THE CASUAL NURSE: AN ENIGMA?

A GROUNDED THEORY STUDY EXPLORING THE EXPERIENCES OF REGISTERED NURSES EMPLOYED ON CASUAL CONTRACTS

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ABSTRACT

This thesis presents a research study in which the methodology of grounded theory has been used to explore the particular way employment on a casual contract forms and constitutes the work experiences of registered nurses. Eleven participants were asked to share their personal experiences during interviews, the intent being to describe, understand, and finally encapsulate in a model the personal and professional impact of casual employment.

Casual nurses, as they have become known, have been utilised within acute, hospital based nursing services for some time, but health reforms and employment legislation changes have resulted in a greater utilisation of these nurses in many areas. While literature documenting the detrimental effects of the inappropriate utilisation of casual nurses on the health services and patient care is abundant, published research is scant, as is any literature exploring the experiences of the casual nurses themselves.

Data analysis in this study has shown the experience of casual nursing to be constituted by interwoven processes of discontinuity, and marginality. Always being on call with no guarantee of work had the potential to be problematic, especially when many nurses desired regular, full or part-time work rather than casual employment. A basic social process and core variable of "compromise for balance" emerged during data analysis, encompassing the way in which casual nurses are involved in an ongoing, changing, and challenging compromise both within and between the domains of their personal lives and nursing practice.

The implications of employing nurses on casual contracts are broad, including direct effects on the individual nurse, colleagues with whom she works, and the nursing profession as a whole. It is imperative that nurses and nursing debate and collectively decide on the relevance, appropriateness and long term impact of this form of employment. Ways of best utilising these nurses need to be agreed upon, taking into account the special demands of casual nursing practice and the individual characteristics and work requirements of nurses.

PREFACE

This thesis has been written using the first person; firstly, to provide congruence with the verbatim extracts included from participants' stories; secondly, to remain true to the epistemology underlying qualitative research; and thirdly, to integrate my own dual roles of sole researcher and author. Webb (1992) has argued successfully for the use of the first person in some academic writing within nursing literature, stating:

> As we grow and mature as academics and researchers, we should be able to have greater confidence in expressing ourselves and in giving a reasoned opinion that is grounded in firm evidence. It is perfectly justifiable and appropriate to do this in the first person, and once again it would be deceptive to disguise such a personal evaluation of evidence by using the apparently neutral and objective third-person form (p. 752).

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It gives me pleasure to acknowledge and thank those who have helped and supported me during the process of completing this thesis. It is impossible for me to mention everyone by name, but to all who have been involved - thank you.

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CHAPTER ONE

INTRODUCTION AND OVERVIEW

BACKGROUND

Recent and ongoing reorganisation of public health services and the deregulation of the New Zealand labour market have led to the changing of employment conditions for many health workers. Widespread changes are also reflected in many other spheres of employment within New Zealand. Traditional employment patterns for nurses, working within the public and private sectors, have altered with the adoption of a "corporate culture and competition between health providers" (Davidson & Bray, 1994, p. 33), which have resulted in a new focus on fiscal restraint and cost reduction. Permanent, full, and part-time positions are less common, with an overall decrease in permanent staffing levels in some areas. Other positions have been replaced by set term, temporary, or casual contracts.

Nurses who are employed on casual contracts in a public hospital setting are the focus of this research. Casual contracts are not new, nor is their application confined to the nursing work force. What is new is the increasing use of "casual" nurses, or nurses employed on casual contracts, in both the public and private health sectors.

The upsurge in the use of casual nurses has been documented. Some areas have shown an increase of 60% in the use of nurses employed on casual contracts between 1990 - 1993, and this has been labelled as a move towards the casualisation of the nursing work force (New Zealand Nurses Organisation [NZNO], 1993b, p. 1). The NZNO (1993a, p. 2) defines this as the "systematic replacement of permanent full-time and part-time staff with staff employed on an ad-hoc basis." The Organisation also states "a casual worker is one who is expected to be available when required but is guaranteed no work on a regular basis" (NZNO, 1993a, p. 2).

CASUAL NURSES: THE NEW ZEALAND CONTEXT

Deregulation within the labour market and changes in New Zealand employment legislation, specifically the implementation of the Employment Contracts Act (1991), have resulted in the loss of a single national employment contract covering all nurses employed in public hospitals. Employers and employees now negotiate on individual or collective worker contracts following the New Zealand adoption of an "international trend to emphasise individual over collective rights" (Working Life Communications, 1993, p. 7). As a result, the employment conditions of nurses employed on casual contracts differ markedly throughout New Zealand. Even the definition of what is casual work varies from award to award (CCH Human Resources Editors, 1994). Some casual nurses are booked for duties in advance, while others receive limited notice of available work. Some are entitled to claim for sick leave, if sick on the day of a duty booked in advance, whereas others receive no sick leave entitlement. As with nurses employed on permanent contracts, casual staff also experience regional, inter, and intra hospital disparities, including their access to orientation, either to the hospital in general, or specific wards or units, the enaction of performance appraisal policies, and their entitlement to study leave.

Staff employed on "casual" may work in different clinical areas each duty, may work part shifts, and are on call with no indication, or guarantee, of the future availability of work. In spite of the inconstancy of this employment, some nurses employed this way work the equivalent of full-time or 40 hours per week, whereas others work infrequently. Casual nurses are also known by different titles including supplemental staff, resource team members, relief, and float staff.

Remuneration is usually linked to the equivalent permanent full-time employee's salary on a pro rata basis, with an additional six percent differential paid in lieu of holiday pay, as is required by the minimum employment conditions under the Employment Contracts Act (1991). Unlike supplemental and agency nurses overseas, who work under similar conditions as New Zealand casual nurses, and who may be entitled to additional benefits, New Zealand nurses employed on casual contracts receive no extra financial reward for their commitment to remain available for their employer or to compensate for the uncertainty of their employment status.

The rationale for the increasing use of casual staff has been linked to the need for flexibility in employment, so that the planned and unplanned fluctuations in the nursing workload can be covered by appropriate staffing levels. These fluctuations are not new, and have always been an integral part of the nurse scheduling equation. Zimmerman, Mattmann and Mechanic (1994) summarise the more recent factors in the equation when they state:

> as changes in the healthcare environment continue to evolve, many hospitals have begun to restructure nursing practice and patient care delivery systems. Coupled with the challenge to reduce operating costs, nursing departments have created innovative approaches to manage increasing patient acuity levels, shortened hospital lengths of stay, and stream-lined staffing patterns (p. 60).

Other management approaches, such as the use of a "pool" of nursing staff on each duty, who could move from area to area as required and who are guaranteed a set amount of work each week, have been disbanded or their use decreased in many hospitals, and replaced by staff on call and employed on a casual contract. The use of casual agency staff is also occurring in many areas in New Zealand.

There can be no argument against the need for some staff to be available to cover the emergencies which are unanticipated and unpredictable but, nevertheless, an expected component of providing any health care service. Concern arises when casual staff are used to cover the normal and expected variances in work load and staffing, and when permanent and part-time positions are replaced with staff employed on a casual basis. Dickson (1993) summarises the NZNO view on the inappropriate use of casual staff when he states:

> in providing nursing care casual staff should be used to cover unplanned or unforeseeable events, such as sickness or absenteeism, not to cover shortfalls in permanent staffing levels. Staffing levels should take into account foreseeable exigencies, such as annual leave and study leave. Casuals should not be rostered on regular duties. Rostering implies permanency and regularity and both these concepts are outside the generally accepted definition of a casual (p. 12).

Prescott (1986, p. 88) calls for a "balanced approach [when] using supplemental services or part-time employees to supplement a stable core of full-time employees". This reflects an awareness of the impact from the use of contingent staff on all nursing staff. Permanent, part-time, and temporary staff who work with nurses on casual contracts are also affected by changes in the employment patterns of their colleagues. Any changes to the way in which the nursing work force is organised also have the potential to impact on the delivery of health services and the nursing care received by the recipients of those services.

WHY RESEARCH CASUAL NURSES?

The motivation to explore the experience of casual nurses arose from my personal background. As a staff nurse returning to hospital nursing after years of working in the community and overseas, I was delighted to be able to obtain casual work when I decided to become a full-time student at university. I needed the financial support for my studies and also revelled in the opportunity to return to nursing, without committing myself to a single ward or unit. The chance of working in all of the areas which I enjoyed, such as medical, surgical and paediatrics, was a real bonus, as was the opportunity to plan my work around my study commitments.

Soon, the reality of different wards, different shifts, and different staff, in a new hospital, lost its sparkle. I wanted to give the best level of care but instead I seemed to spend so much time orientating myself endlessly, and when things were not right, or the way I thought they should be, I felt unable to change them.

Being "just the casual nurse" became part of my vocabulary, sometimes as a way to explain my lack of knowledge about a particular topic, sometimes as a protective mechanism to warn others that I did not belong in that ward and could not be expected to "know it all", and very occasionally, as a snide remark when I felt that my ability as a nurse was devalued by others who only saw my casual employment status rather than my ability. I was also sometimes called "the casual", rather than my name, a term which seemed to be used by other staff for expediency, a way of managing all the casual staff with whom they came into

contact on an infrequent basis. It took months before I considered that my experience of feeling very different about the way I now nursed, could be experienced by others, and I felt driven to explore what was happening to other casual nurses and their nursing practice.

Although there have been some short studies completed on the growing use of staff employed on casual contracts, (NZNO, 1993a), there has been no New Zealand based research completed on the impact of casual employment on nurses and the way that they nurse (Paviell, & New Zealand Press Association, 1993). NZNO (1993a) does raise an impressive but largely unsubstantiated list of concerns about the practice of casual staff, based on anecdotal information. Included are concerns about the continuity of nursing care, the impact on efficiency, teamwork and accountability to patients, the effect on permanent staff, and the possibility of casual staffing increasing "the likelihood of cross infection if correct systems and structures are not operating" (Laurence, 1993). Headlines such as "casual staff causing crisis in hospitals" (Laurence, 1993, p. 6), "destabilisation of nursing services has serious implications for health care" (NZNO, 1993b, p. 1) and "poor casual contracts send Palmerston North into crisis" (Poor casual contracts, 1992, p. 4), have publicised the concerns emanating from within nursing.

The need for research into the compounding impact of this organisational change, so that nurses, together with management, can support each other in providing quality health care, is of vital importance to all involved in the provision of health services. This study looks only at the registered nurse employed on a casual contract and the way she perceives this affects her nursing practice, and therefore is the beginning of what needs to be a much broader examination. Studies into the wider implications, including the casual employment of enrolled nurses and newly qualified registered nurses and the cost effectiveness of this type of employment are also required.

SUMMARY

This chapter has provided the reader with an introduction and overview of this study which explores the experiences of nurses employed on casual contracts. The background to this research, with a specific focus on the New Zealand context, has been provided, and the justification for this present study demonstrated. An overview of the structure of the thesis will now be presented.

CHAPTER CONTENT AND OVERVIEW

Chapter Two: Review of the Literature

The second chapter provides the reader with an in-depth background as to the concept of casual work and the historical utilisation of casual workers. The commonalities between part-time work, especially the correlations between women's employment as part-time and casual workers, are explored, as is the concept of employment flexibility from both the employees and employers perspectives. The issues and debate surrounding part-time employment in nursing are examined and related to a similar debate which has arisen from the increasing use of nurses employed on casual contracts, both within New Zealand and overseas. Finally, the lack of research about the way in which the use of nurses employed on casual contracts could influence other health professional's practice, the delivery of nursing services, and individual nurses, is highlighted.

Chapter Three: The Research Methodology

This chapter explores the research methodology of grounded theory and its link with symbolic interactionism. The grounded theory research process is discussed, with a focus on its special applicability to nursing studies where previous research is limited.

The way in which the methodology was enacted within this research is documented, including the methods of data collection and analysis utilised. The way in which participants were recruited, and the management of ongoing ethical considerations are addressed, and a description of the research setting and participants is offered.

Chapter Four: Coping With Discontinuity

Chapter Four is the first of three data chapters. It begins by providing an insight into the world of casual nurses and then develops its central focus of the experiences and strategies associated with the way in which casual nurses cope with the ongoing process of discontinuity, whilst endeavouring to retain clinical competency. Interlinking processes, encompassing the constructs of practising within limits, starting again, staying in touch, valuing, and normalising the difference are examined and discussed as commonalities within the experiences of casual nurses.

Chapter Five: Managing Marginality

The impact of the process of discontinuity upon the nursing practice of casual nurses continues to be explored within this chapter. Interpersonal processes affected by discontinuity are highlighted, and in particular the aspect of marginality associated with casual nursing is examined. Links between the processes of managing marginality and endeavouring to retain competence are developed to provide an overview of the impact of casual employment on nursing practice.

Chapter Six: Managing Relentless Uncertainty

This chapter explores the various ways in which casual employment results in the nurse making changes and compromises within her personal life to enable her to practise nursing. Managing the uncertainty of when work will be available is developed as a central theme, linking two interrelated processes of decision making by prioritizing and living with intrusion.

Finally, a conceptual model is presented which summarises the commonalities and strategies involved within the experience of being a casual nurse.

Chapter Seven: Discussion

Chapter Seven provides the reader with a discussion of the implications of this research on nursing practice. Recommendations for future research are offered and the specific limitations of this research are discussed. A concluding statement summarises this research.

CHAPTER TWO

REVIEW OF THE LITERATURE

THE USE OF LITERATURE IN GROUNDED THEORY STUDIES

Within the grounded theory methodology, the literature review is an ongoing process (Chenitz & Swanson, 1986). The literature is treated as a data source which is initially reviewed to gain a background to the research and then repeatedly revisited throughout the process of data collection and analysis to check for completeness. Research findings are then compared and contrasted with existing data. The breadth of the literature reviewed during ongoing data analysis reflects the emergence of codes and theoretical categories. A final literature review, performed after data analysis is completed, is used to place the emergent theory or model in context with existing theories and literature.

It has been necessary to search and critique a wide range of literature for this study, including the fields of nursing studies, women's studies and business management. All of these areas offer valuable insights into different perspectives of the experiences of nurses employed on casual contracts.

CASUAL WORKERS: A HISTORICAL PERSPECTIVE

Casualisation is neither a new nor uniquely nursing phenomena. Historically, the utilisation of casual workers has occurred at times of high unemployment and has generally impacted specifically on unskilled or trade workers. Gibbons (1970) examined the role of the New Zealand Department of Labour and casual workers in the 1890s and commented:

> in many ways the swagger was just a casual labourer, or, alternatively, many casual labourers (except the permanent village handyman) were swaggers - they walked the roads (and in winter the city streets), turned a hand to any work that was going, and moved on once more (p. 74).

Stedman Jones (1984) focused on the social position of casual workers in Victorian England and linked casual work with underemployment and fluctuations in the demand for labour. "The industries which employed casual labour tended to be those most subject to arbitrary and unpredictable short-term fluctuations in demand" (Stedman Jones, 1984, p. 52). The utilisation of casual workers at this time appeared to be a response to the market demand for workers rather than worker choice. At present, the use of workers on casual contracts again reflects an employer led trend. The New Zealand Employers Federation (1989, p. 3) called for "restraints on non-standard work forms, such as part-time work, job sharing and casual work" to be lifted to create greater flexibility in the labour market, specifically noting that many women want to work on a part-time basis.

The historical use of casual workers is summarised by Pollert (1990) when she states:

> casual, temporary, part-time and sub-contract labour are not only older than the standard, full-time, eight-hour day, but have existed alongside it for those workers who have not been organised, either by capital or labour (p. 75).

PART-TIME AND CASUAL EMPLOYMENT

One of the difficulties in examining the extent of casual and part-time work is the way in which employment statistics reflect the many definitions accepted by different groups. In New Zealand, part-time work is usually defined as work of under 30 hours per week (Hunt & Tangitu, 1991), although "logically, it comprises work carried out for less than the normal hours for the particular occupation" (Clark, 1986, p. 4). Statistics New Zealand have changed policies since 1986 and now record the usual number of hours per week worked, with part-time work being defined as less than 20 hours per week. This creates no problems for permanent part-time workers, but casual part-timers, whose hours of work may fluctuate dramatically each week, may not be truly represented. White (1983) noted how different definitions of what part-time work is exclude:

> not only the part-year workers and temporary or casual part-time workers, but also all involuntary part-time workers, [and] those who would prefer full-time work but cannot find it (p. 26).

Employment statistics which refer only to those numbers of workers in full-time or part-time employment, or those seeking work, can hide the extent of the use of temporary and casual contracts, leaving workers in a disempowered and devalued position, reminiscent of the way in which traditional, unpaid work of women has been treated (Owen & Shaw, 1979). As over 90 percent of New Zealand nurses are women (Statistics New Zealand, 1993), it is important to examine part-time work from a women's perspective.

WOMEN IN PART-TIME AND CASUAL EMPLOYMENT

The impact of casual and part-time work on women has been noted by a number of authors (McRae, 1989; Organisation for Economic Co-operation and Development [OECD] 1985). Although some women employed on a casual basis work full-time, the majority work on a part-time basis. Statistics New Zealand (1993) state:

> along with a tendency to be concentrated in service sector industries, part-time employment is more likely than full-time to be casual and low-skilled work, and to command a minimum hourly wage (p. 113).

There are many similarities between the reasons why women work either on a casual or part-time basis. Also the debates over the advantages and disadvantages for women, their families, and their employers of these forms of employment are comparable. Kahne (1985) summarises the variability of the need for part-time employment by women. She states:

> Part-time work has a special applicability to the lives of working women. This is not because it is the preferred work schedule for *all* women at some phase in their lives, such as the period of raising young children. Nor is it necessarily the form best suited to *some* working women, such as middle class women, for the *entire* span of attachment to the labour market. But part-time employment can

> provide a critically important work schedule option for many women at particular periods of time. Unlike men's experience, where part-time work is still largely associated either with education or training during youth, or with work just prior to or following retirement, women's need for part-time work, whether deriving from individual preferences or imposed social roles, can occur throughout their working lives (Original emphasis), (p. 45).

