrective strategies demanded more of the part-time nurses' time to be committed to the organisation (Lawrence & Corwin 2003). Therefore the strategies preserved organisational rituals at the expense of part-time nurses' personal time (Lawrence & Corwin 2003). Lawrence and Corwin (2003, p. 936) posited that '(p)art-time professionals will be more likely to engage in compliance strategies when (a) they have little access to organizational resources or power, and (b) they view their part-time status as short term'.

Most participants in the current study did not foresee that they would change their employment status to full-time in the future (section 4.3.6). Based on Lawrence and Corwin's (2003) proposal this should make them less likely to engage in compliance strategies. However, the current study found many examples that could be described as compliance strategies. Nonetheless findings also identified creative ideas that were proactive and innovative approaches to the difficulties that were experienced. Increasing flexibility in the scheduling of educational sessions and job sharing (sections 3.5.1.1 and 3.5.2.1) were two examples reflective of Lawrence and Corwin's (2003, p. 936) 'innovation of new rituals' alternative.

These types of corrective strategies challenged existing work rituals. However, Lawrence and Corwin (2003) proposed that considerable influence and access to organisational resources is needed to significantly change organisational routines. Part-time nurses in the current study were not commonly in a position within the organisation to initiate these changes as they practiced in the lower levels of the organisational and nursing hierarchies and therefore had little access to resources or power. Lawrence and Corwin (2003) suggested that part-time professionals who practice at higher levels within the organisation are more likely to be in a position to be involved in the innovation of new rituals. Therefore part-time nurses in the current study were less likely to be involved in the innovation of new rituals and without organisational support were left to creatively idealise about potential innovative strategies.

The consequences emanating from responses made through the corrective juggling process have been reported in Chapter 5 (section 5.3.3). Disinterest, acceptance and diminished professional self-confidence that was closely associated with lowered self-esteem were all unconstructive outcomes that potentially occurred when part-time nurses' corrective strategies were unsuccessful. As suggested earlier in this chapter, the problem part-time nurses experience is shared. Nonetheless corrective juggling seemed to be an individual and somewhat private process that each nurse traversed throughout the trajectory of their part-time employment. There commonly seemed to be a diminished awareness of what it was that they were actually doing.

A diminished awareness of the phenomenon of part-time nursing has resulted in all stakeholders using a reactive and ad hoc process to adapt and adjust to the challenges. Part-time nurses were using corrective juggling as a reaction to the experiences of specific difficulties rather than developing proactive strategies to respond to the overarching problem. Nurse managers and nurse educators were basically doing the same thing rather than utilising a methodical management process to support part-time nurses to limit the problem. Therefore part-time nurses and healthcare organisations were using independent reactive strategies rather than working collaboratively towards a systematic and proactive approach to correcting or limiting the problem. The current study did not find any indication that those at the macro/meso-levels of healthcare organisations had developed comprehensive strategies that were systematically utilised throughout an organisation or even a facility. Unawareness at the micro-level may be leading to failure to communicate the problem upwards to the higher levels of healthcare organisations.

It appears that at present regional Queensland part-time nurses are being 'accommodated' rather than accepted. However, part-time nurses were found to be necessary as they provide a means to ensure that adequate nursing staff is available to meet nursing service demands. O'Brien-Pallas, Duffield and Alksnis (2004), when providing background commentary in relation to issues surrounding the retention of nurses nearing retirement in New South Wales, proposed that '(w)orkforce planning and policy development based solely on "head counts" and financial concerns are unlikely to be efficient or sustainable' (p. 299). Though not intended to be associated with the situation of part-time

nursing, O'Brien-Pallas and colleagues' comment appears to be very pertinent when considering the need for a more proactive planning strategy to address the problem currently facing part-time nurses.

The current study identified that part-time nurses perceived that their experiences of nursing were considerably different when compared to full-time nurses. Therefore nursing workforce planning and policy development should consider these potential variations. Chapter 5 (section 5.3) provided ample examples of corrective strategies that were or could be used to limit the difficulties experienced when nursing part-time. However, this study did not attempt to develop an exhaustive list of corrective strategies. Further research is needed to systematically investigate organisational rituals that pose a barrier to part-time nursing and strategies that can be used by both part-time nurses and employing organisations to limit the difficulties experienced.

This research will assist organisations to respond to part-time nursing in a 'transformative' manner that would enhance the support provided to part-time nurses. In turn this would enable part-time nurses' corrective juggling to be extended beyond strategies that are compliant with existing organisational rituals. Further research would support the development of new rituals. The report from the *National Review of Nursing Education 2002* (Commonwealth of Australia 2002b) recommended that a culture change is needed and new approaches are required that involve nurses in decision making, promote effective multidisciplinary collaboration, provide access to professional development and

organise care to improve client outcomes. This recommendation is vital for the situation of part-time nursing.

Relevant previous theory has considerably enhanced the understanding of the current study's findings of the corrective juggling process. However, discovery of corrective juggling as the basic social process that part-time nurses use to respond to their difficulties represents a new finding. Therefore the finding of corrective juggling is an important contribution to knowledge that enhances understanding and provides a valuable guide for future action.

6.6.   Conclusion

The previous pages of this chapter have discussed the current study's findings in relation to available existing literature and theories. Much literature has been presented to substantiate the current study's findings. Lawrence and Corwin's (2003) theory of part-time professional work, the 'frame of reference' theory and the 'psychological contract' were found to be relevant to and enhance insight into the phenomenon of part-time nursing. However, this discussion has challenged the applicability of Hakim's (1996a; 1996b; 1998) 'preference' theory and Katz and Kahn's (1978) 'partial inclusion' theory. Previous knowledge gaps in existing available literature have been identified and discussion has drawn attention to how the current study's findings have provided a significant contribution of new knowledge. During discussion in this chapter the study findings have founded many major arguments that have advanced the central tenets of the developed theory of part-time nursing. These arguments are

highlighted in Chapter 7 to emphasise the implications for nursing practice,

organisational knowledge, theory and research.

Chapter 7

Conclusion

7.1. Overview

Chapter 6 provided discussion of the substantive theory of part-time nursing that was developed through this study. Extant literature and theories have enabled the theory of part-time nursing to be contextualised with what was already known. In this final chapter the achievement of the aim of the study is reviewed and the methodology that was used is retrospectively examined to determine its value to the study. Conclusions are made by highlighting and drawing together major arguments made during the previous chapter. These conclusions are used to emphasise the implications of the study's findings for nursing practice, organisational knowledge, theory and research. The study's limitations are acknowledged. The summative section of this chapter provides recommendations that have emanated from the study and brief concluding remarks.

7.2. Achievement of the aim

Chapter 1 (section 1.4) reported that the aim of this study was to discover and describe phenomena and develop theory that explains the 'realities' of part-time nursing in regional Queensland. Chapter 3 described the concepts that led to and explained the basic social problem that was discovered. Descriptions of the contextual conditions were reported in Chapter 4 and these explained why part-time nurses in the study were unable to achieve personal optimal nursing potential. Chapter 5 reported the basic social process of corrective juggling that was discovered by this study. Corrective juggling explained how part-time nurses

in the study were responding to the problem. The summative section of Chapter 5 reported the theory that was developed to explain the 'realities' of part-time nursing in regional Queensland. Therefore the aim of the study has been achieved by discovery and description of the problem, conditions and responses that led to development of explanatory theory.

7.3. Value of the methodology

The grounded theory approach and methods that provided a structure for all research activities associated with the study were reported in Chapter 2. The theoretical perspectives of symbolic interactionism enabled individual meanings to be interpreted so that patterned behaviours could be discovered and understood. The ability to understand underlying meanings has considerably contributed to this study's success. Without this theoretical perspective the study findings may have remained descriptive rather than being explanatory of the complex phenomenon of part-time nursing.

Though other studies have explored elements of part-time nursing, the grounded theory approach facilitated the discovery of new findings that appreciably contribute to previous knowledge. Additionally the grounded theory approach enabled the construction of a theory and this is where the true value of the approach lies for this study. The developed theory provides a comprehensive understanding of the phenomenon of part-time nursing for the regional Queensland context because of its explanatory power. Part-time nursing has been found to be a very complex phenomenon. However, conceptualisation of this study's data has enabled complex issues to be more easily understood.