Although the number of males in part-time work in New Zealand has doubled between 1981 and 1991, women, by far, remain the majority of part-time workers. In 1991, women accounted for 76 percent of part-time workers and 36 percent of full-time workers (Statistics New Zealand, 1993). The higher percentage of women in part-time work reflects the way in which "part-time employment represents the means whereby married women combine paid work with family responsibilities" (McRae, 1989, p. 12).

The negative aspect of working part-time while caring for dependants has been labelled by the OECD (1990, p. 70) as the "double burden" of women.

> This occurs because of societal expectations about the different roles of women and men in the family, and the assumption that men are primary wage-earners. These responsibilities restrict the time and effort women can devote to paid employment, and affect the expectations that employers have about women employees in general. Attitudes and behaviour by employers based on assumptions about women's family responsibilities often effectively limit or deny access to jobs, training or promotion (OECD, 1990, p. 71).

New Zealand studies on part-time work have examined both the reasons for working part-time and the employer's rationale for utilising part-time workers. Glendining and the Equal Employment Opportunities Unit (1989) identified worker's reasons as needing to care for dependants, health restrictions, workers already engaged in other paid employment, less financial necessity to work full-time, and post retirement employment. Other rationale given included job specific restrictions on full-time employment because of the nature of the work, and lack of full-time jobs available. Shipley (1982, p. x) noted the "inverse relationship

between females' full-time and part-time participation for the age groups 20-49 years", part-time work linking closely with care of dependants. Another part-time employment survey (Going & Swarbrick, 1978) identified family commitments as by far the most frequently cited reason for engaging in part-time work.

Employers' rationale for utilising part-time workers include the increased flexibility afforded by part-time workers to meet unpredictable and temporary fluctuations in the workload (Neville & O'Neill, 1979), to suit the needs of existing employees, and insufficient work to warrant full-time employment (Bosworth & Dawkins, 1982). These rationale are set against an historical background of employer reticence to employ part-time workers because of their supposed lack of commitment to the organisation, expense to train and employ, unreliability, and disruption to the work schedules of full-time employees (Neville & O'Neill, 1979).

The increased flexibility offered to employers by utilising casual and part-time workers is only part of the drive for flexibility in the work force. Labour market flexibility, as a concept, has much wider ramifications than just the impact on the individual worker. The OECD (1986) defines flexibility as:

> the ability of individuals in the economy, and notably in the labour market, to abandon established ways and adapt to new circumstances. This is partly a matter of personal capacity, and partly one of given conditions. Personal capacity in turn relates to the talents and qualifications of people as well as their willingness; given conditions may be economic, social or political. It can readily be seen that flexibility, thus understood, is part of a wider social and economic capacity for change, involving institutions as well as individuals, employers as well as workers (p. 6).

The ideology of flexibility of employment for both employers and women has been questioned by Sayers (1993) who noted that:

> women have an extremely important stake in the debate about "labour flexibility" because they have sought flexibility in work patterns to integrate work and family roles more fully (p. 210).

There is contention over who benefits from the flexibility, the woman, or her employer, her partner, or her children, and whether the utilisation of casual workers does lead to the development of a stable core of permanent workers. The OECD (1985) also questioned the benefits of flexibility.

> The flexibility of part-time work is its most frequently cited advantage for women, yet many part-time workers are "on-call", working irregular hours. This makes it even more difficult to manage household responsibilities and especially to arrange for the working parent's alternative child care (OECD, 1985, p. 17).

The underemployment component of part-time work was also noted by the OECD (1985), as was the possibility of deskilling, where on-the-job-training opportunities, in-service education, and advancement opportunities are limited for most part-time workers. Bromley and Gerry (1979), in discussing the rising numbers of casual workers and a link with increasing poverty in Third World cities, noted that the majority of casual workers would undertake full-time and stable employment if this was available. Casual work was therefore a last option for economic survival rather than a preferred employment choice. Statistics New Zealand (1993, p. 88), in discussing underemployment, stated that "the number and proportion of part-time workers who would like to work more hours has grown sharply since 1990, more than doubling for both women and men."

Permanent, part-time work does have advantages over the less secure employment options such as casual and temporary work. Fierman (1994), in a discussion of the rising use of temporary workers in America, highlights how once, temporary employees were used to fill in for a secretary, whereas "companies now rely on outsiders to fill slots at every level of the organisation" and "some even sit at the top" (p. 25). These contingency, temporary workers "typically lead far riskier and more uncertain lives than permanent employees; they're also usually paid less and almost never receive benefits" (Fierman, 1994, p. 24).

The combination of the impact of casual and temporary work on women, with their social roles has been summarised by Owen and Shaw (1979) who state:

> casual work is a totally unsatisfactory arrangement. Women form the majority of people involved in this type of work. It offers next to no security or protection because of its arbitrary nature. Employers exploit women by classing them as casuals despite the fact that they may work regularly for years. Because of this classification they are denied long-service leave, promotion, [and] sick leave" (p. 42).

Although there have been concerns raised about casual and temporary work, especially when related to women's employment, these forms of contract are increasing. Sayers (1991, p. 165), linked this increase to the impact of the Employment Contracts Act, and noted the vulnerability of the "casualised periphery of the work force." Many women have no choice but to accept part-time, casual, or temporary work as they are economically dependent on the work for their own, and their family's financial security, and women accept that sometimes employment on a part-time basis is the only way in which they can incorporate their family responsibilities with paid employment (White, 1983). Shuttleworth (1990, p. 612) summarises the situation of some women when she states "many women can only work part-time - they have other responsibilities (usually their family) which must take first precedence."

It is important to note that some women choose to work part-time. Kemp (1994) looked at the experiences of nursing graduates who no longer worked full-time and concluded that for many young mothers, the benefits of adult company and paid empioyment outside of the home outweighed the difficulties created by that employment. The need to maintain employable skills is also recognised. Others, without dependants, rely on casual or temporary employment until full-time work is available, or at times when their circumstances limit their ability to undertake full-time work.

PART-TIME EMPLOYMENT IN NURSING

Hospitals, by nature of their work, require a flexible nursing work force which can accommodate the unpredictable nature of illness, and provide twenty four hour, seven day a week coverage, in a cost efficient manner. A number of different forms of employment have been utilised to provide this continuous patient contact service.

The history of part-time employment in nursing has been linked back to the Second World War, when part-time workers replaced full-time nurses who had joined the armed services (Auld, 1967). Part-time employment continued to be available when the need for full-time registered nurses out-stripped the supply (Bennett, 1962) and in this way, part-time employment was a response to the requirements of the employee rather than the employer. The presence of married women in nursing practice was, for some time, rare because of the professional regulations requiring nurses to live in Nurses Homes and Hostels.

Professional and societal changes have now allowed married women, and especially part-time nurses, to return to practice. The Management Services and Research Unit of the Department of Health (1983, p. 6) noted that "the availability of part-time work has been a major factor allowing women with children to re-enter the work force while maintaining their family commitments" and this was reflected in the doubling of married women employed in the health service between 1951 and 1976.

Dixon (1987) examined the different patterns of registered nurse part-time employment within the New Zealand context. She compared the extent of part-time employment in psychiatric, psychopaedic and public health nursing with that found in general hospitals and concluded that the much lower proportion of part-time nurses in psychiatric, psychopaedic and public health nursing was linked to the stance on part-time employment adopted by the union representing those workers, the Public Service Association. The New Zealand Nurses Association (now the New Zealand Nurses Organisation), which represented nurses employed in general public hospitals, was much more supportive of part-time employment and this was directly reflected in the part-time employment rates of staff. The union impact on the adoption or non-adoption of part-time employment was clearly obvious.

There has been an ongoing debate about the use of part-time nursing staff, with concerns voiced about the competency of part-timers, including the extent of their orientation, their commitment to work, and impact of their employment on full-time worker's rostering (Auld, 1967). The alternative view points to the discrimination against part-time staff who may receive less in-service education, orientation, pay advancement and fewer opportunities for promotion (Godfrey, 1980; Mangan, 1994). Johnson and Marcella (1977) brought this debate out into the open when they investigated the apparent bias against part-time workers. In their conclusions they noted that "in today's labour force, there must not be any hint of residual bias between full-time and part-time employees" (Johnson & Marcella, 1977, p. 36). Tierney (1983) also explored the experience of part-time nurses and concluded that rather than part-time employment in nursing being seen as a "worrying trend", it could be considered "a highly desirable development if viewed in the particular context of a society with high unemployment" (p. 30).

NURSES ON CASUAL CONTRACTS: CASUAL PROFESSIONALS OR PROFESSIONAL CASUALS?

As defined in the introduction, casual nurses are those who are "expected to be available when required but [are] guaranteed no work on a regular basis" (NZNO, 1993a, p. 2). This definition hints at the flexibility offered to the employer and the variability of the work experience of the employee but takes us no further.

If some nurses want to work on a casual basis and employers need a flexible work force, why are headlines such as "casualisation an increasing worry at workplaces" (Aitken, 1993, p. 31) appearing, and casualisation noted as a major concern in the NZNO's Annual Report (1994)? The increasing use of casual nurses is seen as the product of health reforms and cost cutting, with the nursing budget targeted. Casual staff disguise actual permanent nursing staff shortages (Aitken, 1993) by filling the gaps left by permanent staff.

Concerns have been raised over the quality of nursing care provided by casual nurses (Casualisation causes concern, 1993). The compounding impact on nursing care of the increasing casualisation and the loss of experienced nurses, has

also been identified (Keith, 1993). The difference between the appropriate use of casual staff, to cover unforeseeable circumstances, compared with the instances when casual staff are rostered and utilised as permanent staff, without the benefits of permanent employment, have also been noted (Aitken, 1993).

Overseas, similar concerns are being voiced. Buchan and Thomas (1993, p. 28) provided a British insight when they highlighted the need to be aware of the "potential casualisation of part of the nursing work force", noting the decreasing utilisation of agency nurses, but an increase in the use of "bank" nurses, who are only employed "when required, with no holiday and sick pay and less access to training and professional updating" (p. 29). Implications of these changes on the delivery of health care, continuity of nursing care and the impact on primary nursing were noted and Salvage (1983) commented that at least bank nurses, who were based within a single hospital, had a major advantage over agency nurses, because they developed familiarity with their place of work.

Dickson (1987) published a readership survey comparing the practice of agency nurses and regular ward staff, and noted that 42 percent of readers involved in the study believed that agency nurses provided a lower standard of nursing care than their permanently employed colleagues. Cole (1994) and Buchan (1992) also voiced concerns about the increasing use of bank nurses and nurses employed on short-term contracts, linking the changes directly to National Health Service reforms.

Casual nursing is a relatively new form of employment in New Zealand. Again, statistics depicting the extent of the use of casual nurses are complicated by the different definitions of what casual employment is and the alternative descriptors used. Other descriptors used in New Zealand include "relief" nurses and "special assignment team" nurses. Overseas, casual nurses are known by many titles including "per diem", "supplemental", "bank", or "pull-in" nurses, although the actual terms of their employment contracts may vary.

Other ways of organising nurses, which provide more secure employment options, are also being utilised. Pool nurses, "float" and "resource team nurses" are usually employed on contracts which specify regular hours, although, like casual nurses, they may work in a number of wards or units. Agency and bureau nurses are

another recent addition in New Zealand, although as yet confined to the major centres. Therefore most hospitals independently organise a staffing system to cope with the inherent fluctuations of nurses' work. Some nurses working for bureaus are being employed on contracts specifying the hours of work as zero (Goodman, 1990/1991). In this way the nurses are not classed as casual workers, although they may work under similar conditions as casual staff. In-house agencies, operated by the hospital are also appearing. O'Connor (1993) outlined how the staff at one hospital rejected management attempts to institute casualisation and have instead enlarged the hospital's in-house agency.

SUMMARY

National and international changes in labour market policies and widespread health reforms have resulted in alterations in the way that many health workers are employed. Nurses, as part of a predominantly female work force, experience the combined impact of employment and societal changes. Many nurses work part-time so that they can integrate their need or desire to work with family commitments. The option of part-time work is now often replaced by the option of casual work, leaving many nurses with little or no choice.

As part-time nursing has raised professional concerns about nursing care delivery, so does the increasing use of nurses employed on casual contracts. To date, little research has been completed on how nurses experience being employed on a casual contract, both as individuals and within their nursing practice. These experiences are the focus of this research.

CHAPTER THREE

RESEARCH METHODOLOGY

INTRODUCTION

This chapter will explore the use of grounded theory as a research methodology, its applicability to nursing contexts, and its application to this research study in particular. The participants and setting of the study will be described, as will the processes of obtaining informed consent, the ongoing management of ethical considerations, the interconnected phases of data collection, analysis and literature review, and finally, the stages of the development of a conceptual model which encompasses the experiences of the participant nurses employed on casual contracts.

GROUNDED THEORY AND NURSING

The use of different research methods in the development of nursing knowledge has been well debated. This argument has focused on the respective merits of qualitative and quantitative research methods, their underlying philosophies, and their relationships to nursing (Goodwin & Goodwin, 1984). Polit and Hungler (1989) summarised this when they stated:

> A debate has emerged in recent years about whether qualitative or quantitative studies are better suited for advancing nursing science, but there is a growing recognition that both approaches are needed. The most balanced perspective seems to be that the degree of structure a researcher imposes should be based on the nature of the research question (p. 312).

Increasingly, nurses are identifying the relevance of the qualitative paradigm which "explicitly expresses a value for the thoughts, perceptions and feelings of subjects about lived experiences" (Parse, Coyne & Smith, 1985, p. 2). Not only do qualitative research methodologies relate to the types of questions that nurses are asking, and wanting to find answers for, but also there is a compatibility with underlying belief systems (Stevens Barnum, 1990). Grounded theory, as one of

the qualitative research methodologies, has been well utilised in nursing research because it "offers a systematic method to collect, organise and analyse data from the empirical world of nursing practice" (Chenitz & Swanson, 1986, p. 14).

Other links between grounded theory and nursing have been documented. Stern, Allen, and Moxley (1984) noted an historical link. The discovery of the methodology occurred when the developers, Glaser and Strauss, were working within a school of nursing. The focus of nursing practice and grounded theory research on processes within a naturalistic setting, as occurs both with the enaction of nursing and the data collection within grounded theory, also provides a commonality. Simms, writing in 1981 (p. 356), stated that grounded theory "is particularly suitable for nursing studies because often the literature has a scarcity of information on a topic, which precludes the generation of hypotheses on the bases (sic) of previous work."

WHY GROUNDED THEORY?

As has been discussed in the preceding chapters, little research has been completed about casual nurses. Therefore, it is impossible to test or verify other research in this area and instead, preliminary research, focusing on the experience of casual nurses, is appropriate.

It would be possible to research this topic in a number of ways, each highlighting a different component of the experience of being a casual nurse and each reflecting a different underlying philosophical perspective. As my personal experience as a casual nurse provided the initial interest and motivation for the study, and my nursing background provides me with a philosophical focus on human experiences, I chose to explore the human perspective underlying the experience of being a casual nurse.

The aim of the study was to:

> explore with registered nurses the way in which they perceive that their employment on a casual basis impacts on themselves as individuals and their nursing practice.

A qualitative method, focusing on the experiences and social contexts of the individuals, was therefore necessary and grounded theory, with its use of inductive and deductive processes to generate substantive theory, was chosen as the research methodology. Stern (1980, p. 20) described this sort of situation, where grounded theory is used in the investigation "of relatively uncharted waters" as the "strongest case" for the use of this methodology.

THE GROUNDED THEORY METHODOLOGY

Grounded theory was developed by Glaser and Strauss (1967) as an inductive, qualitative research technique which is primarily used to generate theory from empirical data. Chenitz and Swanson (1986) describe the methodology as:

> a highly systematic research approach for the collection and analysis of qualitative data for the purpose of generating explanatory theory that furthers the understanding of social and psychological phenomena. The objective of grounded theory is the development of theory that explains basic patterns common in social life (p. 3).

Grounded theory evolved from the Chicago School of Sociology which was intellectually linked with symbolic interactionism. Symbolic interactionism "was in part a reaction against the grand functionalist theories of social action which dominated sociological thought during the mid-nineteenth century" (Bowers, 1988, p. 33). The acceptance of symbolic interactionism as an underlying philosophy to grounded theory means that grounded theory is more than a method of data analysis. "It is an entire philosophy about how to conduct field research" (Polit & Hungler, 1989, p. 324).

Symbolic Interactionism

Symbolic interactionism has developed as a label "for a relatively distinctive approach to the study of human group life and human conduct" (Blumer, 1969, p. 1). It has been built upon the similarities and commonalities in the ideologies of a number of scholars including Dewey and Mead (Blumer, 1969). The theoretical focus falls upon the acting individual and the analysis progresses from the individual to the larger social group or institution (Bowers, 1988). Baker, Wuest

and Stern (1992) describe this approach as conceiving "reality as dynamic rather than static. It focuses on processes that exist within the individual or groups rather than on social structure" (p. 1357).

The symbolic interactionalist considers the self as a uniquely human concept which is dynamic, interacts within a social context, and evolves over time. Social phenomena, incorporating meanings created from experiences, are the object of study. Three premises underpin the symbolic interaction approach. These are that humans respond towards things as a result of the meanings that those things hold for them, that these meanings result from social interaction with others, and that meanings are formed and reformed by an interpretive process (Blumer, 1969).

These premises are further grounded by a particular view of human society and conduct. Human society is seen as a group of acting individuals who constantly interact with each other in a social response or in relationship to others. Social interaction "is a process that *forms* human conduct instead of being merely a means or a setting for the expression or release of human conduct" (Original emphasis), (Blumer, 1969, p. 8), and reflects two different interaction patterns, those of non-symbolic interaction and symbolic interaction. Non-symbolic interaction is closely associated with reflective responses which occur without the process of interpretation of the preceding action, whereas symbolic interaction involves interpretation and a response mediated by that interpretive process.