Additionally the comparative analysis method has provided an excellent means to ensure that conceptualisations were grounded in data. These factors provide a substantial base for the conclusion that the selected grounded theory approach and methods were invaluable to the success of the study.

7.4. Study conclusion

The current study found wide variations in part-time nurses' *motivators to work part-time*, the *employment hours* that were worked, *individual factors* and the *specialty factors* and *organisational factors* that formed the contexts in which part-time nursing occurred. These in turn led to differences in part-time nurses' experiences of the problem. Additionally their responses to the problem were found to be varied. Therefore part-time nurses in the current study were found to be a heterogenous group. This was a major argument that was made in Chapter 6 that has important implications for organisational knowledge and future research. It has been argued that assumptions that all part-time nurses are similar may be simplistic and inaccurate and lead to a failure to fully understand the phenomenon of part-time nursing. However, even when such wide variations existed part-time nurses in the current study experienced similarities that founded development of the substantive theory.

Part-time nurses in the current study experienced disconnection within the workplace and challenges in providing client care. Unsuccessful communication of needed information was found to have wide ranging negative influences on experiences of part-time nursing. This ineffective communication and the missed participation that was also associated with part-time employment had a

marginalising effect. Effective professional interaction with all stakeholders in the workplace was perceived as essential to nursing practice. However, marginalisation through professional interaction difficulties became a barrier to part-time nurses utilising their full productive potential. Difficulties acquiring knowledge and skills and constrained career progression were also experienced. Though effective professional development was perceived as essential to nursing practice limited access to these opportunities was a further barrier to part-time nurses reaching their optimal potential.

Chapter 6 proposed that individual constructs of professional identity were founded on perceptions that effective professional interaction and development were essential to nursing practice. It was suggested that conflict arose when constructs of professional identity were inconsistent with actual experiences of part-time nursing. Experiences of professional interaction and development difficulties were found to be the properties and dimensions of a higher order problem that was discovered by the study. The problem that part-time nurses experienced was an *inability to achieve personal optimal nursing potential*. This problem was incongruent with constructs of professional identity. However, though the properties and dimensions that are explanatory of the problem had been recognised by part-time nurses, the overarching problem remained hidden.

Though they were unaware of the problem that existed it was shared by all part-time nurses in the current study. Therefore the scope of the problem may be extensive as part-time nurses potentially constitute a considerable percentage of the overall nursing workforce in regional Queensland. Australian nursing labour

force data has failed to provide current statistics or to make a distinction between part-time and casual nurses. Access to current data that differentiates part-time nurses is important to enabling an accurate understanding of the phenomenon of part-time nursing. This deficit has implications for future research.

Regional Queensland healthcare organisations also share the problem that part-time nurses face because these organisations are reliant on nurses to perform effectively so that organisational function is optimised. However, as part-time nurses are unaware of the problem it has remained hidden to all. Irrespective of their lack of awareness, the problem is negatively impacting on part-time nurses, nursing practice and organisational functioning. This study found that not only is there a singular unawareness of the problem that was being experienced but there was a diminished awareness of the conditions that influence the problem and the responses that are made to the problem. The dearth of knowledge that exists in the literature is further indication of diminished awareness. Additionally diminished awareness of relevant policies and guidelines was evident. There was also unawareness that inequalities in part-time nurses' access to professional development could be considered to be indirect gender discrimination. A chief assertion in the discussion throughout Chapter 6 was that lack of awareness is a barrier to gaining a comprehensive insight into the phenomenon of part-time nursing. This may be contributing to the milieu in which part-time nurses in the current study practiced.

Chapter 6 argued that part-time nurses in the current study practiced in a milieu where organisational assumptions may have been based on the belief that to be

effective in their roles professional nurses needed to have high levels of organisational availability. It is proposed that these assumptions provide a basis for key interaction rituals that involve high levels of face-to-face communications. Organisational assumptions and rituals are leading part-time nurses to experience many professional interaction difficulties. Additionally the organisational value placed upon 'availability' was a barrier to part-time nurses' access to professional development.

The argument made in Chapter 6 was that part-time nurses did not conform to these organisational assumptions and rituals and in fact violated these through missed participation. Part-time nurses in the current study were experiencing professional interaction and development difficulties that have confined them within 'glass ceiling and walls'. They can see through the glass to what 'might be' (professional identity) but they remain within their confines. The milieu in which part-time nurses practiced were commonly traditional, unsupportive and inequitable. This situation has important implications for nursing practice, organisational knowledge and future research. It is vital that organisational assumptions and rituals be reviewed as a means to change that will assist to limit the difficulties experienced by part-time nurses.

This study provided much evidence that part-time nurses were not willing to passively accept the difficulties that they experienced. Instead they were responding by a process of *corrective juggling* that aimed to remove the barriers to their effective practice of nursing. However, as Chapter 6 has argued, only those strategies that 'conformed' to organisational assumptions and rituals were

effective. Therefore though part-time nurses in the current study perceived that they were 'accepted' by their employing organisations, they were commonly merely being 'accommodated'. Accommodation inhibited the success of their corrective juggling. This has implications for nursing practice, organisational knowledge and future research.

The challenge faced is to embrace the benefits that part-time employment brings for nurses and their employing organisations, minimise the difficulties that are potentially associated with this employment status and maintain efficient use of both part-time nurses and employing organisations' limited resources. Part-time nurses require support in a healthcare environment of retreating resources and rigidly adhered to practices so that they are able to limit the difficulties that are experienced. This will permit more successful achievement of personal optimal nursing potential.

The final major argument made throughout Chapter 6 was that though extant literature and theories provide assistance in understanding the phenomenon of part-time nursing they have not fully explicated the issues and no theory has previously been developed to explain this situation. Previous nursing and other literature has substantiated the findings related to the difficulties experienced when nursing part-time. However, this literature provided meagre description and explanation of the difficulties and has not identified the overarching problem that exists. The literature and previous theories that have generally been applied to the phenomenon of part-time employment substantiated the findings and enhanced the understanding of the conditions found by this study. Lawrence and

Corwin's (2003) theory of professional part-time work has provided much assistance in extending understanding of the current study's findings. The developed substantive theory was drawn from data, offers insight into the phenomena, improves understanding and provides a valuable guide to action (Strauss & Corbin 1998). Therefore the theory of part-time nursing for the regional Queensland context represents a considerable contribution to knowledge that has vital implications for nursing practice, organisational knowledge, theory and research.

7.5. Limitations

This study was designed to explore phenomena, interpret, describe and develop a substantive theory that explains the experience of part-time nursing in regional Queensland. Consistent with the grounded theory approach, the developed substantive theory is specific for the study sample from which it was developed. The sample was large for a qualitative study and included wide demographic diversity. This sampling strategy was a deliberate attempt to enhance the potential for discovering variations that could be accounted for by the developed theory. Nevertheless no claims are made related to generalisability. The theory is presented for further testing in other contexts that will facilitate transferability.

Grounded theory, as with all qualitative designs, provided limitations as the researcher was the tool for data collection and analysis. The researcher is a regional Queensland nurse who works part-time in a managerial position. The researcher presented herself as a peer to participants and ensured that all who knew her were aware that this study was not associated with her nursing position,

as was described in Chapter 2. Resultant data provided much evidence that the researcher achieved the goal of gaining distance from her nursing role and instead was perceived as a peer who was exploring issues through a research study. Techniques such as self-awareness, constant comparative analysis and validation of findings, as described in Chapter 2, were used to minimise other methodological limitations.

7.6. Recommendations

The major recommendation emanating from this study is that the theory of part-time nursing for the regional Queensland context needs to be tested in other contexts to determine the applicability of the theory's explanatory capacity. Further testing will establish the theory's generalisability.

Other recommendations include:

There needs to be greater awareness of the phenomenon of part-time nursing.

- A lack of awareness exists of the problem that is experienced when nursing part-time and there is also diminished awareness of the conditions that influence the problem and the responses that part-time nurses use. Part-time nurses and their employing healthcare organisations need to become more aware of these factors so that the complex phenomenon of part-time nursing is more clearly understood. The findings from this study should be utilised to assist in this process.

- Part-time nurses represent a heterogenous group. Healthcare organisations need to develop a greater awareness of the heterogeneity of

the part-time nursing workforce to more fully appreciate the phenomenon of part-time nursing and its potential contribution to the profession.