Symbolic interaction also defines the nature of objects or things which exist in the worlds of human beings and their social groups. Blumer (1969, p. 11) defines objects as "anything that can be referred to. The nature of an object - of any and every object - consists of the meaning that it has for the person for whom it is an object." The meanings associated with objects will both change and be changed by the processes of living in a human society.

The human being has a propensity and ability to act and interact with itself, resulting in self communication or a dialogue of interpretation, which in turn results in action. Collective action within a group also results from shared interpretation. Any human act therefore integrates symbolic interaction, taking on the role of others, developing meaning by interpretation, thought processes, and the presence of a socially constructed self (Meltzer, 1967), and any comprehensive

study of human action and behaviour must demonstrate an awareness of both the overt and covert dimensions of activity (Meltzer, Petras & Reynolds, 1991).

The Grounded Theory Research Process

Grounded theory "utilises an inductive, from-the-ground-up approach using everyday behaviours or organisational patterns to generate theory" (Hutchinson, 1986, p. 113). No pre-existing theory is used as an organising framework (Burns & Grove, 1987), instead a number of distinctive features and methodological guidelines are utilised. These include the process of theoretical sampling, constant comparison between all data sources, and the "use of a coding paradigm, to ensure conceptual development and density" (Strauss, 1987, p. 5).

Grounded theory can lead to the development of two basic types of middle-range theory, either substantive theory, developed from empirical, substantive inquiry, or formal theory from research into conceptual areas of interest (Glaser & Strauss, 1967). Social research and the processes of generating theory are seen as interconnected and interlinking. Glaser (1978) summarises these interconnections by stating:

> How the analyst enters the field to collect the data, his method of collection and codification of the data, his integrating of the categories, generating memos, and constructing theory - the full continuum of both the processes of generating theory and of social research - are *all* guided and integrated by the *emerging* theory (Original emphasis), (p. 2).

Within this methodology, the research question focuses on what is happening in a particular situation - what is happening here? Wilson (1989, p. 481) describes the initial research question as "what are the basic social and psychological processes that explain interaction in a particular setting or under certain conditions?" The emphasis is on the meanings that the participants develop which form and constitute their understanding of the situation.

The researcher aims to understand the situation from the perspective of the participant, in this case nurses who are employed on casual contracts, and therefore data collection processes reflect the need for the researcher to "intentionally become immersed in the world of the research subjects" (Bowers, 1988, p. 43). The processes of data collection, analysis and interpretation are reliant on the skills, sensitivity and intuition of the researcher who is involved in observation, interpersonal interaction with participants, constant analysis and interpretation of data collected, and synthesis of clinical knowledge and experience. In this way, the researcher is the instrument of the research (Bowers, 1988). The development of theoretical sensitivity by the researcher is paramount to the research process (Strauss & Corbin, 1990).

The need for a position of marginality, whereby the researcher becomes immersed in the participant's world while maintaining a degree of separation to facilitate the necessary development of an analytical and conceptual stance, has been noted (Bowers, 1988). The researcher needs to remain open to what is happening and sensitive to the data (Glaser, 1978). Bowers (1988) states:

> A marginal status allows us to see both worlds simultaneously, to make comparisons between them, discover how they are similar, and how they are different. It not only exposes us to a new and different world but, at the same time, causes us to become more sensitive to our own world. Seeing how others perform differently raises questions for us about that which we had previously taken for granted and not been consciously aware of. This juxtaposing of worlds and the consequent heightening sensitivity allow the researcher to observe with greater acuity than would otherwise be possible (p. 44).

As field research, data collection occurs in the natural setting where the phenomena under study occurs. Data sources are broad and include literature, participant interviews, and records of observation. The search for these sources begins where the phenomena under study is known to exist and then further data collection is guided by the process of theoretical sampling (Chenitz & Swanson, 1986).

Theoretical sampling involves the decision making process of the researcher as to what data to collect next and where this data could be found. This process reflects the ongoing emergence of the theory during data collection and analysis (Strauss, 1987). Theoretical sampling gives flexibility to the research process and allows the researcher to explore new dimensions of the research topic as they arise. Combined with the need to saturate codes and categories with data, theoretical sensitivity restricts the researcher's ability to pinpoint, at the outset, exactly how many participants will be in the study or where they will be located.

Data collection, coding and analysis occur simultaneously and, in this way, grounded theory is both an inductive and deductive process which results from ongoing verification of the outcomes of analysis (Strauss, 1987). This simultaneous and cyclical process, constant comparative analysis, compares each new piece of data with all of the other data which has been collected, coded and analysed. Hutchinson (1986) describes the aim of this method as:

> the generation of theoretical constructs that, along with substantive codes and categories and their properties, form a theory that encompasses as much behavioural variation as possible. The proposed theory is molecular in structure rather than causal or linear (p. 122).

Data analysis revolves around a search for patterns and processes, while remaining vigilant for the emergence of a core variable and its related properties. The analysis is accomplished utilising line by line analysis of the data and by asking questions of the data such, as "what is going on here?" Cumulative stages of coding, firstly at substantive, and then theoretical levels, reflect a progression of the emerging theory from a descriptive to an abstract and conceptual level. Categories, which link clustered themes of coded data are further linked by the development of a conceptual formation in which "the investigator attempts to discover the main problems in the social scene from the point of view of the interactants, or actors (or subjects participating in the study), and how these interactants deal with the problems" (Stern, 1980, p. 21).

Data collection continues until codes at all levels are saturated with data. If time restraints or external limitations on the research result in early foreclosure before all codes are saturated, the emergent theory may lack density (Hutchinson, 1986). Concept development and refinement occur by ongoing processes of reduction of the coded and categorised data, selective sampling of the literature and theoretical sampling of data sources.

The emergence of the core variable or category, which explains the action in the social context (Glaser & Strauss, 1967), is aided by conceptual reduction. A core variable is always present in a grounded theory, and it may or may not also be a basic social process, which is a category demonstrating a process changing over time (Chenitz & Swanson, 1986).

The review of the literature is an ongoing and selective process, reflecting the position taken by grounded theorists' that literature is a data source. Even so, the literature, as data, must be treated with considerable caution, if it is not to direct the research process and data analysis (Glaser, 1978). It is initially reviewed to gain a background for the research and then revisited throughout the research process, specifically sampling literature which reflects the emerging categories.

This use of the literature can be problematic for researchers who are required to present a comprehensive research proposal with a detailed literature review before commencing the study. In this instance, the literature review provides a description of what the researcher knows at the outset of the study, and further literature will be sourced as the data analysis progresses, identifying new themes and new directions within the process of theoretical sampling. Literature which reflects the new themes and processes is included in the presentation of data in the final report. A final literature review, at the completion of the research, revisits the literature, thereby placing the emerging theory within the context of existing theoretical knowledge. Glaser and Strauss (1967) describe the process of generating theory as "placing a high emphasis on *theory* as *process*; that is, theory as an ever-developing entity, not as a perfected product" (Original emphasis), (p. 32). This process continues within the final writing of the grounded theory research report.

Christensen (1990) identified the special ramifications involved both with nurses researching nursing practice and the use of nursing literature and stated:

> A nurse researcher cannot pretend that there is no background of experience and knowledge, as well as some familiarity with the literature and the nursing setting, to influence the research conduct and outcomes. (...). Therefore, the researcher who is a nurse, while always remaining 'grounded' in the field data and using this as the primary source for the emergent theory, will also acknowledge that the study is 'grounded' within current nursing theory and knowledge (p. 234).

A strategy of memoing is utilised by the researcher throughout the whole research process to record and preserve "emerging hypotheses, analytical schemes, hunches, and abstractions" (Stern, 1980, p. 23). These memos, which document conceptualisation and abstraction of the data, are sorted and utilised in the production of the research report. Field notes, of a less abstract nature, are also collated during data collection and are included in the coded data.

Because of the nature of qualitative analysis, the terms of reliability and validity are usually not utilised. Instead, issues of evidence and credibility are explored (Chenitz and Swanson, 1986). Sandelowski (1986) defines credibility when she states:

> A qualitative study is credible when it presents such faithful descriptions or interpretations of a human experience that the people having that experience would immediately recognise it from those descriptions or interpretations as their own (p. 30).

The trustworthiness of qualitative research is also enhanced by the researcher making visible the decision trail followed throughout the research process (Koch, 1994; Sandelowski, 1993). Grounded theory studies are evaluated by specific criteria which are described as the fit, grab, and work of the theory, and their modifiability. The construct of fit reflects the need for the categories to fit the data, without being forced or preselected. Grounded theories with grab are recognisable by the way the phenomena which they represent is immediately

manifest. The theory should also work, so that it explains, describes and is relevant to what is happening within a social context. Modifiability reflects the process component of the theory, which reflects the continual change occurring in any social group (Glaser, 1978).

The applicability of a grounded theory is also important. Chenitz and Swanson (1986) describe the test for reliability in grounded theory studies as the "use of the theory and its applicability to similar settings and other types of problems over time" (p. 14). In this study of nurses and their practise of nursing, the test of the theory would be its acceptance by the participants and other nurses as being generally representative of their experiences. Theoretical development throughout the process of generating the theory changes the focus from one of looking at an individual participant's story to that of conceptualising and abstracting the whole of many stories and associated data.

THE STUDY OF CASUAL NURSES: METHOD AND PROCEDURE

The application of the grounded theory research methodology to the present study will now be examined and described.

Organisation of the Study and Recruitment of Participants

Casual nurses, the focus of this study, work in a number of different environments. I made an initial decision to limit the study to the experiences of registered nurses employed on casual contracts who worked in public hospitals. This reflected my own area of interest and also the need to negotiate access to participants.

Permission for the study was first granted by the Massey University Human Ethics Committee and then I approached the Nurse Adviser at one regional hospital, who informed me of the steps necessary to gain consent for the study within that hospital. Research proposals were presented to the Manager of Clinical Services, who had responsibility for the service organising the use of casual nurses, the Personnel Manager and the Chief Executive, and permission for the study was granted by all. A further research proposal was also forwarded to the Ethics Committee who reviewed research proposals for the Crown Health Enterprise which encompassed the selected regional hospital. This proposal was also

accepted. I discussed the proposed research with the Nursing Coordinator, directly responsible for staff employed on the casual roster, and the secretary of the Nursing Resource department, who was involved in coordinating the use of casual staff within the hospital, both of whom were supportive.

I developed a number of selection criteria for participants and these were used as an initial guide for me to check that potential participants had experience of the phenomena under study. The selection criteria were that the nurses:

- were registered nurses
- had been employed on casual contracts for at least three months
- had worked in the present hospital facility for at least three months
- had worked at least 10 duties or part duties on a casual contract
- voluntarily agreed to participate in the study as outlined in the information sheet (Appendix Two)
- agreed to be interviewed and the interview tape recorded at a time and place convenient for the participant
- signed the study consent form (Appendix Three)

Newly graduated nurses were excluded because it would have been difficult for them to compare their experience of casual employment with that of permanent staff nursing, and this aspect was seen as important. It was initially planned to recruit participants by asking the secretary of the Nursing Resource department to invite nurses to participate in the study. The names and phone numbers of those who agreed to participate would then have been forwarded to me. The implementation of changes brought about by the Privacy Act (1993) required a change in procedure and instead, all registered nurses on the casual roster at this hospital were sent a letter inviting their participation in the study (Appendix One, Letter of Introduction). Potential participants were asked to contact me by phone at home and in this way the privacy of the participants was maintained, as their employing authority was unaware of who decided to participate.

On contacting me, the potential participants were given information about the study, how their confidentiality and anonymity would be maintained, their ability to withdraw from the study at any time, and what their involvement would be if they chose to participate. They were also encouraged to think further about the

study before making a commitment and some participants chose to contact me with their acceptance at a later date. Participants voiced varying concerns at this stage, including their need for confidentiality, especially in relation to their employer, and their perception that they had little to offer the study as they liked, or did not like casual employment (Field notes, p.7).

An initial meeting was then organised individually with each participant and again the study was discussed. A copy of the study information sheet was supplied for each participant and discussed in further detail, as were the ethical issues associated with informed consent. The participants were then again invited to participate in the study and asked to sign two identical consent forms, one which was made available for the participant and the other which was retained by myself.

Participants' responses to the initial written invitation to participate were received over a period of time, and so the interviews and data analysis occurred concurrently at a number of levels. Some participants were reinterviewed for a second or third time after analysis of their interview transcripts and after the comparison of their data with that received from other interviews. A few participants were interviewed once only.

Nearer to the end of the study, when most of the interviews had been completed, it became obvious that little new information was appearing. A decision was made to interview a small number of participants employed in other geographical locations, but still fulfilling the selection criteria, to see if new information appeared. These participants were invited to participate by a third person not directly involved in the study, and when their verbal agreement to participate was obtained by that third person, the participants were contacted by myself. The same procedure, of obtaining informed consent after a discussion of the study and the answering of questions was followed.

The Participants

Eleven participants were involved in the study. All of the participants were female and will therefore be referred to as "she" in this study report. Post registration nursing experience ranged from two to over twenty years' and encompassed all areas of clinical nursing practice, including specialty units, community based nursing and nurse tutoring. All had worked in a full-time capacity as a nurse at some stage.

The rationale for their present employment on a casual contract varied. For a number of participants, casual employment was the only work available. It was also seen as a way back in to nursing after a period of absence for family or personal reasons. For others, casual work was accepted as the modern day equivalent of part-time work for those who desired part-time rather than full-time employment. Others had chosen casual as a temporary option, because it suited their present personal circumstances. All of the participants would have accepted either part-time or full-time employment if it had been available, but a general lack of vacant positions, as well as a lack of part-time positions with limited hours, such as two or three shifts a week, meant that these options were not available.

A recurrent trend amongst the participants was a circular movement between temporary positions and casual employment, with a number of participants having had two or three temporary position with periods of casual employment in between. Lengths of time employed on a casual basis ranged from three months to over three years and experience within other systems of casual employment at other hospitals and including overseas agency work, was common.

The Setting

The primary setting for recruitment of participants was chosen because it employed registered nurses on casual contracts. Although research using the grounded theory methodology generally utilises participant observation in the naturalistic setting, this research was focusing not on the provision of nursing care by nurses employed on casual contracts, but instead on how the nurses perceive

this situation impacts on themselves and their practise of nursing. Therefore, no participant observation of nurses in their workplace occurred and interviews were conducted outside of the hospital in a setting convenient for the participant and the researcher. Approximately half of the interviews occurred in the participant's home and the remaining interviews were held at my home.

At the commencement of the study, and for some of the period of data collection, I was employed and working as a casual nurse. The potential for a conflict of interest impinging on the research process, was identified early in the study and strategies to manage this were discussed with the Ethics Committees and Management before the commencement of the study. The strategies included that I would not personally recruit participants with whom I came into contact because of my employment as a casual nurse, and that no participant observation of casual nurses working would be involved.

I also felt the need to identify my beginning standpoint at the commencement of the study and so commenced writing a diary from the stage of the first research proposal. This allowed me to identify and clarify my position as well as, with reflection, see the changes and developments of this perspective over time. Wiener and Wysmans (1990) stated that "biases, are not good or bad by themselves. It is what you do with them that matters" (p. 76).

Bowers (1988) identified a number of problems for grounded theory researchers related to the difficulty of maintaining the marginality necessary for immersion in the world of the research subjects, at the same time as having a degree of separation to raise analytical questions. These included the initial difficulty in entering the world of the participants and then the separate process of stepping back from this arena. As an experienced casual nurse, entering the world was easy, although I was aware of a constant need to gain the participants' interpretation and meanings rather than accept my own interpretation. The closeness to the phenomena, living it, working it and researching it was overwhelming at times and one of the reasons as to why I changed employment, to a permanent position outside of the hospital, during the research. This made the stepping back process much easier as I developed a distance from the phenomena which facilitated data analysis and conceptualisation.

Data Collection

As stated earlier, literature reviews are an ongoing process, commencing with an initial review giving the background to enable production of the first research proposal. The participants were interviewed, with interviews ranging from one to two and a half hours. Most participants were interviewed twice although some were involved in one interview and others, three. These interviews were semi-structured, with the direction of the interview following the participant's lead. The first interview usually had a broad focus, looking at general issues such as the participant's nursing background, and reasons for casual employment. Second and subsequent interviews addressed issues arising from the first interview for which I required clarification, as well as issues raised by the participants. The participants who were involved in subsequent interviews usually had direct experiences to relate and on occasion I was contacted by participants who wanted to add data to their interviews of experiences they thought I would be interested to know about. Phone contact was also utilised, especially when clarifying categories and during stages of concept formation. Memos, field notes and a research diary have also been maintained throughout the research process.

Data Analysis

All of the interviews were tape recorded using a dictaphone and notes were taken from the telephone conversations. The tapes were transcribed, with removal of identifying features, by myself, usually within a day of the interview. The taped interviews were then compared with the transcripts and special features such as loud speech and long pauses were identified and marked. Specific questions which arose and on which I required greater clarification or further thought, were also noted.

These transcripts were then analysed by a process of line by line analysis. Colour coding of the initial transcripts for emerging codes, which represented different processes, descriptions, and themes, aided the process of manual coding. The processes of data collection, coding and analysis were simultaneous as new participants were involved in the study at different stages, new categories emerged at different times, and multiple literature reviews were completed.

A large number of codes emerged and the data building these codes was constantly compared, both with the other data within the code and with data in other codes, to check for similarities and differences. A number of initial codes were later collapsed into a single code because of similarities and then later, codes were merged into larger and broader categories. Theoretical categories and propositions linking those categories appeared late in the process of data analysis and, by this time, the codes appeared saturated and little new information was obtained by theoretical sampling.

A core variable emerged last, when finally its integrating perspective was recognised. The core variable had initially been both a substantive and theoretical code, but it was the discovery and emergence of its propositional link which identified it as both a basic social process and core variable. Diagramming was used later in the process to clarify the links between categories.