- There is meagre nursing literature related to part-time nursing. Nurse researchers need to be encouraged to focus more on the phenomenon of part-time nursing as a priority for future nursing management research so that this knowledge deficit is further addressed.

- Part-time nurses and their managers' knowledge of relevant organisational policies and guidelines is limited. To enhance awareness and promote utilisation organisations must develop strategies that enable the effective communication of available policies and guidelines to all organisational levels.

Creative strategies that limit the difficulties associated with part-time nursing must be developed.

- Organisational assumptions based on professional nurses having high levels of workplace availability are unrealistic and not functional in an era of increasing numbers of part-time nurses. Healthcare organisations need to acknowledge the growing trend of nurses working in part-time employment. Rather than 'accommodating' these nurses, organisations must develop strategies that enable highly supportive continuous reorganisation of work and career paths that can adapt to part-time practice and nurses and optimises these nurses' ability to achieve their full productive potential.

- When the expectations and assumptions of the part-time nurse are not consistent with those of their employing organisation this potentially leads to a breach of the psychological contract. Nurse managers need to

use effective collaborative strategies to optimise congruency between organisational and part-time nurses' expectations and assumptions.

- Historical strategies of communication are not effective in meeting the information needs of part-time nurses. Innovative communication strategies must be developed to enhance the potential for successful interaction between part-time nurses, clients and all other stakeholders in the workplace.

- Inequitable organisational decision making and practices are leading to professional development difficulties for part-time nurses. Healthcare organisations must review and change decision making processes and practices to ensure equitable access to professional development opportunities for all nurses.

7.7. Concluding remarks

The study found that the interweaving of the motivators to work part-time, employment hours, specialty, individual and organisational factors form contextual conditions that lead to professional interaction and/or development difficulties resulting in an inability to achieve personal optimal nursing potential. Nurses respond to this experience through a process of corrective juggling. This theory is dynamic and accounts for wide variations in experiences, conditions and responses. The theory is explanatory of a very complex phenomenon and therefore offers insight, enhances understanding and provides a valuable guide to action (Strauss & Corbin 1998).

From this researcher's perspective the discovery of the problem faced by regional Queensland part-time nurses was surprising yet saddening. However, the discovery that corrective juggling can be used to alter the conditions that have a 'causal' influence on the problem provides hope. The recommendations that emanated from this study found a guide for action towards a more positive and optimistic future for part-time nurses.

References

ABS 2001, *Work - paid employment: Trends in part-time work.*, Australian Bureau of Statistics, Commonwealth of Australia, viewed 30 August 2002, <http://www.abs.gov.au/Ausstats/abs@.nsf/94713ad445ff1425ca25682000192af2/5e165f3>.

ACTU 2000, *Working families in the new millennium: An ACTU action plan for balancing work and family life- 2000-2003.*, ACTU, Carlton South.

Adams, SM 1995, 'Part-time work: models that work.' *Women in Management Review*, vol. 10, no. 7, pp. 21-31.

AIHW 2003a, *Nursing labour force 2001*, cat. no. HWL 26, Australian Institute of Health and Welfare, Canberra.

---- 2003b, *Nursing Labour Force 2002*, cat. no. HWL 26, Australian Institute of Health and Welfare, Canberra.

---- 2004, *Rural, regional and remote health: A guide to remoteness classifications.*, Australian Institute of Health and Welfare, viewed 19 March 2004, <http://www.aihw.gov.au/publications/phe/rrrh-gtrc/rrrh-gtrc.pdf>.

---- Unpublished, *Table: All employed nurses: level of main job and hours worked per week by geographical location of main job.*, Australian Institute of Health and Welfare, Canberra.

Annells, M 1996, 'Grounded theory method: Philosophical perspectives, paradigm of inquiry, and postmodernism.' *Qualitative Health Research*, vol. 6, no. 3, pp. 379-93.

Armstrong-Stassen, M 1998, 'Alternative Work Arrangements: Meeting the Challenges.' *Canadian Psychology*, vol. 39, no. 1-2, pp. 108-23.

Armstrong-Stassen, M, Al-Ma'aitah, R, Cameron, SJ & Horsburgh, ME 1998, 'The relationship between work status congruency and the job attitudes of full-time and part-time Canadian and Jordanian nurses', *The International Journal of Human Resource Management*, vol. 9, no. 1, pp. 41-57.

Asselin, M 2003, 'Insider research: Issues to consider when doing qualitative research in your own setting.' *Journal for Nurses in Staff Development*, vol. 19, no. 2, pp. 99-103.

Australian Nursing Council 2000, *Australian Nursing Council: National competency standards for the registered nurse.*, 3rd edn, ANC, Dickson, ACT.

Backman, K & Kyngas, HA 1999, 'Challenges of the grounded theory approach to a novice researcher.' *Nursing and Health Sciences*, vol. 1, pp. 147-53.

Bailey, J & Hocking, J 1997, 'Part-time work for nurses: A case study.' *International Employment Relations Review*, vol. 3, no. 1, pp. 1-19.

Bampton, R & Cowton, CJ 2002, *The E-Interview*, viewed December 3 2003, <http://www.qualitative-research.net/fqs/fqs-eng.htm>.

Barbour, R 2001, 'Checklists for improving rigour in qualitative research: A case of the tail wagging the dog?' *British Medical Journal*, vol. 322, no. May, pp. 1115-7.

Barling, F & Gallagher, DG 1996, 'Part-time employment.' *Review of Industrial and Organizational Psychology*, vol. 11, pp. 243-77.

Barnett, RC & Hyde, JS 2001, 'Women, Men, Work, and Family: An Expansionist Theory.' *American Psychologist*, vol. 56, no. 10, pp. 781-96.

Barriball, KL & While, AE 1996, 'Participation in continuing professional education in nursing: findings of an interview study.' *Journal of Advanced Nursing.*, vol. 23, pp. 999-1007.

Becker, P 1993, 'Common pitfalls in published grounded theory research.' *Qualitative Health Research*, vol. 3, no. 2, pp. 254-60.

Benoliel, JQ 1996, 'Grounded theory and nursing knowledge.' *Qualitative Health Research*, vol. 6, no. 3, pp. 406-28.

Bertrand, JT, Brown, JE & Ward, VM 1992, 'Techniques for analysing focus group data.' *Evaluation Review*, vol. 16, no. 2, pp. 198-209.

Blumer, H 1969, *Symbolic interactionism: Perspective and method.*, Prentice Hall, New Jersey.

Borbasi, S 1999, 'Advanced practice/ expert nurses: Hospitals can't live without them.' *Australian Journal of Advanced Nursing*, vol. 16, no. 3, pp. 21-9.

Branine, M 2003, 'Part-time work and job sharing in health care: is the NHS a family-friendly employer?' *Journal of Health Organization and Management*, vol. 17, no. 1, pp. 53-68.

Brooks, I 2000, 'Nurse retention: Moderating the ill-effects of shift work.' *Human Resource Management Journal*, vol. 10, no. 4, pp. 16-31.

Brooks, I & Swailes, S 2002, 'Analysis of the relationship between nurse influences over flexible working and commitment to nursing.' *Journal of Advanced Nursing*, vol. 38, no. 2, pp. 117-26.

Brown, C & Jones, L 2004, 'The gender structure of the nursing hierarchy: The role of Human Capital.' *Gender, Work and Organization*, vol. 11, no. 1, pp. 1-25.

Burke, RJ 2004, 'Work status congruence, work outcomes, and psychologic well-being.' *The Health Care Manager*, vol. 23, no. 2, pp. 120-7.

Burke, RJ & Greenglass, ER 2000, 'Juggling act: Work concerns, family concerns.' *The Canadian Nurse*, vol. 96, no. 9, pp. 20-3.

Carey, M & Smith, M 1994, 'Capturing the group effect in focus groups: A special concern in analysis.' *Qualitative Health Research*, vol. 4, no. 1, pp. 123-7.

Cavanagh, SJ 1996, 'A 'new' psychological contract for nurses: some management implications.' *Journal of Nursing Management*, vol. 4, no. 2, pp. 79-83.