Areas needing clarification have been referred back to the participants throughout the study and the conceptual model developed has also been discussed with many of the participants. A number of nurses who have experience with casual nursing but who were not involved as participants, have also discussed the model.

Ethical Considerations

This study involved the interviewing of registered nurses employed on casual contracts. Participant observation of nurses at work was not undertaken, neither was the interviewing of patients, nor examination of their medical records. Wilson (1989) identified the four basic rights of research participants as the right to anonymity and confidentiality, the right to full disclosure, the right to self determination, and the right not to be harmed. These rights were maintained during the research process by a number of strategies.

Although management of the regional hospital gave their permission for the study, and it was discussed with a number of senior nurses, the nurses who chose to participate were not identified at any stage. The potential participants contact with myself was voluntary and occurred outside the hospital setting.

The need for confidentiality and anonymity extended to both the nurse participants and their employing institutions. It is of utmost importance that nurses, when discussing their practice, are guaranteed confidentiality and anonymity and therefore no identifying details of the nurses or institutions are included in the data. Nom de plumes have been utilised within the data, these being different from the code used to identify the participant in interview transcripts.

As the study was on nurses' perceptions of their practice, and their employing institution was not the focus of the study, and because of issues of commercial sensitivity, the institution also requires its anonymity and confidentiality to be preserved. Other than identifying the primary setting as a regional hospital, no other identifying features have been given. Wards or units have only been identified by generic labels when a degree of clarification is necessary.

All data, field notes, interview tapes and transcripts were coded and a list of the codes was kept separate from the participants' identifying details and consent forms, in a locked place. I was the only researcher involved and completed all of the transcripts myself. Participants were given the option of either having their interview tape returned to them or wiped at the completion of the study. Tape identification was coded and tapes and computer disks were kept in a locked, secure place.

Informed consent was voluntarily obtained after participants had read the information sheet and had time to discuss the proposal with myself, or others, if required. The information sheet was given to participants to retain, as was a copy of the consent form. Participants were advised of their rights to decline to answer specific questions, to ask for tapes to be wiped or turned off, and to withdraw from the study at any time. These rights were reiterated before the first and each subsequent interview.

The possible uses for the research were also outlined, including the possibility of the research, including anonymous verbatim extracts from interviews, being published and/or used in educational forums. A copy of the completed thesis will be available for participants to read and each will be supplied with a summary of the research.

SUMMARY

This chapter has examined grounded theory as a research methodology which is appropriate for the study of many issues facing nurses and nursing. Its applicability to this research study was also discussed. The process of this research has been outlined, including how ethical considerations, access to participants, and data analysis has been managed. The following three chapters will present the data and its development into a conceptual model.

INTRODUCTION TO THE DATA

Key to Interview Abbreviations

The following conventions have been used within the data chapters and are presented here to assist the reader's interpretation.

...	pause
(...)	material edited
[ ]	editorial comments
Numbers	for example, 1:2 - interview one, page two
(Field notes)	Field notes and page of reference
Bold	emphasis eg. loud speech
plain	researcher comment/question
italics	participants speech

CHAPTER FOUR

COPING WITH DISCONTINUITY

INTRODUCTION

In this chapter data, concurrent analysis and the discussion are presented. As associated literature and researcher field notes are also identified as data within the grounded theory method, these are also integrated. Data analysis moves from description of empirical data to the development of abstract constructs at the theoretical level (Chenitz & Swanson, 1986). This chapter provides the reader with an introduction into the world of the casual nurse and then explores the processes and experiences associated with working within this world.

An Introduction to the World of Casual Nurses

The casual nurse is a term used to denote the employment status of a nurse, rather than her approach to nursing. Before being employed as casual nurses, these individuals have firstly become nurses. They have undergone the same nursing education, work in the same areas, and frequently have had similar background nursing experience before commencing casual employment, as their colleagues who are permanently employed. Anecdotal evidence suggests that family commitments are similar for any group of women of a similar age range who are in paid employment. But for casual nurses, both their experience of being a nurse, and of nursing, is altered by their employment status.

> *I find it difficult to go on, look after someone and know I probably won't see them again. I find it easy to make a relationship with someone. I've been nursing so long you can just come on and do that. I really would like some more continuity.* (...). *And I feel a little insecure. Usually when we work as a casual nurse it's busy and things like medications. I know now that it's not necessary to have your drugs checked by somebody else but I've been brought up to check my drugs with someone else, so I hunt round to find someone to check them with...*
>
> (Alice, 1:2-3)

> *The stress from not knowing* ***when*** *you are going to get work and* ***waiting*** *for that phone call, and wondering if there is going to be enough pay in the pay packet to pay the bills, ... and sometimes, if you haven't been on a ward for a while, going back into the ward and thinking am I going to be able to cope and where do I start, and readjusting to the staff and the environment on the ward. Yeah, it's the stress thing of constant change. It's the one thing that I enjoy, but at the same time it's the constant fear, stress, of change.*
> (Emma, 1:4)

The as and when required nature of casual employment results in many changes to the way in which these nurses are employed and work. As described earlier, casual nurses may work only in one ward or unit or may work in many, changing work areas on a day to day basis. Some casual nurses work full-time, or as near to this as their changing duties and the hospital requirements allow, and others work rarely. Employment condition entitlements such as sick leave vary, as does the amount and type of orientation offered, and the casual nurses access to paid or unpaid study leave. One nurse, Sue, applied to gain casual employment at one hospital and was asked to work for one month on orientation for no pay. She declined this offer and gained employment at another hospital, where she was given one month's paid orientation to casual work. Variations of conditions between and within hospitals are marked.

Part shifts are common, when either the hospital only requires a casual nurse for the busiest part of a duty, or in some cases, where the casual nurse is only available for a limited time. For women with family responsibilities, these duties can allow them to work when they may otherwise be unable to do so, and at a time when employment policies are generally restrictive to permanent part-time work.

> *...people know that after six o'clock at night, if they get busy and ring me up, I will probably say yes.*
> (Debbie, 2:5)

> *...because I only wanted to work school hours and I only wanted to work two or three days a week and I didn't want to commit myself, you know, to having to work rostered duties.* (...). *I've got three children, so I've got to work in what to do with them when I'm working.*
> (Gay, 1:2-3)

Those nurses on casual employment who are not financially reliant on their income have a greater degree of choice as to where and when they will work. For others, the choice is limited.

> *I might do this long sort of stretch* [of duties] *because I think, well, when is the work going to dry up. And then you think, hey, I've hardly had a day off. I've only had a day off here and a day off there.*
> (Kate, 2:1)

Other nurses find their lack of choice, as to when and where they will work, frustrating in terms of their own professional development. Hilary summarised her experience as a casual nurse by stating:

> *as far as* ***getting ahead*** *with your nursing career, it's no good. It's good maybe if you are unsure what you want to do, you want to see different areas, get an idea of where you would like to specialise, but as a job itself, it's the pits.*
> (Hilary, 1:16).

The lack of knowledge of future rostering also means that different shifts may be worked each week.

> *Like you could do a couple of mornings, afternoons, and you could end up doing nights. You know you sometimes do two or three shifts in a week and it does, you know, have a toll on the old body.*
> (Kate, 2:2)

> *And nights, I don't mind doing an occasional one. Say, doing a couple in a fortnight, if they are, say, two in a row. I went through a phase (...) where I was doing a night shift here, a couple of days off, do another night shift, have another day off, do another night shift. And they could never tell you before you went home in the morning if they would need you again that night. That made it really difficult to organise your sleep.*
> (Hilary, 1:2)

The disjointed manner of working, especially for those who work in a number of clinical areas, or who work infrequently, does impact on the individual's nursing practice. Changing clinical areas and changing shifts means different staff to work with, and changing routines and procedures for each area. Nurses with clinical expertise or specialist skills in an area may take a full patient workload. In other areas, the work responsibilities of a casual nurse are defined by hospital protocols, providing a basis upon which to decide which patients would be cared for by casual nurses. Generally, the casual nurse has little input into the process of patient allocation, this being the responsibility of the permanent ward staff. If the casual nurse's skills do not match the ward's requirements then the casual nurse may be used throughout the ward rather than being allocated patients. Carol described the rationale for using casual staff in this way.

> *...they* [the ward staff] *know the layout of the ward, they know the specialists, the surgeons who come around and everything that's going on and all you've got to do is float round, shower people, make beds.* (...). *... it's no good having the responsibility of having a whole room full of patients if you don't know where everything is. By the time you find your way round a ward it's lunch time.*
> (Carol, 1:6)

The world of the casual nurse is a constant interaction between that nurse, the nurses she works with, the hospital organisation, the patients she cares for, the other health professionals, and her personal life. These dimensions and links, which describe the way in which being a casual nurse impacts on the nurse as an individual and her nursing practice, will now be explored.

Although it is impossible to separate the nurse from her nursing practice, and the domains of her personal life from her professional life, there are dimensions within the experiences of casual nurses which relate directly and specifically to the nurse's practise of nursing. These are the focus of this chapter.

COPING WITH DISCONTINUITY

A feature of casual work is that it is discontinuous. The availability of work reflects the hospital's need for extra staff at that time, resulting from the fluctuating acuity of patient conditions, emergency situations, and staff absence. Some of these conditions can be anticipated, and therefore extra staff obtained, whereas in other circumstances, planning is impossible. Casual staff are therefore on call, receiving limited notice of their need to work.

One of the debates in New Zealand about the use of casual nurses has centred on the way in which some casual staff are booked for duties well in advance. The NZNO sees this practice of rostering as an inappropriate use of casual staff (Dickson, 1993) as a degree of permanency in the status of the employment is inferred. For casual staff there is uncertainty as to when they will work and when they will have days off. The impact this has on the nurse and her personal life will be discussed in the following chapters.

The inconstancy of casual work and the way in which many casual nurses work in a variety of clinical areas can result in a new clinical area each duty. Different clinical areas each duty, or just working infrequently, always means a new patient caseload. Practising nursing within this context requires the nurse to cope with the impact of discontinuity.

Discontinuity is one of the central processes and experiences within the nursing practice of casual nurses and its management reflects the nurse's ability to create a balance within her nursing practice. Discontinuity occurs at the levels of when and where the nurse will work and is also reflected in how she manages and organises the nursing care which she provides.

> *... if I was working here all the time this wouldn't be a problem. But it is a problem today because I don't know who I'm working with. I don't really know the ward layout, or I haven't been here for six months. The Charge nurse has changed. The routine has changed slightly and what's okay and what's not okay is slightly different...* (...) *...everywhere has their own little ways and it's just knowing that.*
> (Ruth, 1:9)

Continuity of nursing care has important implications for both the nurses providing the care and the patient who receives it. Methods of organising nursing care such as primary nursing rely heavily on a stable work force so that a degree of continuity of care for patients can be maintained. The use of casual staff can undermine and threaten these processes (Buchan & Thomas, 1993; Chellel, 1987) but Prescott (1986) noted in a study of the use of supplemental and agency staff, that "the lack of continuity frequently associated with utilisation of agency nurses is at least partially due to how these nurses are utilised by permanent staff" (p. 86). A 1983 study (Prescott, Janken, Langford & McKay, 1983) also supported this conclusion.

Coping with discontinuity, whether the result of disjointed duties or because of the way in which casual staff are organised and utilised, was an important process for casual nurses. Ruth worked a series of duties in one ward and noted the impact of discontinuity when she was allocated a different patient caseload each day.

> *... I would go to this one ward three or four days in a row, because they were really short. But it wasn't the same person off every day so I just picked up four different loads of clients, instead of having four days where I could really do some good nursing, feel like I was being useful. I would end up starting from square one everyday.*
> (Ruth, 1:13)

Emma worked a number of duties in the same ward and noted the way in which this experience of continuity altered her nursing practice.

I nursed more confidently. I didn't, I wasn't having to think about things so much. Doing things automatically. I didn't have to look where things were all the time, you know, because I got to know the people over time. You could go back and ask them things and check up on things, or chit chat. Just social. What's happened during the day. And yeah, it was kind of different. And knowing exactly where you were going and who you were going to have. A lot more settling than walking in and thinking okay, what am I going to do tonight?
(Emma, 2:2)

ENDEAVOURING TO RETAIN COMPETENCE

Casual nurses cope with the discontinuous nature of their employment by two interlinked processes, those of endeavouring to retain competence and managing marginality. Endeavouring to retain competence, which is an ongoing process, is the major theme of this chapter and encompasses the theoretical constructs of starting again, staying in touch, practising within limits, valuing, and normalising the difference.

Starting Again

The discontinuous nature of casual work means that casual nurses constantly engage in a process of **starting again**. Each new duty can mean exposure to a new clinical area, new staff, new patients and the nurse's responsibility is to assimilate these changes and provide competent nursing care. The starting again process begins within the transition between work and home. For casual nurses, this transition is frequently initiated by a phone call which offers them the choice of work. At times the nurse is needed immediately, at other times she may be booked for work in advance.

So they rang me at eleven o'clock [pm] *and said "she hasn't turned up, can you come." So I got there at half past eleven. I had gone to bed about nine o'clock and thinking they hadn't rung, I'm not working tonight.*
(Emma, 2:4)

The transition between home and work begins and for many, involves a complex organisation of home, family, and self, before work can commence.

> *I've got an hour to get my daughter to the baby sitter, that's if she's free, pack her tea, ring my husband to pick her up, plus getting my own self actually physically ready and dressed, and possibly cancelling what I was meant to be doing.*
> (Beth, 1:14)

Part of the transitional period is involved with mental preparation of the nurse for her day's work. Although this would be a normal feature for all nurses, the time frame is somewhat compressed for casual staff, who may have little warning of the duty. Sometimes this transitional period is compressed into minutes rather than days and casual nurses cope with this in different ways. Getting to work, and the complex processes involved, became the focus of the time between accepting work and starting the duty.

> *I used to find it stimulating driving up in the car and thinking well I'm going to do something important today.*
> (Beth, 1:10)

Once at work, starting again begins in earnest, demonstrating the need to cope with the inherent discontinuity experienced.

> *So I would get there when I could. And then, so all my workload would be just left. So I would have to try and catch up and was always an hour or so behind everyone else. I would get there and half of everyone's washes would be done and I had still just arrived. Trying to read my notes and thinking I don't know any of these people and I don't know where they are. I don't know the rooms and I don't know this and I don't know that. And then I would have to catch up with the work.*
> (Ruth, 1:9)

The other ward staff, and their approach to casual nurses, had a marked impact on what was involved in the starting again process.

> *... they usually say "have you been here before?" And some staff will say, "if you don't know, sing out", and other staff, just "here's your patients, go for it." It just depends on who's on duty and what the patients are.*
> (Kate, 1:11)

> *...it just depends which staff members are on duty and who else is on duty. Some days it's go for it and that's tough. We've got our workload and we are busy as well. And that's it. It was baptism by fire and they all walked out of the office, left me to it and that was my first duty there ever.*
> (Ruth, 1:20)

Another factor was how busy the ward was. Frequently ward staff have little time to spend orientating casual staff to the area. Although this was understood by the casual staff, it still created concerns, especially if they were unfamiliar with the area.

> *...just arriving in a place. You may not have been there for weeks, months, and all of a sudden you are in the middle of, it's usually busy, chaos.*
> (Debbie, 1:3)

The starting again process was directed at organising and providing the nursing care necessary for the patients. Firstly, the nurse needs to find out which patients are allocated into her care. This often involved different processes in each ward or unit. Then she needs to assimilate a large amount of information about the patients before she can start providing nursing care. The difficulty of prioritizing nursing care for each patient, and between patients, is made more complex by not knowing those patients at all.

> *Well simply that you don't know the patient. You know what the needs are, the general needs of a patient with CORD* [chronic obstructive respiratory disease] *or a post op. patient or an unconscious patient. But, for example, if you've got an unconscious patient you don't, ... caring for the family is just as important and you don't know the family. You don't know how they are coping, what sort of support they need, how involved they are in their relative's care. How they feel about it all. By the time you suss that out it's the end of the night and you've gone and you are not coming back. And you can document it, you can read all the documentation from what the nurses have said, but it's not the same.*
> (Hilary, 1:5)

The focus could easily slip to providing task nursing, as there are set tasks to be completed for each patient each duty, and these are what become documented in the nursing notes and reported on at the end of each duty. Providing comprehensive nursing care was made difficult, if not impossible, by the discontinuous process.

> *They're* [the patients] *very different, different levels of anxiety, different idiosyncrasies. The way, all the little things that make the difference to the patient's perception of their hospitalisation. Cos you could be giving good quality care, like I know the nursing care, the special care I give is good, but the patient's perception of their care is different. They haven't got someone who knows all about them and knows what they want, knows how to look after them.*
> (Hilary, 1:5)

Noting improvement and deterioration over a period of days amongst patients is complicated by the process of starting again and its relationship to discontinuity.

> *And sometimes I actually see a patient and it's only a one off situation and it's very hard to judge the improvement, or whatever, so you are sort of in limbo.*
> (Gay, 1:9)

Following patients throughout their hospitalisation and seeing improvement is something that provides job satisfaction for many nurses. The focus on the present, a commonality amongst casual nurses resulting from the constant discontinuity and the starting again process, often limits further contact with patients whom they have nursed.

> *I didn't get to follow through* [the patients] *that had been really ill and see them really pick up and go.* (...)... *so I probably didn't get quite the same personal satisfaction from it.*
> (Beth, 1:11)

Satisfaction was instead gained from doing the best that they could for those patients on that duty.

> *I was still encouraged by it. It wasn't my own personal satisfaction, but I could come home from a duty feeling a job well done still, even though I had only been there once.*
> (Beth, 1:11)

The casual nurses are reliant on careful documentation within the nursing notes and ongoing assessment of their patients. Storr and McDonald (1993), in discussing nurses who permanently worked on a resource team, noted that one of the benefits of working in a variety of clinical areas, with a changing patient case load was that the nurses developed "global assessment skills" (p. 6). These skills, which develop when a nurse applies her nursing knowledge over a wide range of clinical areas and utilises observation and assessment skills which have global applicability, are also an important component of the practise of casual nurses. Adapting their practice to specific areas was also important, as was knowing when to ask for assistance.

> *A man the other day, he was asthmatic, chronic CORD, and he wanted to know if he could get oxygen at home and I said "I would find out for you" and so I went out and asked the nurses.* (...). *And if you were coming from a different hospital* (...) *you can give the patient the wrong impression of what's available...*
> (Julie, 1:3)

Of course patients are always exposed to many nurses during their hospitalisation and they frequently have contact with different nurses each shift. For the casual nurses, the ideal of continuity of care, facilitated by continuity amongst the nursing staff, was seen as paramount. Because the nurse has a focus on the present she may be unaware of the actual discontinuity among carers, and it may only be the patient, nursed by a succession of casual staff, who is aware of the actual extent of the discontinuity.

> *They usually say "oh you are a new face around here" and I usually say "I'm a casual. (...). I'm helping out this morning. They are a bit short staffed, or something." And usually they say, "they are always short staffed. They have never got their own staff on."*
> (Julie, 1:19)

Casual nurses cope with **starting again** by a number of strategies. Most had routines which began with planning in case of work. Once on duty, they each had ways of planning, organising and providing the nursing care.

> *I always go around and introduce myself to them* [the patients]. *I don't say I'm casual, but sometimes they ask you questions that you just don't know like "what time does the tea lady come?", (...) little things like that and quite often then I'll say "I'll find out for you because I don't usually work here." (...). I always make the point of letting them know that* ***I am*** *experienced because sometimes you see their faces drop. (...). Cos you do sometimes wonder what they think when you say you are casual.*
> (Hilary, 1:12)

> *But I usually say to everyone who I am and that I'm casual. (...). "But if I neglect to do something, just point it out and I won't get upset. Cos it's probably much more helpful for me for you to say that they usually do my dressing at nine o'clock than for me not to do it till later and muck the system up."*
> (Ruth, 1:14)

And you're late because they rang you late and you're not familiar with the routine. (...). *And now I often get over that. People think I am taking too much time sitting in the office reading the notes and often I'm not even reading the notes. I'm just sitting in the office trying to come to terms with what I'm going to be doing.*
(Ruth, 1:20)

Paterson (1989) described the experiences of nurses working in an acute care setting and described this initial period as "settling in" (Paterson, 1989, p. 34), a process which commenced in the anticipatory stage before work and included thinking about the likely progress of the day, receiving patient reports, and the nurse orientating herself to individual responsibilities for the day. Casual nurses must both settle in and **start again** on each duty.

Having nurses who are working with unfamiliar staff, patients, and sometimes in an unfamiliar ward, does have the potential to change the way in which all of the nurses on duty work. Although they may take a full case load of patients, the casual nurses were constantly reminded by experiencing the starting again process that they were in unfamiliar territory. Where they may previously have made decisions regarding changes to nursing care, they now felt required to check with the ward staff, so that the nursing care provided was consistent with that ward's procedures. The need for the ward staff to take some of the responsibility for decisions made about their patients was also evident. Asking questions of their colleagues and checking became the trade mark of casual nurses.

... sometimes you feel a pain in the back because you don't know where things are, you still have to ask so many things.
(Sue, 1:8)

And trying to lay my hands on it quickly would have been okay if I had worked there all the time. (...). *You feel stupid saying "excuse me where are your bandages?" or "excuse me where do you keep your...?"*
(Ruth, 1:12)

Asking questions and checking with other staff slows the pace of the nurse's work.

> *So you are slower and you do have to get people to check more things with you. But sometimes it's hard to do that because obviously you get called to places that are busy.*
> (Hilary, 1:10)

The process of **starting again** can occur each day for casual nurses. It is frequently part of the experience of being a casual nurse which is enjoyed. The meeting of new people, both staff and patients, the constant exposure to new ideas, and the need to constantly assess one's own practice is both challenging and gratifying. It also provides the major frustration and pinpoints why, for many, casual nursing is only seen as a temporary job.

> *It's challenging, but now I find that it's losing that challenge because I'm getting frustrated because there are things that I'm seeing that I don't like, that I want to do something about. And the least that you can do about things is leading by example and you can't do that as a casual. You are only there for eight hours and then you leave.* (...). *You make comments, make complaints or what ever but you are not there to back it all, not there to hound people...*
> (Julie, 1:3)

Because many of the participants worked in a number of clinical units, they gained a rather unique view of different wards and their relationships to other areas within the hospital. Being competent to work in a number of areas at once resulted in some casual nurses working as resource staff, overcoming the artificial barriers created by labelling areas medical or surgical, when in fact, the patient frequently required nursing care from nurses possessing both medical and surgical nursing skills.

> ... *it would be really handy to know what is going on* [in] *that ward because we communicate quite a bit. As a casual worker, you can do that. You can go back. You can be that medium of information, although people don't see you like that.*
> (Sue, 1:10)

Being able to share information between areas was seen as important, with casual nurses able to provide a link. Booth (1990) believed that agency nurses were also able to fulfil this role because of their breadth of experience from different clinical areas. Melville (1993) worked as a bank nurse after gaining specialist skills in an intensive care unit. She noted the way in which her understanding of the pressures facing nurses in other areas developed because of her contact with different clinical units.

> I do miss having regular colleagues but, on the other hand, get the chance to meet a lot of new people. As a result, I have a deeper understanding of the problems nurses face in different areas and a broader view of local health care provision in the acute sector (Melville, 1993, p. 53).

Starting again is an integral part of casual nurses' experiences. It both creates and constitutes the way in which casual nurses practise nursing and is a reflection of the discontinuous nature of this form of employment, and the discontinuity which arises within practice.

Staying in Touch

Casual nursing becomes a different type of nursing from that carried out by permanent staff members. The nursing care given to patients may be similar but casual nurses need to work in a different way. Not belonging to a single ward or unit, and practising in a wide range of clinical areas, working with different patients and staff every day, and frequently, not being included in in-service sessions means that the emphasis on keeping their clinical practice at a competent level falls completely on the casual nurse. Casual nursing allows basic skills to be maintained but the chance to progress within a clinical area, or gain and retain specialist skills, was limited. **Staying in touch** with nursing rather than progression was the result.

> *I think for me casual has its place, just to sort of keep your hand in, but I wouldn't rely on it. I wouldn't want to do it for a long period of time.*
> (Beth, 1:10)

... [I] *have tended in the long run to gravitate more to relating to the person side because that's the side I feel strongest in and my skills are.* (...). *I don't know if they are being kept up to date, they are actually slipping* (...). *Unless someone comes and watches you and tells you where you are going wrong, you don't know.*
(Emma, 1:7)

I'm getting enough work in the medical wards to maintain my skills but I'm definitely losing my [specialist] *skills.* (...). *Sometimes I feel that I'm not doing any more that what a hospital aide could do if they were shown how to do it. I'm not being used to my full potential as a registered nurse.*
(Hilary, 1:9)

The individuality of casual nurses and their history of experience is often overlooked. Hospitals rarely have the luxury of having experienced nurses available to fill all of their staff requirements and casual nurses are frequently utilised to fill gaps rather than providing the specialist required, or desired, by the ward. If the organisation focuses on gap filling with casual staff, then the experience of casual staff may not be utilised in the best possible manner. The specialist skills or experience of casual nurses may also be rejected by the way in which others see their role.

I, for one, was on a medical ward a couple of weeks ago (...) *and they wanted to put a naso-gastric down and in the end I asked if they wanted me to do it because the other girl couldn't and she said "no you can't do it because you are casual." And I said "but I'm a staff nurse so I can, so I should be able to do it." And they said "well, we will get the doctor to do it", because none of the staff nurses, they were all fairly juniorish, had put a naso-gastric down and I thought, my God.*(...). *So they went to the registrar and he said he hadn't done it either and I said "well, I know how to do it" and so then I had three nurses and a house surgeon and I was showing them how to do it.* (...). *I felt quite chuffed about that. But it was something I didn't pick up on casual. That was something I did in my surgical training.*
(Julie, 1:10)

For some nurses **staying in touch** signifies a stage within their nursing careers. Family or personal responsibilities limit their ability to work full-time at this particular phase and casual nursing allows them to maintain contact with nursing, without the commitment of a full-time or regular part-time position. Nurses who have had senior positions often enjoy the chance to return to providing patient care rather than being involved in ward management.

> *I actually quite enjoy, ... I think because I used to have to put so much into it* [ward management], *it's quite nice not to have to. I think it's just a phase that I'm going through, enjoying not having to.* (...). *I don't have to do the ordering on a Monday or Tuesday or Wednesday like everyone else, I mean that's not my area. I'm quite happy to go and do their daily checking, their daily cleaning and that sort of thing, okay, that's part of my job, but their extra ordering and their unpacking and goodness knows what else, that's their problem.*
> (Debbie, 1:15)

The discontinuity of work and the way in which casual staff are utilised results in them being involved with a greater level of direct patient care and less ward management. This also reflects their employment in a gap filling capacity rather than as senior staff on duty. It is quite difficult for staff who work in many clinical areas to fulfil administrative and ward management duties although, the nurses were keenly aware that if they were not completing these, then the ward staff would have extra administrative work to complete.

> *As the RN* [registered nurse] *in charge you are in charge of running the ward and not just your own patients but it's much harder to do that as casual staff. I think that night, if there had been things like admissions, although clinically I could have taken charge, but the running of the ward, one of the enrolled nurses probably would have had to do it because she would have.* (...) *The little idiosyncrasies of each ward about which patients go into which rooms under which teams and allocated to which primary nurse and the enrolled nurses would have had to take responsibility for that because I wouldn't have a clue, like clinically I could have been in charge, but...*
> (Hilary, 1:11)

Sayer (1990) completed a study which compared the work patterns of agency and hospital nurses in London. She noted:

> the two groups spent approximately the same amount of time on direct patient care. However the hospital nurses spent twice as much time on indirect care activities, such as discharge planning or preparing medications, as the agency nurses. The agency nurses spent more time than hospital nurses (20% v. 12.3%) doing clerical tasks, cleaning and so on (Sayer, 1990, p. 51).

The impact of **staying in touch**, rather than developing specialist skills, is especially obvious for the nurses who choose to work in a number of clinical areas. This choice is usually motivated by the need to obtain regular work, which may not be available within a single ward or unit. Compromise was necessary if the nurse wished to obtain sufficient work for her own needs.

> *I said I'm not interested in medical, surgical, okay surgical, just to get some work. Otherwise there won't be enough work.*
> (Sue, 1:2)

Other nurses were encouraged to work in a number of areas because this suited the hospital.

> [The casual staff coordinator] *asked me what areas I would like to work in and we just thought we would put the whole lot down. I wasn't sure about* [specialist areas] *but she thought I would handle it.*
> (Emma, 1:3)

> *They wanted me to orientate to medical and surgical wards and I said I was not interested. Why do I have to be orientated in those two fields if I'm not going to be doing casual work in those*?
> (Sue, 1:3)

Some nurses chose to work in a wide variety of clinical areas, often as diverse as acute psychiatric care and paediatrics. This variety was seen as a two edged sword. The nurses enjoyed the constant change and it was seen as part of the

challenge of casual work (Julie, 1:3). The challenge also resulted in casual staff only being able to stay in touch rather than develop or maintain specialist skills. Becoming a jack of all trades and master of none was problematic for some.

> *To a degree you see a lot of things happening, but you become a jack of all trades and that is one thing I don't like about casual is that you become a real jack of all trades and master of nothing. You know a bit about this and a bit about that.*
> (Julie, 1:10)

> *Like I know I am a jack of all trades and a master of none, but I don't, ... in nursing,*
> Is that okay?
> *No. In nursing it's not okay.*
> (Emma, 2:11)

The problematic nature of having generalist rather than specialist skills was perceived to arise because of fundamental changes in the organisation pertaining to all nurses. Rotation of nurses around wards on a regular basis has decreased markedly and in many places, is restricted to new graduate staff nurses gaining initial experience. Most nurses who have permanent positions are now based in one ward or unit, gaining specialist skills in that area. This was seen as not only creating problems for casual nurses, for whom changing areas was part of the job, but also for permanent staff.

> *But I think the fact that people don't rotate any more and it must make, it makes it really hard. You can't adapt.* (...). *You're not that generalised any more, are you. Cos we're all taught to be specific* [specialist] *basically.*
> (Debbie, 2:2)

This places the use of casual nurses firmly within the debate about the advantages and disadvantages of specialist or generalist nursing practice. Some casual nurses had previously worked in specialist areas or had gained skills and experience within specific areas such as orthopaedic and paediatric nursing. Continuing to work in these areas on casual nursing meant that staying in touch with these areas

could be a viable option, of course dependent on the frequency of their work. None of the participants in the study were employed by institutions which had policies requiring nurses to work a specific number of duties in a set time frame. This requirement is a common feature of many supplemental nursing programs and in-house agencies overseas and is directly linked with the need for staff to practise regularly to maintain clinical competence (Crome, McDaniel, Rotunna & Tachibana, 1993; Dougan, Lanigan & Szalapski, 1991; Stenske, Biordi, Gillies & Holm, 1988).

The need for specialised practice in all clinical areas caused the nurses concern about the need to retain competence within their nursing practice.

> *Every area has its own little peculiarities and its own little distinctions. I can't remember all the signs and symptoms of all the diseases and all the conditions in every single area of nursing.* (...). *You're more familiar with what you are handling frequently, day in day out and you are continuously being presented with and you get to pick up and know things a lot quicker.* (...). *You can't keep up with a half, a third of that if you are a generalist, a general nurse.*
> (Emma, 2:12)

Increasing specialisation within nursing practice does have many implications for the organisation of nursing practice. Aydelotte, in 1978, noted that:

> The increase in specialisation has introduced constraints in staffing within hospitals. No longer is the staff nurse able to move freely from one nursing unit to another unless those units have the same kinds of patients, treated by the same kinds of therapy (p. 128).

The practice of utilising nursing staff in areas other than those in which they regularly worked, was seen as based on a belief that nurses could work in a generalist capacity, a view which went against the specialist environment of nursing today (Beard, 1994). Paterson (1989, p. 3), voiced concerns about treating nurses as "interchangeable units that can be slotted into any position as the need arises with no reduction in their effectiveness." Parkes (1994, p. 27), in discussing the development of specialisation within nursing, took a more moderate

view and commented that "the concept of advanced practice and credentialing for generalists, or nurses who were not specialists, needs to be fully explored."

International moves towards cross-training and cross-utilisation of nursing staff across a number of clinical areas have also raised similar issues of the potential of creating nurses who were jacks of all trades and able to work in many areas, without having an extensive knowledge in any one area (Eickhoff, 1992: Graf, 1992; Strohbach, 1992), although the need for nurses to maintain skills which enhance their employability, and the hospital's need for a flexible work force, are also noted (Haeger, 1992; MacDonald, 1992; Mascarinas, 1992). The debate has centred over nurses' ability to provide quality nursing care in a number of clinical areas. Cross-utilisation of staff within associated clinical areas, such as critical care areas, has been forwarded as a cost effective method of best utilising nursing staff (American Organisation of Nurse Executives, 1993; Arnold & Levy, 1988; Bechtel & Printz, 1994; Riley, 1990). Crissman and Jelsma (1990) examined the cross-training dilemma and applied the work of Benner (1984), concluding that nurses who were cross-trained would practise at two levels, an advanced level in their primary unit, while being prepared to practise at the level of an advanced beginner in the area in which they were cross-trained.

For nurses to **stay in touch** with up to date nursing practice they needed to be working on a regular basis and also be receiving feedback from colleagues about their practice. Working in different areas or working infrequently makes it difficult for constructive peer appraisal to occur. Even providing feedback about the casual nurse's work on a day to day basis seemed problematic and very subjective. Some nurses always asked the ward staff for feedback on their practice.

> *I always ask people, "how did I go" and "was it alright" and they say "no it was really good", so that gives you a bit of confidence ...*
> (Carol, 1:11)

None of the participants had been involved in a formal performance appraisal while they were employed on a casual basis. When asked if this aspect of their nursing was important, all replied in the affirmative, although who would complete

the appraisal was seen as problematic, when the nurses worked with so many different staff.

> *I would like more assessment. I don't know if they do assessments at the hospital but I've certainly never had any.*
> (Alice, 1:6)

The issues surrounding the provision of feedback and evaluation of the practise of supplemental, agency, and float staff are numerous and well debated. Bower (1987) recommended the use of an anecdotal float record for all staff who worked on a float capacity in another area. This record was to be completed on each duty and acted as written documentation of the verbal feedback given to each nurse by the Charge nurse. Metzger (1990) presented a tool for evaluating supplemental staff which was to be completed either after each duty or after a series of consecutive duties in one unit. Also presented was a tool to enable the supplemental staff to evaluate the unit or ward in which they had worked, identifying both what was useful and what needed modification to enable supplemental staff to work efficiently in that area. The common denominator was that it is beneficial to both the nurse and the organisation to have regular and formal ongoing performance appraisal.

Staying in touch was a position of compromise for casual nurses which enabled them to keep in contact with nursing practice. It incorporated the nurses' responses to the invariable state of discontinuity within which they worked and the ways in which their nursing practice was altered to assimilate these differences.

Practising Within Limits

Casual nursing, and especially the associated discontinuity, has the potential to impart limits upon the nurses and the way in which they practise. These limits arise from the way in which casual nurses are organised and utilised by the hospital, as well as being imposed by the casual nurses themselves. Combined, these limits sometimes had the effect of leaving casual nurses to believe *that you can never progress beyond a casual nurse* (Hilary, 1:7).

Organisational limits included stopping nurses employed on a casual basis from applying for internally advertised positions. As the participants all saw casual work as a temporary phase and many hoped to gain either permanent part-time or full-time positions in the future, this stance effectively isolated them.