Charmaz, K 1994, ''Discovering' chronic illness: Using grounded theory.' in B Glaser (ed.), *More grounded theory methodology. A reader.*, The Sociology Press, Mill Valley, California.

Chiovitti, R & Piran, N 2003, 'Rigour and grounded theory research', *Journal of Advanced Nursing*, vol. 44, no. 4, pp. 427-35.

Clinton, M & Scheiwe, D 1995, *Management in the Australian health care industry.*, Harper Educational, Pymble.

Commonwealth of Australia 2001, *National review of nursing education: Discussion paper.*, DETYA - Commonwealth Department of Education, Science and Training, viewed 24 May 2004, <http://www.dest.gov.au/archive/highered/nursing/pubs/discussion/default.htm>.

---- 2002a, *The patient profession: Time for action. Report on the inquiry into nursing.*, viewed February 11th 2003, <http://www.aph.gov.au/senate/committee/clac_ctte/nursing/report/index.htm>.

---- 2002b, *National review of nursing education 2002: Our duty of care.*, DETYA - Commonwealth Department of Education, Science and Training, viewed 17 March 2004, <http://www.dest.gov.au/highered/nursing/pubs/duty_of_care/Duty_of_care.PDF>.

Conway, N & Briner, R 2002, 'Full-time versus part-time employees: Understanding the links between work status, the psychological contract, and attitudes.' *Journal of Vocational Behavior*, vol. 61, pp. 279-301.

Courtney, M, Yacopetti, J, James, C, Walsh, A & Finlayson, K 2002, 'Comparison of roles and professional development nees of nurse executives working in metropolitan, provincial, rural or remote settings in Queensland.' *The Australian Journal of Rural Health*, vol. 10, no. 4, pp. 202-8.

Cowin, L & Jacobsson, D 2003a, 'The nursing shortage: Part way down the slippery slope.' *Collegian*, vol. 10, no. 3, pp. 31-5.

---- 2003b, 'Addressing Australia's nursing shortage: Is the gap widening between workforce recommendations and the workplace?' *Collegian*, vol. 10, no. 4, pp. 20-4.

Coyne, IT 1997, 'Sampling in qualitative research. Purposeful and theoretical sampling; merging or clear boundaries?' *Journal of Advanced Nursing.*, vol. 26, pp. 623-30.

Creegan, R, Duffield, C & Forrester, K 2003, 'Casualisation of the nursing workforce in Australia: driving forces and implications.' *Australian Health Review*, vol. 26, no. 1, pp. 201-8.

Creswell, JW 1994, *Research design: Qualitative and quantitative approaches.*, Sage, London.

Cutcliffe, JR 2000, 'Methodological issues in grounded theory.' *Journal of Advanced Nursing.*, vol. 31, no. 6, pp. 1476-84.

Davey, B & Robinson, S 2002, 'Taking a degree after qualifying as a registered general nurse: constraints and effects.' *Nurse Education Today*, vol. 22, no. 8, pp. 624-31.

de Ruyter, A & Burgess, J 2000, 'Part-time employment in Australia - Evidence for globalization?' *International Journal of Manpower*, vol. 21, no. 6, pp. 452-63.

Dealy, MF & Bass, M 1995, 'Professional development.' *Nursing Management*, vol. 26, no. 8, pp. 32F-I.

Doherty, C & Doherty, W 2005, 'Patients' preferences for involvement in clinical decision-making within secondary care and the factors that influence their preferences.' *Journal of Nursing Management*, vol. 13, no. 2, pp. 119-27.

Duchscher, JEB & Morgan, D 2004, 'Grounded theory: reflections on the emergence vs. forcing debate.' *Journal of Advanced Nursing*, vol. 48, no. 6, pp. 605-12.

Duffield, C & O'Brien-Pallas, L 2002, 'The nursing workforce in Canada and Australia: two sides of the same coin.' *Australian Health Review*, vol. 25, no. 2, pp. 136-44.

---- 2003, 'The causes and consequences of nursing shortages: a helicopter view of the research.' *Australian Health Review*, vol. 26, no. 1, pp. 186-93.

Duffy, K, Ferguson, C & Watson, H 2004, 'Data collecting in grounded theory-- some practical issues.' *Nurse Researcher*, vol. 11, no. 4, pp. 67-78.

Eberhardt, BJ & Shani, AB 1984, 'The effects of full-time versus part-time employment status on attitudes toward specific organizational characteristics and overall job satisfaction.' *Academy of Management Journal*, vol. 27, no. 000004, pp. 893-900.

Edwards, CY & Robinson, O 2001, '"Better" part-time jobs? A study of part-time working in nursing and the police.' *Employee Relations*, vol. 23, no. 5, pp. 438-53.

---- 2004, 'Evaluating the business case for part-time working amongst qualified nurses.' *British Journal of Industrial Relations*, vol. 42, no. 1, pp. 167-83.

Ekblad, S, Marttila, A & Emilsson, M 2000, 'Cultural challenges in end-of-life care: reflections from foucs groups' interviews with hospice staff in Stockholm.' *Journal of Advanced Nursing*, vol. 31, no. 3, pp. 623-30.

Elliot, N & Lazenbatt, A 2005, 'How to recognise a 'quality' grounded theory research study.' *Australian Journal of Advanced Nursing*, vol. 22, no. 3, pp. 48-52.

England, P 1998, 'What do we mean when we say something is gendered?' *Organizations, Occupations, and Work*, vol. Fall, p. 1.

Ezzy, D 2002, *Qualitative analysis: practice and innovation.*, Allen & Unwin, Crows Nest, Australia.

Fagermoen, MS 1997, 'Professional identity: values embedded in meaningful nursing practice.' *Journal of Advanced Nursing*, vol. 25, pp. 434-41.

Feldman, DC 1990, 'Reconceptualizing the nature and consequences of part-time work.' *Academy of Management Review*, vol. 15, no. 1, pp. 103-12.

Feldman, DC & Doerpinghaus, HI 1992, 'Missing persons no longer: Managing part-time workers in the '90s.' *Organizational Dynamics*, vol. Summer, pp. 59-72.

Fitzpatrick, JM, While, AE & Roberts, J 1999, 'Shift work and its impact upon nurse performance: current knowledge and research issues.' *Journal of Advanced Nursing*, vol. 29, no. 1, pp. 18-27.

Fraser, D 1999, *QRS NUD*IST Vivo: Reference Guide.*, Qualitative Solutions and Research, Melbourne.

Furze, G & Pearcey, P 1999, 'Continuing education in nursing: A review of the literature.' *Journal of Advanced Nursing*, vol. 29, no. 2, pp. 355-63.

Garbett, R 1996, 'Speaking out', *Nursing Times*, vol. 11, no. 37, pp. 52-3.

Glaser, B 1978, *Theoretical sensitivity*, Sociology Press, Mill Valley, California.

---- 1992, *Basics of grounded theory analysis.*, Sociology Press, Mill Valley, California.

---- 1999, 'The future of grounded theory.' *Qualitative Health Research*, vol. 9, no. 6, pp. 836-45.

---- 2002a, 'Constructivist grounded theory?' *Qualitative Social Research*, vol. 3, no. 3, pp. 1-10.

---- 2002b, 'Conceptualization: On theory and theorizing using grounded theory.' *International Journal for Qualitative Methods*, vol. 1, no. 2, pp. 1-31.

Glaser, B & Strauss, A 1967, *The discovery of grounded theory: strategies for qualitative research.*, Aldine Publishing, Chicago.

Godfrey, MA 1980a, 'Is part-time nursing the answer for you?: Part 1', *Nursing*, vol. 10, no. 10, pp. 65-72.

---- 1980b, 'The part-time question and the hospital's answer: Part 2.' *Nursing*, vol. 10, no. 11, pp. 65-72.

Goulding, C 1999, *Grounded theory: Some reflections on paradigm, procedures and misconceptions.*, WP006/99, Management Research Centre, University of Wolverhampt.

Greenhaus, JH & Beutell, NJ 1985, 'Sources of conflict between work and family roles1.' *Academy of Management Review*, vol. 10, no. 000001, pp. 76-88.

Gregg, MF & Magilvy, JK 2001, 'Professional identity of Japanese nurses: Bonding into nursing.' *Nursing and Health Sciences*, vol. 3, pp. 47-55.