> *And I was busy writing applications out and going for interviews and then they said you weren't allowed to apply internally and it was like we are really now on the outer. Not even classed as part of the hospital any more.*
> (Ruth, 1:19)

This approach is surprising when many hospitals overseas see casual and agency work as an excellent way to screen potential staff before employment (Dougan, Lanigan & Szalapski, 1991; Fierman, 1994). Other nurses felt their experience was devalued by employment conditions. One was frustrated when she was informed that her salary remained fixed while she was employed on casual work, while others were unaware of this contract condition until later in their employment.

> *I certainly know they don't take it into account as experience when they calculate your pay.* (...). *You can do five days casual work a week for five years and they don't count it as anything as far as increasing your pay from one level to the next.*
> (Hilary, 1:14)

For nurses who had limited clinical experience before commencing casual employment, casual work was seen as a way into nursing and a method of improving their curriculum vitae. Their transition to permanent work was not always easy or successful. Concerns were raised that casual work was not counted as valid experience when nurses were applying for employment. Kate believed that this arose because of others' perceptions of what casual work entailed.

> *I think a lot of people think casual as one duty here and another there. They don't realise that a lot of casual nurses are actually working full-time.*
> (Kate, 1:13)

Other organisational limits were usually unit based, in many cases specifying which patients could be cared for by casual staff. The protective nature of these protocols for casual and ward staff was recognised, although for them to be enforced all staff needed to be aware of their existence. This created some difficulty for those casual nurses who worked in a number of clinical areas. Time for reading the protocol manuals was limited and the casual nurses frequently relied on the ward staff to allocate appropriate patients into their care, a difficult task when the vast range of experience within casual staff is taken into account.

Endeavouring to maintain competence while working within limits created some conflicts for casual nurses. Their desire to maintain competent practice and to progress to permanent employment if that was what they desired, was often perceived as being limited and compromise was necessary, taking the work that was available now, in the hope of a change in the future.

Normalising the Difference

Casual nurses who believed that they had successfully integrated their nursing practice within the special requirements of casual nursing developed an approach to their nursing in which they **normalised** the experience of being a casual nurse and the differences associated with that type of employment. By normalising, they were able to work within the limitations imposed upon their practice, adapt to the special requirements of casual work.

> *I used to get sick of being in one place all the time. That's why I change jobs fairly often. Not a good habit, but this way I get to work on different wards in a short time without having to change my job.*
> (Emma, 1:4)

Compromise was an integral part of this process and casual work was accepted as *a normal job* (Julie, 1:17). Normalising also required a change in personal

expectations and an acceptance of the need to work within present limitations. Murray (1991) described how changing her personal perspectives and expectations allowed her to value her work as a casual nurse. Accepting that casual work was appropriate, at a time in her life when family responsibilities were paramount, enabled her to work positively within the limitations of this type of employment.

Normalising was facilitated by the job being seen as one of a temporary nature, with different options being available in the future. These future plans were also seen as realistically obtainable. *I can just cruise along on casual until the ideal job comes along* (Julie, 1:16).

Valuing

The participants were aware of a perception that casual nursing was thought of differently than permanent work by many. Some felt that it was seen as a second class job or that it was not a real job, belying the fact that for many, it was either the only work they could obtain at present or that it linked well with the nurse's other responsibilities. One nurse was constantly asked why she remained in casual employment.

> "*Why don't you get a* ***real*** *job?*" *A* ***real*** *job. I say "casual's quite* ***real*** *enough at the moment thank you.*"
> (Julie, 1:4)

Not having a real job was seen by many of the casual nurses as reflecting on their nursing practice in a negative way, devaluing their experience and their commitment to nursing.

> *...I feel resentful that I've got so much of that* [experience and expertise] *and I do a good job and I am a competent and capable person and I end up doing casual work.*
> (Alice, 1:2)

In spite of feeling that their skills and experience were devalued, the casual nurses **valued** their nursing practice, specifically noting how much they were needed and

the special skills involved in being a casual nurse. Not only did they need to be able to come to work at short notice, fit in to an area, and work competently in a number of areas, but they also needed to cope well in situations which were frequently unfamiliar to them, often with limited supervision and support.

> *You've really got to assess the situation quickly, assess it and prioritize, and then step in and start acting.*
> (Emma, 2:5)

> *If you are a good casual nurse you are a valuable asset to the hospital.* (...). *There are so many casual staff and they have to use them so often it's ridiculous, but you can't do without some. You need some casual staff. And to be a good casual nurse is quite a skilled thing. To be able to just walk into a situation, assess the situation and fit in with so many different staff and remember the little routines of so many different wards, make the most of the time you've got with each patient, to assess them the best that you can even though you feel that you wish you could do it again the next day. I think you are very valuable if you are a good casual nurse.*
> (Hilary, 1:12)

Valuing involved the nurses' perception of their usefulness within the hospital organisation, and recognition of their nursing ability, their efforts to remain in touch with developments within nursing, and their ability to give competent nursing care. A *flexible* approach (Ruth, 1:8) was important for casual nurses, as was the ability to accept criticism.

> *You have to be flexible of mind because you get lots of criticism and people don't really understand that you are just there for one day.*
> (Ruth, 1:8)

You've got to know that you are doing it properly. You've got to be confident in the things that you do because people are really super quick to run you down, especially women. You've got to really know your stuff and you've got to do it well, and not take things personally because patients say, "well my regular nurse," you know.
(Carol, 2:3)

The interconnected processes and impact of **discontinuity**, **starting again** and **practising within limits** meant that the casual nurses often felt that their input into the hospital was not recognised, or just ignored, because they didn't belong anywhere.

...there would be very few wards or very few duties where there wasn't a casual nurse on duty, if not more than one, and yet I don't think our services are acknowledged.
(Ruth, 1:19)

Not belonging resulted in distancing by both the casual nurses and the permanent staff, and a frequently cited example was that nurses were sometimes called "the casual" rather than by their name.

I've heard some people actually say they get called ***"the casual"*** *instead of their name and I think that's quite offensive.*
(Alice, 1:8)

Generally though, the casual nurses believed that the ward staff appreciated their help. Circumstances, and specifically the way in which casual staff were utilised by many areas, meant that no one area was aware of the casual nurse's input into the hospital. Although casual nursing was seen as a temporary phase, it was the form of employment, rather than the nurse's commitment to nursing that had changed, and the nurses continued to value their ability, experience and competency to provide a good standard of nursing care.

SUMMARY

This chapter has provided an introduction into the world of casual nurses, with a specific focus on how those nurses practise nursing in a context changed by their employment status. Commonalities amongst the experiences of casual nurses have been explored, including how they assimilate the processes of starting again, staying in touch, practising within limits, valuing and normalising, so that they can retain and maintain their level of nursing competence. Coping with discontinuity has been a linking thread through out this chapter and it continues to be a central process in the next chapter. Chapter Five explores the way in which casual nurses manage the marginality created by their employment.

CHAPTER FIVE

MANAGING MARGINALITY

INTRODUCTION

In Chapter Four, the reader was introduced to the world of casual nurses. The discontinuous nature of nursing, resulting from this type of employment, was explored, as were the processes involved in retaining clinical skills and competency. Chapter Five extends the theme of discontinuity, focusing particularly on the interpersonal components enmeshed in nursing practice, which enable, integrate, and support nurses as they engage in the practise of nursing.

MANAGING MARGINALITY

The discontinuous and frequently part-time nature of casual employment means that often casual nurses are not based in a particular ward or unit, and working in a different ward each day means that casual nurses work with many staff. Being based in a ward or unit creates opportunities for nurses which are frequently taken for granted, such as collegial support, peer appraisal and feedback on nursing practice. Also involved is a feeling of belonging. Belonging encompasses the many interactional aspects of working with others and imparts a degree of safety, support, and a tolerance of human individuality. Ruth provided an example of the way in which belonging and a tolerance for others were linked.

> *Just the fact that you were having a bad day and people would normally compensate for that. You know, she functions really well normally* (...) *and yeah, she's off colour today. But she's not normally like that.* (...). *She's usually pretty good. And today's not a normal day. Whereas if you're casual, you go there and screw up really badly one day and you're a terrible nurse...*
> (Ruth, 1:18)

Casual nurses do not belong. Instead they visit, work, and leave. Although many nurses, both casual and permanent employees, develop collegial relationships, support each other, and work well together, casual nurses are always slightly

separated, slightly distanced and slightly apart (Field notes, p.5). **Marginality**, to a greater or lesser degree, is the consequence. Marginality results from a combination of the situation of casual nurses and the way in which they are utilised, rather than from a deliberate approach from the ward staff, but nevertheless, it has a marked impact on casual nurses.

Those casual nurses who only worked in a single ward or unit experienced less marginality than those who worked in many. Gay, who works in a limited number of clinically related areas, is both invited and encouraged to participate in ward activities, as well as availing herself of the opportunities for involvement in a unit she frequently works in.

> *Well I do try to attend* [staff] *meetings and things and read up books whenever possible. That sort of thing. We just had* [an in-service] *seminar which I attended and they paid.*
> (Gay, 1:5)

This sort of involvement was rare for most casual nurses, and it is impossible for those nurses who work in many areas to attend all the ward meetings. The lack of inclusion in ward activities is a reminder of the difference between ward staff and casual staff.

> *But when, say, a drug rep. comes on the ward, the casual staff run the ward.* (...). *The casual nurses get kicked out* [of the in-service education] *to do the work basically.*
> (Julie, 1:12)

With the implementation of unit based budgeting in many areas, which covers the nursing salaries, casual staff are unlikely to be paid to attend in-service education sessions, and teaching by ward staff, who already have their own patient load, may be limited. Hilary was eager to gain new skills, especially in a specialist area in which she had little experience.

> *...probably it* [teaching by ward staff] *would require effort on their part, and I suppose that they feel that because you are not there all*

> *the time, that the effort's not worth it, it's not worth their time. Training you up to that level.*
> (Hilary, 1:7)

Her frustration at being placed in a marginalised position and being treated differently than other staff was obvious.

> *... they didn't seem to think it was my place, as a casual, to be doing that sort of thing. It was really frustrating because I feel I'm perfectly capable of gaining those skills, but you know, I don't really get a chance.*
> (Hilary, 1:7)

Although competent nursing relies heavily on a sound clinical knowledge and skill base, collegiality between staff is of vital importance for the provision of quality nursing care. Hegyvary (1982, p. 183) stated that "many of the conditions for improving professional nursing practice centre on the nurses' need to work and identify themselves as colleagues." Just knowing the names of other staff who you are working that duty with is important, and a difficult task if the nurse is working in different areas frequently.

> *Developing that rapport with the staff, and so that you can get the help that you need. Even remembering their names. It's all very well walking into a ward and you need something in a hurry, trying to think of who you want to ask. Walking around just looking for people. Wastes time because I can't call out, "yoo hoo," because I can't remember their names. "Hello, is there a nurse around," so I end up prowling around looking for people and wasting time.*
> (Ruth, 1:9)

Not belonging to a ward or unit results in a marginal status for the casual nurse. She is called upon to work in a ward and practise competent nursing care without the benefits of belonging within the ward staff. Sklar (1992) discussed the use of nursing staff in a float capacity and noted:

> ... most nurses believed they had the skills they need to do the job on any surgical unit, but that was only 50 percent of getting the job done.

> The other 50 percent came from dealing (with) different unit cultures and the effects of different leadership styles (p. 104).

It is the dealing with these other components embedded within nursing practice with which casual nurses are faced. **Managing marginality** is therefore a component of casual nursing practice, encompassing processes of creating mutuality, protecting self and others, and stepping back.

Creating Mutuality

Working effectively in different areas was enhanced when the ward staff knew the casual nurse. Knowing included knowing the nurse's name and knowing her nursing practice, her approach to nursing, and her clinical experience.

> *I was the only one who had worked there before and when I walked in the nurse said, thank God you are here. She said* ***thank God it's you.*** *At least you* ***know*** *the ward.* (...). *And I didn't really know the ward that well.*
> (Ruth, 1:10)

> *I'm most probably known in the areas I work in. I must be reasonably well liked or else they wouldn't keep calling, and they do think I have some level of knowledge, and I* (...) *know I'm useful.*
> (Debbie, 1:3)

Knowing each other, and their nursing practice, made working easier for everyone. One nurse noted that she *became a regular member of staff* (Ruth, 1:4) whenever she worked in one clinical area where she was well known, and where she felt she knew the ward and staff well. **Creating mutuality**, therefore, took time to develop and was reflected in subtle ways in which the casual nurse was received on a ward.

> *I mean there are wards I have been to lots of times before and they seem to quite appreciate you and know you and now I'm much more just left to do my own thing.*
> (Emma, 2:1)

Creating mutuality also involved knowing what it was like to be in the other person's shoes, in this case, the experience of being permanent ward staff. The participants were acutely aware of the pressures facing these staff, and also recognised that casual staff had markedly different levels of experience which did create problems for permanent staff working with them.

> *I have found the times that I have worked over there most of the staff have been obliging. They don't mind telling you. But then I've sort of been lucky that it hasn't been overly, overly too busy. Sometimes if it's at the other extreme they haven't got time to show you and that makes it harder.*
> (Kate, 1:6)

The participants recognised how it was for the ward staff if they worked with casual staff who were inexperienced in their area. Hilary was asked to work in a clinical area in which she was unfamiliar and where she had no post registration clinical experience, because of a lack of experienced staff. She advised the nursing coordinator of her lack of experience but was informed that *someone's better than no-one* (Hilary, 1:6). She commented:

> *...if you need someone to do something and you have to check how they have done it, or supervise them doing it, it takes longer than doing it yourself most of the time. I'm sure I was some help that night but it must be very, I think very frustrating for the ward staff. Most of the time I think the ward staff are quite accepting of casual staff because they know that, especially if you haven't been there before, they know that and accept that.*
> (Hilary, 1:6)

There was recognition that the ward staff needed more than a pair of hands. They needed an "extra pair of professional hands" (Cushing, 1983, p. 297). There was also the understanding that sometimes the casual nurse, with or without the expertise for that area, was all that was available.

Fitting in was an important strategy for casual nurses within the process of creating mutuality. For the casual nurses who worked in a large number of clinical areas, always working with different staff was aligned to being a visitor rather than one of the staff. Nurses who worked in areas where they were well known fitted in easier and were *treated more as part-time staff than casual* staff members (Debbie, 1:8).

Sometimes the marginal status of casual staff meant that fitting in did not occur.

> *Well, if the team is sitting having a chat and a cup of tea, you don't really feel like one of them, so you sort of wander away and do some other things and you feel like they are looking at you more critically than they would towards other colleagues.*
> (Sue, 1:11)

Sue also found herself working in a situation where casual staff were being used to replace permanent staff and this, of course, had an impact on the fitting in process.

> *... and new people, casual workers came along and took over their jobs while they were still there, so there was this negative attitude towards casual workers.*
> (Sue, 1:7)

Fitting in was an ongoing strategy which was also used to summarise how the casual nurse had felt that a duty had progressed, encompassing the processes of coping with the discontinuous nature of the job, creating mutuality and managing marginality.

> *You may not have been there for weeks, months and all of a sudden you are in the middle of, it's usually busy, chaos. Sometimes it's very hard, yeah, fitting in or even getting started and sometimes you don't fit in for the whole shift and you wonder why you've been there.*
> (Debbie, 1:3)

A process similar to creating mutuality also occurs between casual staff when they are working on the same ward together. Mutual experiences of casual work frequently allow a rapport to be developed so that these nurses supported one another, their casual status providing a commonality of experience.

> *Generally there are usually only one or two casuals. Usually one casual looks after the other one. You know, you keep an eye on each other because you know that you are both in the same boat.*
> (Julie, 1:13)

The participants were aware of not only their separateness from ward staff, but also their separateness from other casual staff. Ruth described casual nurses as *just a body of people whose only contact was the book up in the nursing resource room* (Ruth, 1:15). Knowing other casual staff, especially for those nurses who worked in many areas, and who worked on a full-time basis, was identified as being important, but even more important was the identification of casual nurses as a specific group.

> *To be thought of as a special body of nurses. You know you've got the ward x nurses, the ward y nurses, and the casual nurses who are a group of people.*
> (Ruth, 1:15)

By belonging to a specific group, other benefits could also accrue. Having their own casual nurse in-service education sessions, their own nursing coordinator and regular casual nurse staff meetings were all suggestions provided by participants to increase their sense of belonging and so that they could create a supportive casual nurse group. Many of these suggestions have been successfully implemented elsewhere.

Bodak (1990, p. 15) described a program commenced for float staff because it was recognised that the traditional structures in place did not provide float staff with the "opportunity for camaraderie, development and cohesiveness available to nurses stationed permanently on a unit." Integrated within the new program were monthly educational and staff meetings, social staff functions, and an independent Head nurse for supervision and support of the float staff. Nash, Miller, Everett,

Faber-Bermudez, Libcke and Nalon (1991) discussed a supplemental staffing program which utilised its own nursing coordinator, who was also responsible for focusing on the professional development needs of supplemental staff. This program was designed to be implemented within budgetary restraints, and when evaluated, was found to be both cost effective and enabling of quality nursing care. A climate of "solidarity and unity" (Libby & Bolduc, 1994, p.82) was created between staff when a speciality group of float staff was formed. This group operated as an independent unit and its success was measured by cost effectiveness, the job satisfaction of staff, and its achievement as a networking resource. Casual staff need to both create mutuality with their ward based colleagues and also between other casual staff to support and enable their nursing practice.

Creating mutuality is an ongoing process whereby the nurse works to develop a link to the ward and ward staff, thereby overcoming some of the effect imparted by the marginality of her position. It allows the development of a rapport with ward staff which enables nursing practice to occur within the context of a ward culture. It is also reliant on the casual nurse being confident and competent both in her nursing practice and communication skills, so that trust can develop between both groups.