Grinspun, D 2002, 'A flexible nursing workforce: Realities and fallouts', *Hospital Quarterly*, vol. 6, no. 1, pp. 79-84.

---- 2003, 'Part-time and casual nursing work: the perils of healthcare restructuring.' *International Journal of Sociology and Social Policy*, vol. 23, no. 8, pp. 54-80.

Grosswald, B 2003, 'Shift work and negative work-to-family spillover.' *Journal of Sociology and Social Welfare*, vol. 30, no. 4, pp. 31-56.

'Grounded theory and constant comparative analysis.' 2004, *Orthopaedic Nursing*, vol. 23, no. 6, pp. 403-4.

Guest, DE & Conway, N 2002, 'Communicating the psychological contract: An employer perspective.' *Human Resource Management Journal*, vol. 12, no. 2, pp. 22-38.

Hagbaghery, MA, Salsali, M & Ahmadi, F 2004, 'A qualitative study of Iranian nurses' understanding and experiences of professional power.' *Human Resources for Health*, vol. 2, no. 9, pp. 1-14.

Hakim, C 1996a, *Key issues in women's work: Female heterogeneity and polarisation of women's employment.*, Athlone, London.

---- 1996b, 'The sexual division of labour and women's heterogeneity.' *The British Journal of Sociology*, vol. 47, no. 1, pp. 178-88.

---- 1998, *Social change and innovation in the labour market.*, Oxford University Press, Melbourne.

Hall, EM 1993, 'Job sharing: Evidence from New Zealand.' *Australian Journal of Management*, vol. 18, no. 1, pp. 63-8.

Halliday, S 1998, 'Winds of change: Indirect discrimination and university culture.' paper presented to Winds of Change: Women and the Culture of Universities International Conference, Sydney.

Havlovic, SJ, Lau, DC & Pinfield, LT 2002, 'Repercussions of work schedule congruence among full-time, part-time, and contingent nurses', *Health Care Management Review*, vol. 27, no. 4, pp. 30-41.

Hawksworth, G 1999, *The nursing perspective.*, Queensland Nurses' Union., viewed 30 December 2002, <http://www.qnu.org.au/worktimelife.htm>.

Heath, H & Cowley, S 2003, 'Developing a grounded theory approach: A comparison of Glaser and Strauss', *International Journal of Nursing Studies*, vol. 41, no. 2, pp. 141-50.

Heflich, DA & Rice, ML 2001, 'Educational research online: Lessons learned', *International Journal of Educational Telecommunications*, vol. 7, no. 4, pp. 393-405.

Hegney, D, Plank, A & Parker, V 2003, 'Nursing workloads: the results of a study of Queensland Nurses', *Journal of Nursing Management*, vol. 11, no. 5, pp. 307-14.

Higgins, C, Duxbury, L & Johnson, KL 2000, 'Part-time work for women: Does it really help balance work and family?' *Human Resource Management*, vol. 39, no. 1, pp. 17-32.

Hill, EJ, Martinson, V, Ferris, M & Baker, RZ 2004, 'Beyond the Mommy track: The influence of new-concept part-time work for professional women on

work and family.' *Journal of Family and Economic Issues*, vol. 25, no. 1, pp. 121-36.

Hiscott, RD 1994, 'Changes in employment status: the experiences of Ontario registered nurses', *Canadian Journal of Nursing Research*, vol. 26, no. 2, pp. 43-60.

Hom, PW 1979, 'Effects of job peripherality and personal characteristics on the job satisfaction of part time workers.' *Academy of Management Journal*, vol. 22, no. 3, pp. 551-65.

Hopkinson, JB 2002, 'The hidden benefit: the supportive function of the nursing handover for qualified nurses caring for dying people in hospital.' *Journal of Clinical Nursing*, vol. 11, no. 2, pp. 168-75.

Horsburgh, D 2003, 'Evaluation of qualitative research.' *Journal of Clinical Nursing*, vol. 12, no. 2, pp. 307-12.

HREOC 2004, *Federal discrimination law 2004.*, Human Rights and Equal Opportunity Commission, viewed 15 January 2005, <http://www.hreoc.gov.au/legal/fed_discrimination_law_04>.

ICN 2000, *Nurses and shift work.*, International Council of Nurses, viewed 21 July 2004, <http://www.icn.ch/psshiftwork00.htm>.

Irurita, V 1999, 'Factors affecting the quality of nursing care: The patient's perspective.' *International Journal of Nursing Practice*, vol. 5, no. 2, pp. 86-94.

Jackson, V 1991, 'A wasted asset?' *Nursing Times*, vol. 87, no. 14, p. 49.

Jacobsen, DI 2000, 'Managing increased part-time: does part-time work imply part-time commitment?' *Managing Service Quality.*, vol. 10, no. 3, pp. 187-200.

Jamal, M & Baba, VV 1992, 'Shiftwork and department-type related to job stress, work attitudes and behavioral intentions: A study of nurses.' *Journal of Organizational Behavior*, vol. 13, pp. 449-64.

Jamieson, L & Mosel Williams, L 2003, 'Focus group methodology: Explanatory notes for the novice nurse researcher.' *Contemporary Nurse*, vol. 14, no. 3, pp. 271-80.

Jansen, NW, Kant, I, Kristensen, TS & Nijhuis, F 2003, 'Antecedents and Consequences of Work–Family Conflict: A Prospective Cohort Study.' *Journal of Occupational and Environmental Medicine*, vol. 45, no. 5, pp. 479-91.

Jenkins, S 2004, 'Restructuring flexibility: Case studies of part-time female workers in six workplaces.' *Gender, Work and Organization*, vol. 11, no. 3, pp. 306-33.

Jeon, Y-H 2004, 'The application of grounded theory and symbolic interactionism.' *Scandinavian Journal of Caring Sciences*, vol. 18, no. 3, pp. 249-56.

Jones, J & Cheek, J 2003, 'The scope of nursing in Australia: a snapshot of the challenges and skills needed', *Journal of Nursing Management*, vol. 11, no. 2, pp. 121-9.

Kapborg, I 2000, 'Swedish nurse's experiences of being forced into part-time employment.' *Nursing and Health Sciences*, vol. 2, pp. 173-7.

Katz, D & Kahn, RL 1978, *The social psychology of organizations.*, 2nd edn, Wiley, New York.

Kemp, J 1994, 'Career paths revisited: the experiences of graduates in nursing who no longer work full-time.' *Journal of Advanced Nursing.*, vol. 20, pp. 377-81.

Kerr, MP 2002, 'A qualitative study of shift handover practice and function from a socio-technical perspective.' *Journal of Advanced Nursing*, vol. 37, no. 2, pp. 125-34.

Khalil, A & Davies, N 2000, 'The experiences of nurses returning to work after childbirth: 'making a difference'', *Journal of Nursing Management*, vol. 8, no. 6, pp. 337-44.

Kidd, P & Parshall, M 2000, 'Getting the focus and the group: Enhancing analytical rigor in focus group research.' *Qualitative Health Research*, vol. 10, no. 3, pp. 293-308.

Kitzinger, J 1994, 'The methodology of focus groups: The importance of interaction between research participants.' *Sociology of Health and Illness*, vol. 16, no. 1, pp. 103-21.

Kramar, R 1998, 'Flexibility in Australia: implications for employees and managers.' *Employee Relations*, vol. 20, no. 5, pp. 453-60.

Kreuger, RA 1994, *Focus groups: A practical guide for applied research.*, 2nd edn, Sage, London.

Kropf, MB 1999, 'Flexibility initiatives: current approaches and effective strategies', *Women in Management Review*, vol. 14, no. 5, pp. 177-85.

Lally, S 1999, 'An investigation into the functions of nurses' communication at the inter-shift handover.' *Journal of Nursing Management*, vol. 7, no. 1, pp. 29-36.

Lane, N 1998, 'Barriers to women's progression into nurse management in the National Health Service.' *Women in Management Review*, vol. 13, no. 5, pp. 184-91.

---- 1999a, 'Sources of career disadvantage in nursing.' *Journal of Management in Medicine.*, vol. 13, no. 6, pp. 373-89.

---- 1999b, 'Inequality in the careers of NHS nurses: A regional case study of qualified nurses in NHS Wales.' *Personnel Review*, vol. 28, no. 4, pp. 319-35.

---- 2000a, 'The Management Implications of Women's Employment Disadvantage in a Female-Dominated Profession: A Study of NHS Nursing.' *Journal of Management Studies*, vol. 37, no. 5, pp. 705-31.

---- 2000b, 'The low status of female part-time NHS nurses.' *Gender, Work and Organization*, vol. 7, no. 4, pp. 269-81.

--- 2004, 'Women and part-time work: The careers of part-time NHS nurses.' *British Journal of Management*, vol. 15, no. 3, pp. 259-72.

Lane, N & Piercy, NF 2003, 'The ethics of discrimination: Organizational mindsets and female employment disadvantage.' *Journal of Business Ethics*, vol. 44, no. 1, pp. 313-25.

Lawrence, TB & Corwin, V 2003, 'Being there: the acceptance and marginalization of part-time professional employees.' *Journal of Organizational Behavior*, vol. 24, no. 8, pp. 923-43.

Lee, MD, MacDermid, S & Buck, M 2000, 'Organizational paradigms of reduced-load work: Accommodation, elaboration, and transformation.' *Academy of Management Journal*, vol. 43, no. 6, pp. 1211-26.

Lomborg, K & Kirkevold, M 2003, 'Truth and validity in grounded theory – a reconsidered realist interpretation of the criteria: fit, work, relevance and modifiability', *Nursing Philosophy*, vol. 4, no. 3, pp. 189-200.

Luker, KA, Austin, L, Caress, A & Hallett, C 2000, 'The importance of 'knowing the patient': community nurses' constructions of quality in providing palliative care.' *Journal of Advanced Nursing*, vol. 31, no. 4, pp. 775-82.

MacDonald, M & Schreiber, RS 2001, 'Constructing and deconstructing: Grounded theory in a postmodern world.' in RS Schreiber & PN Stern (eds), *Using grounded theory in nursing*, Springer, New York.

Madsen, W 2000, 'Learning to be a nurse: The culture of training in a regional Queensland hospital, 1930-1950.' *Transformations*, vol. 1, pp. 1-9.

Maguire, H 2002, 'Psychological contracts: Are they still relevant?' *Career Development International*, vol. 7, no. 3, pp. 167-80.

Malone, JA 1994, 'Milieu and part-time nurses: A contradiction?' *Journal of Psychosocial Nursing & Mental Health Services*, vol. 32, no. 7, p. 7.

Markey, R, Hodgkinson, A & Kowalczyk, J 2002, 'Gender, part-time employment and employee participation in Australian workplaces.' *Employee Relations*, vol. 24, no. 2, pp. 129-50.

Marsland, L, Robinson, S & Murrells, T 1996, 'How new nurses manage work and family responsibilities.' *Nursing Times*, vol. 92, no. 24, pp. 44-6.

May, KA 1991, 'Interview techniques in qualitative research: Concerns and challenges.' in JM Morse (ed.), *Qualitative Nursing Research: A contemporary dialogue.*, Sage, London.

McCabe, C 2004, 'Nurse patient communication: an exploration of patients' experiences.' *Journal of Clinical Nursing*, vol. 13, no. 1, pp. 41-9.

McCallin, A 2003, 'Designing a grounded theory study: some practicalities', *Nursing in Critical Care*, vol. 8, no. 5, pp. 203-8.

McCann, TV & Clark, E 2003, 'Grounded theory in nursing research: part 1--methodology.' *Nurse Researcher*, vol. 11, no. 2, pp. 7-18.

Miller, S & Fredericks, M 1999, 'How does grounded theory explain?' *Qualitative Health Research*, vol. 9, no. 4, pp. 538-51.

Milliken, PJ & Schreiber, RS 2001, 'Can you "do" grounded theory without symbolic interactionism.' in RS Schreiber & PN Stern (eds), *Using grounded theory in nursing*, Springer Publishing, New York, pp. 177-90.

Mok, E & Chiu, PC 2004, 'Nurse patient relationships in palliative care.' *Journal of Advanced Nursing*, vol. 48, no. 5, pp. 475-83.

Morgan, DL 1995, 'Why things (sometimes) go wrong in focus groups.' *Qualitative Health Research*, vol. 5, no. 4, pp. 516-23.

Morse, JM 1991, 'Qualitative nursing research: A free for all.' in JM Morse (ed.), *Qualitative nursing research: A contemporary dialogue.*, Sage, London.

---- 2001, 'Situating grounded theory within qualitative inquiry.' in RS Schreiber & PN Stern (eds), *Using grounded theory in nursing.*, Springer, New York.

Morse, JM & Field, PA 1996, *Nursing research: The application of qualitative approaches.*, Chapman and Hall, Melbourne.

Newell, S 1992, 'The Myth and Destructiveness of Equal Opportunities: The Continued Dominance of the Mothering Role.' *Personnel Review*, vol. 21, no. 4, pp. 37-47.

Nordgren, S & Fridlund, B 2001, 'Patients' perceptions of self-determination as expressed in the context of care.' *Journal of Advanced Nursing*, vol. 35, no. 1, pp. 117-25.

Nyamathi, A & Shuler, P 1990, 'Focus group interview: A research technique for informed nursing practice.' *Journal of Advanced Nursing*, vol. 15, pp. 1281-8.

O'Brien-Pallas, L, Duffield, C & Alksnis, C 2004, 'Who will be there to nurse?: Retention of nurses nearing retirement.' *Journal of Nursing Administration*, vol. 34, no. 6, pp. 298-302.

O'Connell, B 2000, 'Ways of knowing in nursing.' in J Greenwood (ed.), *Nursing Theory in Australia*, 2nd edn, Prentice Hall, Frenchs Forrest.

Ohlen, J & Segesten, K 1998, 'The professional identity of the nurse: concept analysis and development.' *Journal of Advanced Nursing*, vol. 28, no. 4, pp. 720-7.

Olofsson, B, Bengtsson, C & Brink, E 2003, 'Absence of response: a study of nurses' experience of stress in the workplace', *Journal of Nursing Management*, vol. 11, no. 5, pp. 351-8.

Patton, M 2002, *Qualitative research and evaluation methods.*, 3rd edn, Sage Publications, Thousand Oaks.

Pocock, B 2001b, *Having a life: Work, family, fairness and community in 2000.*, Centre for Labour Research, Adelaide University, viewed 1 March 2004, <http://www.arts.adelaide.edu.au/social_inquiry/staff/pocock_barbara.htm>.

---- 2003, *The work / life collision.*, vol. 2004, Federation Press, Australia.

Poissonnet, CM & Véron, M 2000, 'Health effects of work schedules in healthcare professions.' *Journal of Clinical Nursing*, vol. 9, no. 1, pp. 13-23.

Queensland Health 1999, *Ministerial taskforce: Nursing recruitment & retention.*, Queensland Health, Queensland Government, viewed 17 March 2004, <http://www.health.qld.gov.au/publications/hau/qh_nrr.pdf>.

---- 2002, *Flexible work arrangements guide: Achieving a work life balance.*, Queensland Health, Queensland Government.

Queensland Nurses' Union 2001, *Summary of QNU recommendations: Senate inquiry into nursing 2001.*, viewed 21 March 2004, <http://www.aph.gov.au/Senate/committee/eet_ctte/skills/submissions/sub015b.pdf>.

---- 2002, *Submission by the Qeensland Nurses' Union: Queensland Work and Family Taskforce 2002.*, viewed 25 February 2004, <http://www.qnu.org.au/__data/page/253/sub_workfamily.pdf>.

---- 2004, *Part-time provisions in nursing awards*, Personal Communication.

Queensland Nursing Council 1998, *Scope of nursing practice decision making framework.*, QNC, Brisbane.

Radwin, LE 1996, "Knowing the patient': a review of research on an emerging concept.' *Journal of Advanced Nursing*, vol. 23, no. 6, pp. 1142-6.

Richards, L 1999, *Using NVivo in qualitative research.*, Qualitative Solutions and Research, Melbourne.

RNAO 2003, *Survey of casual and part-time registered nurses in Ontario.*, Registered Nurses Association of Ontario, viewed 14 January 2004, <http://www.rnao.org/html/PDF/RNAO_part_time_casual_report.pdf>.