Protecting Self and Others

The nurse's need to protect herself and others, in this case her patients, comes about because of many factors. These include unfamiliarity in clinical areas and the constant change of working in different wards where protocols and procedures are modified on an ongoing basis. The necessity for many casual nurses to work in a generalist capacity was also a factor. Protecting reflects an awareness of the vulnerability of the practise of the casual nurse when she feels marginalised. Kate described casual nursing as *basically looking after yourself and making sure that the person* [patient] *is safe* (Kate, 1:5).

The enaction of **protecting self and others** was demonstrated in the way which the casual nurses described the differences between their practice as casual nurses compared to when they had worked as permanent ward staff. It was also obvious in their decision making as to whether or not they would work in an area.

> *... and they rang me and asked me if I would go to work but I said no because I was going to be the only person on looking after in-patients and I really didn't know their routines ... (...) ... and the only person on and supposed to know everything. For that reason I turned it down. I felt awful turning it down but felt that I would be putting myself in a situation that was not really safe.*
> (Gay, 1:5)

Although some nurses were able to turn down work, others felt unable to do so for financial reasons or because they wanted to gain experience in the area. Those nurses were more likely to accept the assignment with the proviso that the person who requested them to work informed the other ward staff of their lack of experience in that area.

Protecting themselves professionally was of major importance for the casual nurses. All were uncomfortable about being in a senior position on a ward, when employed on a casual basis, even though a number of the participants had previously worked in positions of seniority. Beth (1:6) commented *I used to be comfortable being the senior on and* [now] *I'm not comfortable being the casual and being senior on. I don't think its right.*

> *...if a doctor comes on they want someone senior and they want to know everything and I would only know the patients that I had read up about because there's no way I would read up on all the patients when I came onto a shift.* (...). *If you were full-time you're there for several days, you would pick up what's going on in the ward much better.* (...). *I had a heavy workload and very inexperienced staff on with me. I would legally be responsible for those other patients, and there's no way I would have had time to oversee what was going on and I think* (...) *if it had been a senior person that wasn't a casual, they would have had a better idea of what was going on in the ward than I would of, just coming on.*
> (Beth, 1:7)

Protecting self and others extended to the casual nurse's concern and awareness about which patients she cared for. There was a wide level of difference in the nursing experience within the participant group, although this was not always taken into account when patients were allocated to the casual nurses. A frequent comment was that casual staff were given some of the more difficult assignments.

> *... I feel I walk into a ward and I get the patients that nobody else wants. They don't want these ones because they are difficult, or hard, or just a bit obnoxious, so okay, we'll give them to the casual, cos she's just here for the day and it gives us a break.*
> (Emma, 1:11)

> *Sometimes, you quite often get the so-called, in quotation marks, the difficult patients, that everyone else is sick of looking after, and I don't mind that because I do feel that because I feel that I'm only there for one night, and no matter how much, how difficult this patient is, you can do your ultimate, absolute best, and know that I'm not going to have to look after him tomorrow. (...). But that's the only time when you feel that the patient is better off having you than one of the other staff.*
> (Hilary, 1:5)

Casual staff appear to often exist within a vacuum, without a history of experience, or knowledge by the staff they are working with today as to which patients they looked after yesterday, and in which area. A future perspective, of where they will be tomorrow, is also missing. Safety arose as the major trigger to intervene in a situation where the casual nurse felt that the patients allocated into her care were inappropriate for her skill level.

> *... unless they gave me someone that I felt I was going to be unsafe with then I just basically did as I was told.*
> (Emma, 1:10)

Part of the experience of being a casual nurse for Julie has been developing the ability to say no to patient assignments which she believes she does not have the skills or experience to manage competently. She stated that she had become:

> *...very confident in saying, "I'm sorry I'm not going to take that person on." And not feeling guilty about it and not blaming or feeling bad or useless or a failure for saying no.*
> (Julie, 1:1)

Protecting self and others included refusing to undertake some skills for which the nurses felt they either had insufficient experience, or insufficient supervision would be available. The giving of intravenous additives (IV's) was frequently cited as a skill which casual staff refused to perform, although the nurses were aware of how this created difficulty for the ward staff with whom they were working. Beth completed her intravenous additives certification because of the problems identified for other staff if she was not IV certified.

> *I had to try and make a real effort because I wasn't there very often.* (...)... *but I did get on* (the intravenous additives register) *because it was really annoying for the other staff for me to be called in as a staff nurse and not be able to give the stuff* (intravenous additives).
> (Beth, 1: 12)

Powers (1993) provided a compelling case for nurses to refuse assignments for which they felt they had inappropriate skills or experience. She stated:

> As registered nurses, we are responsible not only to our patients, but also to ourselves and to our profession. Patients have a fundamental right to receive safe, professional nursing; therefore, we must accept only those assignments we are qualified to perform (Powers, 1993, p. 64).

The giving of medication was the major concern for casual staff who felt unable to remain up to date with drugs in all clinical areas. The processes of discontinuity were especially obvious in this area, as was the impact of not belonging in a ward.

> *Some things that you have to be really careful with, like drugs in* [a specialist area]. *You never feel that confident because you aren't doing it all the time. You're never quite sure what the right, you know, you can see what's charted but you haven't got in the back of your mind the knowledge, what is the appropriate dosage of this drug for* [this patient], *you know, so it would be harder to recognise something that's charted incorrectly.*
> (Hilary, 1:9)

Protecting self and others also involved using available resources to check and confirm before nursing actions were performed.

> *I'll go through the New Ethicals* [Drug Manual] *and read up things when I get the chance, and with IV drugs I tend to get the book out just about every time I give one just to make sure I'm doing it right and how I should be doing it, and yeah, when I come across a procedure in the ward that I'm not sure of I'll go and find someone, drag someone out, and hang round till someone is free and can tell me or show me what I should be doing, rather than just launching in there and doing it off pat, in case I stuff up badly.* (...). *I won't do anything, undertake anything that I'm not sure what I'm doing.*
> (Emma. 1:8)

There was an expectation that other staff would be particularly careful when checking medications with the casual staff.

> *... it annoyed me when the person who was checking something wasn't careful because I relied on them* ***more*** *than what I would have used to. I'm pretty, like, I'm quite confident with my actual* [drug] *calculations, myself, but it annoys me to see someone else be slack because it takes two people, and if two people put their signatures to something, I believe they should be checking it properly.*
> (Beth, 1:10)

A constraint against changing this situation was that the nurse perceived her position to be marginalised.

And I didn't think it was my place to be telling them, when I was the casual, to tell them, "hey, come on get your pencil out."
(Beth, 1:11)

Although this nurse was confident and experienced in this area of nursing, and she felt positive of her ability to practise safely in this situation, not all nurses have the ability to be as assertive, especially when placed in a marginal position. It can also be difficult to speak out when your employment status is insecure, especially if you and your family are financially reliant on that employment. This situation is in no way confined to casual employees, although their positions are the least secure of all employees. Nazarko (1993) noted that many nurses in Britain felt that their employment would be tenuous if they spoke out about employment conditions.

Protecting self and others is an extension of the usual protective component of nursing practice which is embedded in safe practice. The need for extra caution and alertness arises from the way in which casual nursing occurs within a context of unfamiliarity, discontinuity and marginality.

Stepping Back

Casual nursing involves many subtle changes to nurses' practise of nursing. The work involved of coping with discontinuity and managing marginality resulted in the participants thinking differently about their own nursing. How the participants perceived the way in which casual employment had changed their approach to nursing was included in the process of **stepping back.** Stepping back was a reactive strategy and was deeply enmeshed within the participants' experiences of casual nursing.

... it's not that I'm not dedicated. I don't know what it is. I actually have a different feel about going into an area. It's a, there's a different feel about going. Not that you're not dedicated, it's hard to explain. You just know you are there for eight hours, you're going to get your money, you do your job while you are there and you do it well, but there's a sort of floating feeling, temporary, yeah.
(Debbie, 1:10)

Casual nursing was seen as a phase and so was the stepping back process, with the nurses believing that their perception of nursing would again be different when they returned to permanent employment.

> *... because I see casual as being something that suits me, you know, and I don't actually feel that I don't belong. It's just a temporary phase. Going to work is a temporary phase.*
> (Debbie, 1:11)

Stepping back was often a response to the discontinuous nature of casual nursing. It also reflected the casual nurse's focus on the present, as she was unlikely to play a part in the future care of the patients she has cared for today. Closely aligned was also the separateness from the ward staff felt by many casual staff. The participants' commitment to nursing was focused on the here and now and the provision of nursing care in this particular duty, rather than the provision of nursing care within a set ward or unit.

> *... and it's very easy to think, I'll let them sort that out in the morning. It's not my ward, it's not my responsibility. I'm only accountable for what I do here tonight and you know you don't have to be there tomorrow to sort it out.*
> (Hilary, 1:15)

> *... it's really easy to take a back seat role* [when] *you think you don't know the place as well as everyone else.* (...). *It is much harder to, say, make a decision that goes against the grain, or to really push for something for your patient that your patient does or doesn't want. It's really hard, to really push for it. It's easier to leave it to tomorrow to someone else's responsibility.*
> (Hilary, 1:16)

Stepping back was often a reaction to the way in which casual nurses focused much more on the provision of direct nursing care. Their involvement with ward management was therefore lessened. Others felt that being able to step back was one of the positive aspects of being a casual nurse.

> *I used to leave notes for* [the ward clerk] *to get things fixed the next day instead of writing requisitions and sending them off myself, which I probably could have done if I had used my initiative.*
> (Beth, 1:13)

Unfortunately, for some casual nurses stepping back was a deliberate response to how they perceived they were treated by the whole experience of being employed as a casual nurse. Stepping back involved a retreat from a previous commitment to their employment. In spite of this, their commitment to nursing remained. The nurses still focused on providing the best nursing care they could because this was what their patients deserved, but felt that as their employing organisation was showing what they perceived as little commitment to their nursing practice, their commitment to the hospital was also limited.

> *So I just thought I would come to work and work and anything else I do extra will be for myself and not for the hospital.*
> So it has really changed the way you think about your nursing [being employed as a casual nurse]?
> *It has. I won't do anything for the hospital unless it's to my advantage. I mean I'm quite prepared to do things and get involved whereas a lot of nurses won't.*
> (Kate, 1:10)

Stepping back was therefore a protective mechanism for the participants. It enabled the nurse to distance herself from the perception of feeling marginalised by the hospital's apparent lack of commitment, which was reflected in her status as a casual employee. Andersson (1995, p. 134) explored the concept of marginality as it relates to student nurses undertaking clinical experience and noted that some students coped with the marginality of their role by a process of withdrawal especially "when demands became too great or go against the students' own conceptions of what the profession stands for." These students withdrew into pupil behaviour, where as some casual nurses step back from their commitment to the hospital.

Always being available, being flexible and fitting in with what the hospital needed, without the reciprocity of having the guarantee of the work, took its toll on the commitment of some nurses.

> *... we were on call till the day we were called in to work. If we weren't called to work we were unemployed. And if they didn't call us for a month we were unemployed.*
> (Ruth, 1:19)

This resulted in a change in commitment which altered to focus on providing patient care and gaining personal satisfaction from that process, rather than a commitment to the organisation as a whole. Historically, part-time workers have been expected to demonstrate less commitment to their work, a myth challenged by Clark (1986), who saw this belief as allowing employers to place constraints on the training and career development of part-time workers. The need to take into account the special commitment of workers who are not employed in a full-time permanent capacity has also been recognised (Hughes & Marcantonio, 1991). The type rather than degree of commitment will understandably be altered by different employment conditions and the way in which different staff are utilised.

Munroe (1988) linked the two concepts of organisational socialisation and organisational commitment and related these to part-time nursing employees. She stated:

> part-time nursing personnel usually are responsible for providing services directly to the organisation's clientele. The failure of all professional nursing personnel to identify with the organisation's attitudes and beliefs can reflect negatively on the agency and the nursing care it provides (Munroe, 1988, p. 60).

Commitment is also seen as a two way process involving both the employee and employer, and Deeks (cited by Smith, 1993, p. 50), states "employee commitment is more a function of how companies treat people. If people have energy, are interested and want to be involved, they will do the work." If staff perceive that their employer has less of a commitment to them than to their counterparts, who

are permanently employed, then an alteration in commitment from the employee could be expected.

The negativity was felt towards their employer, in particular senior management, rather than the department responsible for organising the casual staff. It was the employment policy which created the problem.

> *Well they don't have to pay holidays, they don't have to pay sick leave. They can call people in when they are needed rather than having a steady work force. They don't seem to mind that the care is probably less committed.*
> (Alice, 1:7)

Stepping back was a consequence of the way casual nursing impacted upon the individual nurse. It was reflected in an altered level of commitment to the hospital as an organisation, although the commitment to nursing, as a whole, remained. Stepping back was seen as a temporary phase, as was casual nursing, and for some, was an intermittent response to the interlinking processes of coping with discontinuity, endeavouring to retain competence and managing marginality, all of which are components of the casual nursing experience.

COMPROMISE WITHIN PRACTICE

Chapters Four and Five have explored the experiences of casual nurses and their perceptions of the way in which these have had an impact on their nursing practice. The processes of managing marginality and endeavouring to retain competence have been explored as a way of theoretically ordering and organising these experiences. Coping with discontinuity, as a central theme which integrates these concepts, provides the propositional link. Coping with discontinuity and the interrelated processes combine to describe the way in which casual nurses manage, integrate and assimilate these experiences, by a process of **compromise within practice.**

The concept of compromise within practice reflects nurses' reactions and responses to the way in which casual employment impacts on and alters their nursing practice. Compromise, a process of modifying and making concessions

(Thompson, 1992), enables the integration of both the unique diversity of personal circumstances and the complexity of professional demands associated within nursing practice in a way which allows individual nurses to manage their complex lives.

SUMMARY

This chapter has continued the exploration of how discontinuity within the practise of casual nurses impacts on their provision of nursing care. The marginal position of casual nurses, in relation to their permanently employed colleagues, has been discussed and the associated processes of creating mutuality, protecting self and others and stepping back, were explored. Finally, the linkages between managing the experience of marginality and endeavouring to retain competence, are developed by the emergence of the construct of compromise within practice, which provides a unifying perspective illuminating the impact of casual employment on the nursing practice of casual nurses. Chapter Six will now explore the way in which casual nursing affects and impacts on the nurse as an individual.

CHAPTER SIX

MANAGING RELENTLESS UNCERTAINTY

INTRODUCTION

Chapters Four and Five have presented the reader with a description and analysis of the impact that working on a casual contract has on casual nurses' practise of nursing. Coping with discontinuity encompassed the processes associated with working as a casual nurse and summarised how practising as a casual nurse required ongoing compromise within their practice. The discontinuous nature of casual nursing also results in its impact extending past the domain of the nurse's practice into the area of her personal and private life.

Casual nurses, by definition, are on call at short notice. They need to be contactable and available if they want to gain work. The more work the nurse requires, for what ever reason, the more she must make herself available, therefore developing a constant underlying consciousness and alertness to the possibility of work. The possibility of work is also buffered by the uncertainty of will there, or will there not, be work? For some nurses, particularly those who want to work frequently or who have to for financial reasons, this uncertainty becomes relentless.

MANAGING RELENTLESS UNCERTAINTY

The participants who worked infrequently or who were not attempting to gain full-time employment from casual work experienced less disruption within their personal lives. They were likely to be contacted less by the hospital requesting them to work and they were usually in a better position to decline work. For some, one of the major advantages of casual work is being able to decline work.

> *But the thing with casual is that it suits me wonderfully really. I can do whatever work I like and I can work when I like and I can take weeks off when I like. There's no obligation.*
> (Julie, 1:4)

Nevertheless, by never knowing when they would work, uncertainty remained as a major feature of casual employment for all participants.

> *But the only thing is it's never certain that you are going to get all the work that you want in a week. So say, for instance, I decided to have Tuesday or Wednesday off next week. It's all very well having those days off, but I might not have work on Saturday and Sunday, in which case I've only had three days in that week ...*
> (Julie, 1:6)

Managing the uncertainty of when they would next work required individual strategies and processes, sometimes resulting in elaborate organisation of not only the individual nurse but also her family, just in case work eventuated. It also was a process which altered over time.

> *... when I first went on casual I thought, well great, I'll be able to have a much better social life because I can just say no if I don't want to work. If I've got something else planned I just won't work, and that sounded really wonderful. But you find that's not the case at all. I find that you end up cancelling far more things ...* (...). *So you end up cancelling what you had planned out of fear that this might be the only day that you are offered all week.*
> (Hilary, 1:3)

The way in which a hospital organises its casual staff also has a marked impact on how the uncertainty of when work will be available is experienced by the nurses employed as casual staff. Prior knowledge, such as a day's notice of the availability of work, does decrease some of the experience of uncertainty, but the possibility of being called in to work remains.

> *... never knowing when the phone is going to go. You planned to do something, banking on the fact that nobody is going to ring you, and then they do. I'll think, oh well, it's three o'clock and so obviously no*

> *one wants me for an afternoon duty, so if they want me for a night they can leave a message on the answer phone, and I'm going to go out for an afternoon. And you just get ready, I've often just got ready to walk out the door to plan to go and meet someone, and the phone's gone and I've thought do I answer it or let it ring.*
> (Ruth, 1:9)

Gaining work is, of course, a reflection of the hospital's need for extra staff, a factor over which the nurse has no control. Being available and contactable provides no guarantee that work will be available.

> *I worked five days last week, or four and a half days. I worked four days before that and only two days the week before that. It's been quite good. I think it's the time of the year and the wards have been quite busy and more people are off sick so it's a good time to work. When I was doing casual over Christmas last year, it was terrible. I hardly got any work between the end of November and the end of January. I was, you know, lucky to get one day a week. (...). I could go for a week and do no work and then get three days the next week, but I wasn't getting more than four days a fortnight.*
> (Hilary, 1:2)

Nurses work for many reasons including financial need, social contact, and maintaining professional practice. These reasons for working do not change just because the hospital has no work available at that time.