Roberts, P 1997, 'Planning and running a focus group.' *Nurse Researcher*, vol. 4, no. 4, pp. 78-82.

Robinson, S, Marsland, L, Murrells, T, Tingle, A & Smith, R n.d, *Careers of registered general nurses. Combining work and family: Nurses' experiences four to eight years after qualification. Executive summary.*, viewed 5 March 2005, <http://www.kcl.ac.uk/nursing/nru/pdf/rgn/RGN%20Exec%20sum-final.pdf>.

Robrecht, L 1995, 'Grounded theory: Evolving methods.' *Qualitative Health Research*, vol. 5, no. 2, pp. 169-77.

Rosendaal, BW 2003, 'Dealing with part-time work', *Personnel Review*, vol. 32, no. 4, pp. 474-91.

Rotchford, NL & Roberts, KH 1982, 'Part-time workers as missing persons in organizational research.' *Academy of Management Review*, vol. 7, no. 2, pp. 228-34.

Rousseau, DM 1990, 'New hire perceptions of their own and their employer's obligations: A study of psychological contracts; Summary.' *Journal of Organizational Behavior*, vol. 11, no. 5, pp. 389-400.

Russell, G & Bowman, L 2000, *Work and family. Current thinking, research and practice.*, Department of Family and Community Services, viewed 6 May

2004,
<http://www.facs.gov.au/internet/facsinternet.nsf/vIA/families/$file/work_family.pdf>.

Sarantakos, S 1993, *Social research.*, MacMillan Education Australia, Melbourne.

Schreiber, RS 2001, 'The "how to" of grounded theory: Avoiding the pitfalls.' in RS Schreiber & PN Stern (eds), *Using grounded theory in nursing*, Springer, New York.

Selwyn, N & Robson, K 1998, *Using e-mail as a research tool*, Department of Sociology, University of Surrey, viewed December 3 2003, <http://www.soc.surrey.ac.uk/sru/SRU21.html>.

Sexton, A, Chan, C, Elliot, M, Stuart, J, Jayasuriya, R & Crookes, P 2004, 'Nursing handovers: do we really need them?' *Journal of Nursing Management*, vol. 12, no. 1, pp. 37-42.

Shattell, M 2004, 'Nurse patient interaction: a review of the literature.' *Journal of Clinical Nursing*, vol. 13, no. 6, pp. 714-22.

Sherer, PD & Coakley, LA 1999, 'Questioning and developing your part-time employee practices.' *Workforce*, vol. October, pp. 4-7.

Sheridan, A & Conway, L 2001, 'Workplace flexibility: reconciling the needs of employers and employees.' *Women in Management Review*, vol. 16, no. 1, pp. 5-11.

Sim, J 1998, 'Collecting and analysing qualitative data: Issues raised by the focus group.' *Journal of Advanced Nursing*, vol. 28, no. 2, pp. 345-52.

Skinner, D, Saunders, MN & Duckett, H 2004, 'Policies, promises and trust: improving working lives in the National Health Service.' *International Journal of Public Sector Management*, vol. 17, no. 7, pp. 558-70.

Smith, K & Biley, F 1997, 'Understanding grounded theory: principles and evaluation.' *Nurse Researcher*, vol. 4, pp. 17-30.

Smith, M 1995, 'Ethics in focus groups: A few concerns.' *Qualitative Health Research*, vol. 5, no. 4, pp. 478-86.

Sparbel, KJ & Anderson, MA 2000a, 'Integrated literature review of continuity of care: Part1, conceptual issues.' *Journal of Nursing Scholarship*, vol. 32, no. 1, pp. 17-24.

---- 2000b, 'A continuity of care integrated literature review, Part2: Methodological issues.' *Journal of Nursing Scholarship*, vol. 32, no. 2, pp. 131-5.

Stern, PN 2005, *Personal Communication*, 15 February.

Stern, PN & Covan, EK 2001, 'Early grounded theory: Its processes and products.' in RS Schreiber & PN Stern (eds), *Using grounded theory in nursing.*, Springer, New York.

Stewart, DW & Shamdasani, PN 1990, *Focus groups: Theory and practice.*, Sage, London.

Strachota, E, Normandin, P, O'Brien, N, Clary, M & Krukow, B 2003, 'Reasons Registered Nurses Leave or Change Employment Status.' *Journal of Nursing Administration*, vol. 33, no. 2, pp. 111-7.

Strauss, A & Corbin, J 1998, *Basics of qualitative research: techniques and procedures for developing grounded theory.*, 2nd edn, Sage, London.

Sword, W 2003, 'Prenatal care use among women of low income: A matter of "Taking care of self".' *Qualitative Health Research*, vol. 13, no. 3, pp. 319-32.

Tansky, JW, Gallagher, DG & Wetzel, KW 1997, 'The effect of demographics, work status, and relative equity on organizational commitment: Looking among part-time workers.' *Revue Canadienne des Sciences de l'Adminishration*, vol. 14, no. 3, pp. 315-26.

Taylor, BM 1997, 'Analysis of job-share as a process of change.' *Journal of Nursing Management*, vol. 5, no. 4, pp. 223-7.

Thomas, L & Ganster, D 1995, 'Impact of Family-Supportive Work Variables on Work–Family Conflict and Strain: A Control perspective', *Journal of Applied Psychology*, vol. 80, no. 1, pp. 6-15.

Thomas, LH, MacMillan, J, McColl, E, Priest, J, Hale, C & Bond, S 1995, 'Obtaining patients' views of nursing care to inform the development of a patient satisfaction scale.' *International Journal for Quality in Health Care*, vol. 7, no. 2, pp. 153-63.

Thornthwaite, L 2002, *Work-family balance: international research on employee preferences.*, ACIRRT, University of Sydney, viewed 22 April 2004, <http://www.acirrt.com/pubs/WP79.pdf>.

Thorsteinson, TJ 2003, 'Job attitudes of part-time vs. full-time workers: A meta-analytic review.' *Journal of Occupational and Organizational Psychology*, vol. 76, no. 2, pp. 151-77.

Tilley & Tilley 1999, 'External change and its impact on nurse management: a case study.' *Journal of Nursing Management*, vol. 7, no. 1, pp. 3-11.

Tilly, C 1992, 'Dualism in part-time employment.' *Industrial Relations*, vol. 31, no. 2, pp. 330-47.

Tisdall, C 1999, 'Learning and the part-time worker.' *Journal of European Industrial Training*, vol. 23, no. 3, pp. 121-6.

Totterdell, P, Spelten, E, Smith, L, Barton, J & Folkard, S 1995, 'Recovery from work shifts: How long does it take?' *Journal of Applied Psychology*, vol. 80, no. 1, pp. 43-57.

Tourish, D & Mulholland, J 1997, 'Communication between nurses and nurse managers: a case study from an NHS Trust', *Journal of Nursing Management*, vol. 5, no. 1, pp. 25-36.

Tourish, D & Hargie, ODW 1998, 'Communication between managers and staff in the NHS: Trends and prospects.' *British Journal of Management*, vol. 9, no. 1, pp. 53-71.

Walsh, J 1999, 'Myths and counter-myths: an analysis of part-time female employees and their orientations to work and working hours.' *Work, Employment & Society*, vol. 13, no. 2, pp. 179-203.

Wareham, PL 1996, 'An exploratory study into the experience of part-time nurse teachers compared to full-time nurse teachers.' *Nurse Education Today*, vol. 16, pp. 376-81.

Warren, T 2004, 'Working part-time: Achieving a successful 'work-life' balance?' *The British Journal of Sociology*, vol. 55, no. 1, pp. 99-122.

Wetzel, K, Soloshy, DE & Gallagher, DG 1990, 'The work attitudes of full-time and part-time registered nurses', *Health Care Management Review*, vol. 15, no. 3, pp. 79-85.

White, L & Keith, B 1990, 'The effect of shift work on the quality and stability of marital relations.' *Journal of Marriage and the Family*, vol. 52, no. 2, pp. 453-62.

Wicke, D, Coppin, R & Payne, S 2004, 'Teamworking in nursing homes.' *Journal of Advanced Nursing*, vol. 45, no. 2, pp. 197-204.

Wickett, D, McCutcheon, H & Long, L 2003, 'Commentary: an Australian perspective.' *Journal of Advanced Nursing*, vol. 43, no. 4, pp. 343-5.

Wilkinson, D 2002, 'Issues and challenges facing rural hospitals.' *Australian Health Review*, vol. 25, no. 5, pp. 94-105.

Wilson, HS & Hutchinson, SA 1996, 'Methodologic mistakes in grounded theory', *Nursing Research*, vol. 45, no. 2, pp. 122-4.

Wilson, JL 2002, 'The impact of shift patterns on healthcare professionals', *Journal of Nursing Management*, vol. 10, no. 4, pp. 211-9.

Wimpenny, P & Gass, J 2000, 'Interviewing in phenomenology and grounded theory: Is there a difference?' *Journal of Advanced Nursing*, vol. 31, no. 6, pp. 1485-92.

Wuest, J & Merritt-Gray, M 2001, 'Feminist grounded theory revisited: Practical issues and new understandings.' in RS Schreiber & PN Stern (eds), *Using grounded theory in nursing*, Springer Publishing, New York, pp. 159-75.

Zairi, M 1998, 'Managing human resources in healthcare: learning from world class practices - part 1.' *Health Manpower Management*, vol. 24, no. 2, pp. 48-57.

Appendix A

Information sheet

Dear Fellow Nurse,
You are invited to participate in a research study conducted by **Lynn Jamieson**, a Doctor of Philosophy student at Central Queensland University. This invitation is being extended to you with the permission of your employer. However, they have no financial or management interest in this study.

A significant proportion of Queensland registered and enrolled nurses are employed in a part-time capacity. However, there is little information available related to this segment of the nursing workforce. **The purpose of this research is to discover issues related to the experiences of regional Queensland nurses who are employed in a part-time capacity** and also to identify the perceptions of those who manage this segment of the nursing workforce. The study aims to develop knowledge that will inform policy and policy makers on issues related to the effective human resource management of this segment of the nursing workforce. **Therefore your input is very important**.

If you agree to participate in this study, you will be invited to take part in an individual interview/discussion. This will require approximately 20 minutes of your time (probably either directly before or after your shift). Using the telephone number that you provide on the Consent form, I will contact you and negotiate a convenient venue and time. The sessions will be audio-taped. All information resulting from this study will not contain your name or identify you in any way, thereby ensuring the confidentiality and anonymity of your responses. A summarised report of the outcomes of the study will be available to be mailed to you at completion of the study. If you have any questions, concerns or require further information regarding the study please contact me at home 07 49272602 or at Central Queensland University 07 49306358 or by e-mail: jamieson1@iinet.net.au. A Consent Form is attached to this information sheet. **If you agree to participate in this research study please sign the Consent Form and use the envelope provided for return** (a stamp is not required)**.** Your participation is voluntary and you can withdraw from the study at any stage without any adverse effects to yourself. If you do not agree to participate in the study, thankyou for your consideration.

Yours sincerely,

Lynn Jamieson

> **Please contact Central Queensland University's Office of Research (Tel 07 4923 2607) should there be any concerns about the nature and/or conduct of the research project.**

Appendix B

Consent form

Study Title: The 'realities' of the part-time nursing workforce in regional Queensland.

Researcher: Lynn Jamieson (CQU Telephone: 07 49306358) Ph.D Student, Faculty of Arts, Health & Sciences, Central Queensland University.

Study Supervisors: Doctor Leonie Mosel Williams and Professor William Lauder School of Nursing & Health Studies, Central Queensland University.

I have read the information sheet and the nature and purpose of the research study is understood by me. I agree to participate in this research study.

1. I understand that I may not directly benefit from this study.

2. I understand that the results of the study will be used as the basis of a doctoral thesis and will be disseminated by media and/or conference presentation and publication. I also understand that a written summary of the study findings will be provided to participants who request it and may be provided to other stakeholders such as recruitment site ethics committees, healthcare and nursing organisations. I understand that all verbal, written and published information resulting from this study will not contain my name or identify me in any way, thereby ensuring the confidentiality and anonymity of my responses.

3. I understand that my participation in this study is voluntary and I can withdraw from the study at any stage without any adverse effects to myself.

4. I agree to be contacted again by the researcher if additional information is required or if there is a need for clarification of information collected.

Name (print): _____

Signature: _____ **Date:** ____/____/_____

Telephone contact: _____

> **Please contact Central Queensland University's Office of Research (Tel 07 4923 2607) should there be any concerns about the nature and/or conduct of the research project.**

If you wish to receive a plain English version of the outcomes of the study please provide your name and address for mailing purposes.

_____
_____
_____

Appendix C

Demographic information (Part-time Nurses)
Could you please fill out the following questionnaire by ticking the appropriate box or filling in the required information.

1. **Are you currently employed as a:**
☐ Registered Nurse
☐ Enrolled Nurse

2. **Sex:**
☐ Male
☐ Female

3. **Age:**
☐ < 25 years
☐ 25 to < 30 years
☐ 30 to < 40 years
☐ 40 to < 50 years
☐ ≥ 50 years

4. **How many years experience do you have as a Registered or Enrolled Nurse?**
☐ < 2 years
☐ 2 to < 5 years
☐ 5 to <10 years
☐ 10 to < 15 years
☐ ≥ 15 years

5. **Are you currently employed in more than one job?**
☐ No
☐ Yes (answer the following questions for your primary part-time job)

6. **Do you currently work in the:**
☐ Public healthcare sector
☐ Private healthcare sector

7. **In which area do you presently work?**
☐ Acute Care Hospital
☐ Nursing Home
☐ Mental Health
☐ Community
☐ Private Medical Practice

8. **If you work in the acute care hospital setting, what is your practice area?**
_____

9. **Current employment position:**
☐ Enrolled Nurse
☐ Level 1 Registered Nurse
☐ Level 2 Registered Nurse
☐ Level 3 Registered Nurse

10. **How long have you been employed by the organisation you currently work for?**
☐ < 2 years
☐ 2 to < 5 years
☐ 5 to < 10 years
☐ 10 to < 15 years
☐ ≥ 15 years

11. **How many hours a week are you employed in your:**
Part-time job: .... hours/week
Second job: .... hours/week
Third job: .... hours/week

12. **Do you regularly work extra hours in your part-time job?**
☐ No
☐ Yes (please provide an approximate)
.... extra hours/week *OR* ....
extra hours/month

13. **Was your initial Registered or Enrolled Nurse education gained through a:**
☐ Hospital-based program
☐ TAFE organisation
☐ Tertiary institution

14. **Please identify any other qualifications that you have.**
_____
_____
_____

15. **Are you currently studying towards further qualifications?**
☐ No
☐ Yes (please provide the qualification)
_____

16. **Do you have dependant:**
☐ Children (please provide numbers):
    ☐ < Preschool
    ☐ Preschool
    ☐ Primary school
    ☐ Secondary school
    ☐ Other
☐ Aged dependant
☐ Other
☐ N/A

Appendix D

Demographic information (Nurse Managers/Nurse Educators)

Could you please fill out the following questionnaire by ticking the appropriate box or filling in the required information.

1. **Age:**

☐ < 30 years
☐ 30 to < 40 years
☐ 40 to 50 years
☐ ≥ 50 years

2. **Sex:**

☐ Male
☐ Female

3. **Do** you **currently work in the:**

☐ Public healthcare sector
☐ Private healthcare sector

4. **Is your current employment:**

☐ Part-time
☐ Full-time:
  Have you ever been employed in a part-time capacity?
  ☐ No
  ☐ Yes

5. **How many years experience do you have in managerial (for nurse managers)/educational (for nurse educators) roles?**

☐ < 2 years
☐ 2 to < 5 years
☐ 5 to < 10 years
☐ 10 to < 15 years
☐ > 15 years

6. **In which area do you presently work?**

☐ Acute Care Hospital
☐ Nursing Home
☐ Mental Health
☐ Community

7. **How many years have you been employed by the organisation you currently work for?**

☐ < 2 years
☐ 2 to < 5 years
☐ 5 to < 10 years
☐ 10 to < 15 years
☐ ≥ 15 years

Nurse Managers to answer the following:

8. **How many Registered/Enrolled nurses do you currently directly manage?**

_____ nurses

9. **How many of these nurses are employed in a part-time capacity?**

_____ nurses