> *Oh, I would rather have a full-time job. Just for the security of knowing I had one and having a routine so I could work my life around it because I do have other things in my life other than just waiting for the phone to go. And knowing that I am still going to be able to live at the end of the fortnight because I'm being paid regularly.*
> (Ruth, 1:22)

Managing the relentless uncertainty of when work will be available and the associated effects of this uncertainty are important features within the experiences of casual nurses. Two interlinked processes of living with intrusion and decision making by prioritizing constitute this experience.

Living with Intrusion

Being on call for work, a necessity of casual employment, results in a blurring of the boundaries between home and work. Kabanoff (1980, p. 68) defined work as a "spatially, temporally, and to an extent socially discrete, well defined role." Although it is impossible to completely separate home and work within any form of employment, casual work, by nature of its inconstancy and unpredictability, augments the interconnectedness. Being contacted at home about work can be experienced as intrusive, although in this case, a necessary evil associated with gaining the work needed.

> *I basically put myself down for what I was available that day or that week and they would just ring me.* (...). *I would put myself down for any duty and be rung three times, some days, for different duties. That's actually annoying in some respects because the system fails somewhere along the line and you finish a night duty and the phone goes at ten to see if you want to do an afternoon and you think, look in the bloody book. You've just woken me up for this duty I can't do.* (Ruth, 1:7)

The degree to which contact by the hospital about work was experienced as intrusive was closely linked to a number of factors. Being able to say no to work, rather than being reliant on it, and being contacted during the day, rather than at night or early in the morning, were important, as was whether or not the nurse had notified the hospital of her availability to work that particular duty.

> *I really don't like it when they ring you and you have already said you are not available, cos it's annoying to them, they get frustrated, cos*

> *they are only trying to do their best. And it's frustrating getting out of bed at six o'clock when you have told them you can't work Tuesday mornings...* (...). *But it's not my problem but it becomes my problem if I get contacted unnecessarily.*
> (Beth, 1:15)

Two strategies emerged as components of living with intrusion, those of accepting potentiality and preparing and planning.

Accepting Potentiality

Casual nurses know when they are employed, that their employment is of an as and when required nature, and that no work is guaranteed. For those nurses who choose casual employment, these conditions provide little concern. For others, who accept casual work as all that is available potential employment rather than guaranteed employment is a major concern. Being part of a potential work force does impact on many areas of the nurse's personal life. There is the need to be contactable and available, the need to be able to go to work at short notice, and the need to accept the possibility that sufficient work for personal needs may not be available.

> ... *if it gets that I can't get thirty two hours* [a week] *I would really seriously start thinking about what I'm actually doing.*
> (Julie, 1:2)

> *Cos I'm still feeling tired* [and] *I'm not on top, but I know that if I don't work tomorrow again, by Wednesday I'd be starting to wonder if the work's coming or not.*
> (Emma, 2:11)

Being treated as a potential work force was part of the experience of being a casual nurse. This was particularly in evidence when the participants discussed the way in which they were orientated to different wards and clinical areas.

... when I first went on casual at this hospital they put me in a medical ward to orientate for a day, and then I didn't work there for about a year.
(Hilary, 1:8)

I've been called to work in places and I've said "I haven't worked there before." I haven't had an orientation there, and basically your first day's work there becomes your orientation. They don't often call you in to orientate before you are needed. They just ***suddenly*** *realise that they need you and you haven't done any orientation so they beg and plead and say you will be alright if you go, and that's your orientation for ever after.*
(Hilary, 1:8)

Not only did the nurse not know when she would be required to work, but neither did the hospital necessarily know when they may need extra staff. Accepting the potentiality of work and the associated uncertainty was part of accepting casual employment. Although the participants were aware of these conditions when they commenced work, the social impact was only obvious with experience, as was understanding the degree of intrusiveness that this type of employment involved.

But I'm still mainly getting [work] *day by day. (...). Like when I did those five nights, a couple of nights, I'd go off in the morning* [and] *they would talk to the night staff and say "we are going to be busy again tonight.* [Emma] *is free. Can she come back?" It still wasn't, it's still rare if I get rung up for work a week in advance. It's usually the day before. One night I got rung up at eleven o'clock to work at eleven o'clock.*
(Emma, 2:3)

... and that's the thing about casual, they can ring you at a moment's notice. I suppose if they could be a bit more courteous and think of that person's life it wouldn't be so bad.
(Kate, 1:14)

The ability to cope with the potentiality of the employment was also seen by the casual nurses as one of their strengths.

> *But the fact that they can ring you, and at six thirty in the morning and you have taken it upon yourself, by being, casual to be there by seven, which I think is a real plus for casual nurses.*
> (Debbie, 2:5)

> *And in a way I think they were grateful being able to call me. I sometimes wonder if it's misplaced faith to call on someone so infrequently, and have every trust in them.*
> (Beth, 1:8)

Accepting the potentiality of casual nursing reflected the uncertainty associated with this form of employment. Although some of the participants had years of experience as casual employees, they still experienced a constant, underlying, concern that sufficient work may not be available or that the hospital could stop using casual staff. Knowing that there was only a set amount of work available for all casual staff gave little confidence to a nurse trying to meet her own employment needs, and for some, created a cyclical process of making themselves even more available so that they could gain the work necessary, in preference to others.

> *... with the job situation the way it is at the moment, you are not sure if they are going to continue with casuals. Are they suddenly going to stop using casuals? Are they going to employ 30 more casuals so the amount of work drops off?* (...). *You think, flip, where do we fit in all of this?*
> (Emma, 1:13)

Casual nurses could do little but accept the potentiality of their employment as one of the conditions which enabled them to work. Being part of a potential work force was more problematic for those who wanted regular work, but had important consequences for all casual nurses. **Accepting the potentiality** of casual nursing and coping with that process was assisted by continuous preparation and planning for the possibility of work.

Preparing and Planning

The uncertainty of casual work and the way in which it necessarily intrudes into the home life of the nurse, is managed by a number of individual strategies, all of which result from an ongoing process of preparing and planning for the potentiality of work. **Preparing and planning** occurs within two areas, that of the family and home and individual nurse, and also the preparations she makes specifically to cope with the on call nature of casual work. Being organised for work, or having time to organise oneself for work, made the process of going to work easier.

> *I love it when I get rung in the morning and I'm not going to work till that night or that afternoon.*
> (Debbie, 2:6)

No matter how organised or prepared the nurse may be for the potential of work being available, there was a necessity to be organised and plan other activities in case work did not eventuate. Therefore, frequently the nurses accepted work and then had to cancel their day's plans. The difference between working a set roster and casual work was obvious.

> *You know that you are going to work that day. And that's good. You can work around that. You fit everything in with that, cos you know you are going to be working so you don't do things on that day because that's the day you are going to work. Whereas casual, you might be going to do something else, and so you put that off to work.*
> (Gay, 1:9)

Those nurses who contacted the hospital in advance regarding their future availability for work frequently experienced a dilemma when their availability changed unexpectedly. They may have planned to be available, in many cases giving up to a week's notice of their availability, only to find that circumstances intervened. Some contacted the hospital regularly to notify them of their changing availability. Others just hoped that the hospital would not ring.

I've heard people say they put themselves down as available and then you ring up and they say no. So why do you put yourself down as available. But you don't know what's going to happen today. You might have a sick child or... They think that you should be at their beck and bloody call basically, and that's where they get you on casual. And they know we need the work. It's our way of surviving and then on the other hand, we've got to have a life too.
(Kate, 2:5)

Maintaining the stance of being available and contactable took a degree of planning which, in some instances, became quite elaborate, and frequently involved other family members.

Like you can be at home and you can be called every minute of the day. Like I had this whole roster set out. I gave the (...) hospital two phone numbers, one of this home and one of my husband's at work. And he would know where I was. (...). And that's sort of giving you more stress because you think I had better do things now whilst I'm still at home.
(Sue, 1:8)

I've said I'm going now and I will be back after lunch and I will give [the hospital] *a ring. If anything comes up I will work, and that way I have sort of sussed my morning out and got the evening meal ready for them at home and I was sort of resigned to the fact that I could work this afternoon.*
So that was a lot of forward planning?
It's what you've got to do. Plan and think well, I might be working this afternoon and a lot of times you could be starting something and you've just got to drop it and organise your family life too.
(Kate, 1:15)

Some participants organised their family responsibilities and engaged in this sort of planning to enable them to go to work if required. Others engaged in the planning to modify the nature of being on call and to enable them to maintain their life style and non-work commitments.

The thing is with casual that gets me is that I hate the way you have to wait around. I don't. I won't wait around. So if I'm busy I just ring and say "I will ring you after twelve." (...). Cos otherwise they don't get an answer from me. I'm not around and they think I'm not interested in the work.
(Julie, 1:5)

But with casual I (...) presume that you're going to work, so you may bustle ahead and do things, whereas if you knew tomorrow you had a certain shift, you could put some of it off and do it then.
(Emma, 2:6)

Planning and preparing also greatly assisted those nurses who were wanting to work frequently, by increasing their contactability. They contacted the hospital to notify them of their availability, and some purchased answer phones so that they were contactable, even when not at home. Being contactable increased their chances of gaining work, as did being able to agree to work frequently.

Saying no to work did become problematic for some nurses who felt their employment to be tenuous and based on them remaining available. *Sometimes you wonder if you say no too often, will they stop asking you* (Hilary, 1:3). Attempting to remain available, and trying not to have to say no to work, also required extensive planning at times.

But sometimes I've got something on and (...) I don't really like saying no. I get the person on [answering] *the phone to say I'm not home. It's awful, cos I know if you say no a couple of times they get annoyed with you and they won't ring you up again, so it's easier to say she's not at home...*
(Kate, 1:6)

Others felt more secure in their employment, and were able to decline work without feeling so vulnerable. **Planning and preparing** allowed casual nurses to actively manage the uncertainty of their employment status and the potential nature of casual nursing while still fulfilling both their individual and family responsibilities. Planning and preparing occurred in different extents for individual

nurses, depending mainly on their reliance on the work and the frequency which they were available to work. Planning and preparing also allowed the nurses to maintain the contactable state, so important for their continued employment.

Decision Making by Prioritizing

A major component of the experience of being a casual nurse was the constant uncertainty regarding the availability of work and the personal consequences resulting from this. Accepting or declining work involved many interconnected decisions and a constant process of prioritizing personal and professional responsibilities.

> *... so I learnt from that, you're risking not getting paid, but to make sure that I have at* ***least*** *one set day off a week that I'm not going to be available so I can really rest and know they're not going to call me. I don't have to worry about the phone, and just make that a real rest day.*
> (Emma, 1:5)

There was also a degree of choice, although for some, this choice was illusionary.

> *... say you have planned to go out to a movie or have some friends, or go to friends for dinner and then the phone rings and you are asked to work and you don't just say no because you think, well, I only worked three days last week and I might not get any work for the rest of the week....*
> (Hilary, 1:3)

> *I made this policy to say no once a week. (...). To say no. Just so then that they knew you* ***would*** *say no. But then that wasn't always the case because then if I hadn't worked or if they hadn't called me all week I would be, oh neat, I need the money. I have to go.*
> (Ruth, 1:18)

Two main strategies were involved in the decision making process, those of linking, and responding to reciprocity.

Linking

Casual work was seen by many as a way in which to successfully link work and non-work responsibilities, specifically allowing women with children to remain in the work force when they would have been unable to undertake full-time work. The need to fulfil simultaneously responsibilities, both at work and home, continued to be a factor within the decision making processes involved with accepting or declining any work which was offered. *I asked specifically for social hours or night shift, just because of* [my family] *you know* (Carol, 1:2).

The financial basis for working often provided strong motivation to accept work.

> *But then again if you have something planned, like they ring you up and you really desperately need the money, there goes your social life again.*
> (Sue, 1:10)

An important consequence of casual work was that, with no work guaranteed, neither was a regular income. Few participants did not rely on their income from casual work to either support their family or themselves. Lacking a regular and guaranteed income had important social consequences, including difficulties with credit ratings and obtaining financial support. In particular, it made planning a financial future difficult. Cole (1994) discussed the same situation affecting bank nurses in Britain and commented "you can't get a mortgage or even an HP agreement because you are not considered a good risk" (p. 20). New Zealand casual nurses faced similar problems.

> *Because, just, no bank's going to give me a loan on my income and there's no guarantee. Your pay can fluctuate so much from one pay to another. A great pay next week and nothing for a month.*
> (Emma, 2:14)

> *That's not a good feeling, if you have a mortgage and you want to have some future planning.*
> (Sue, 1:7)

Linked to the lack of guaranteed income was also the lack of sick leave and sick pay available to casual nurses. Although employment conditions differed, and in particular, the entitlement to sick leave was variable in different areas, nurses were left feeling financially vulnerable. Whereas agency and supplemental nursing staff overseas commonly receive premium salaries to compensate this vulnerability (Bliss & Alsdorf, 1992; Braddy, Washburn & Carroll, 1991), casual nurses within New Zealand are unlikely to receive any extra financial compensation.

> *That was the one thing I'm kind of worried about, if I get sick.* (...).
> *You can't afford to get sick.*
> (Emma, 2:6)

Making a choice not to work when unwell was a possibility, but also linked with a financial penalty. Going to work when unwell was the only other option.

> *Since then I've learnt to say no and if I feel like I'm getting run down*
> *I just ring up and take my name off.*
> (Emma, 2:6)

Linking work, family and financial responsibilities was a complex task, further compounded by an ongoing process of prioritizing. The participants not only needed to decide if they could work, but if they could also maintain other professional interests as well. A common theme was an interest and willingness to attend hospital based in-service sessions, even if this was without pay, but frequently the financial reward associated with accepting work, instead of attending an in-service session, in the nurse's own time, was more important. Carpenito (1991), in discussing the need for a commitment to voluntary lifelong learning to retain professional competence in nursing, has called for individual nurses, management, educators and professional organisations to take combined responsibility for encouraging ongoing nursing education. If casual nurses are to participate in in-service sessions, then recognition of the financial constraints needs to occur.

> *I really wanted to go too, but I got called the night before to do a night shift and it was one of those situations again when I thought, gosh, you know, I haven't worked for a few days so I had better go to work and the in-service was at one in the afternoon and I thought I would get out of bed and go, but I didn't quite make it. And you know I couldn't plan my shifts around that I wanted to go to this in-service and when it came down to it, earning the money was more important than attending that lecture...*
> (Hilary, 1:8)

Attending in-service programs in the nurse's own time was also difficult, if not impossible, for those with pre-school children.

> *... it's actually coming home to me a little bit lately after looking at the in-service and things. It's virtually impossible for me to get to them, mainly because of the children, because most of them are during the day. I'm not prepared to leave my family so it is difficult, but I know I'm missing out. And that's partially by choice I suppose at this stage, and that is partially why I'm not working full-time and that's why I am on casual.*
> (Debbie, 1:4)

Hardy (1990) discusses the need for the nursing profession to investigate the impact of the "second shift" on women who carry a significant majority of the family responsibilities as well as undertaking paid employment. Concerns were raised about the major implications of the "second shift" on nursing as a profession. Within this research, women with dependants were distanced from professional issues, not because of their lack of interest, but because their employment status resulted in a continuous process of balancing. When the women were offered work, they made their decision based on family, work and personal priorities, compromising their own needs rather than those of their families. At times, this compromise was not recognised from within the profession.

Although the benefit of casual work for many was the way in which it could be fitted to suit other non-work responsibilities, the nurses were constantly involved in prioritizing work and other responsibilities. Therefore making the choice of whether or not to accept work was a complex decision. Some components of casual nursing, such as being able to decline work, were beneficial in the **linking** process, whereas other components such as the uncertainty of when work would be available and the financial insecurity, were at times detrimental.

Responding to Reciprocity

A final factor involved in the process of decision making, inherent in accepting work, was the presence of the feeling of reciprocity between the nurses and the staff involved in organising their work. Accepting work occurred for many reasons, including wanting to work now, and as a way to guarantee more work in the future. Also involved was the way in which the casual nurses understood both the positions of the ward staff, working in an area that was short staffed, and the position of the staff requesting them to work, who were attempting to provide nursing cover for short staffed areas.

> *I feel sorry for the poor person that rings through the list and can't get anyone.* (...). *... and I do think it's a waste of a nursing staff member's time.* (...). *... she can sit there for an hour and go through the call list and get no one...*
> (Debbie, 1:12)

The understanding of this personal perspective of casual nursing altered the professional relationships which developed between some casual staff and the staff involved in coordinating the casual staff, and had a definite impact on the decision making processes involved with accepting available work. Responses such as *I didn't have the heart to say "look, stuff it." I mean she has been so good to me,* (Emma, 2:4) were common.

Responding to reciprocity was a two way process, with the nurses who would say yes to work, even though they may not have made themselves available for that shift, understanding that by saying yes, they were both helping the hospital at a time of crisis as well as improving their chances of getting work in the future.

The way in which employment involving blurring of the domains between work and non-work had implications for the relationship between the employee and employing organisation was noted by Ronen (1984). Also involved would be the employee's relationship between the non-work domains of leisure and maintenance activities.

> *... it does put a lot of pressure on you to work. And I can understand from their point of view, if they have rung everyone else that is available and they can't get anyone else, they may think you will change your mind if they ring you. So I can sort of understand it from their point of view, but it is frustrating.*
> (Hilary, 1:4)

The inability of the hospital to always obtain casual staff for all of their staff vacancies was definitely seen as a hospital problem rather than that of the casual nurses. Attempts to encourage staff to work by telling them of an inability to gain staff had both positive and negative consequences.

> *But I need the money and I go through this major crisis every time the phone goes thinking do I, don't I? Occasionally I've been made to feel really guilty for saying no. There's a couple of supervisors who will say, "we've tried* ***everyone*** *else on the list and we* ***really*** *need someone to work," and then you say yes and think I didn't really want to say yes.*
> (Ruth, 1:8)

Williams (1992) supplied a different perspective in a rare and enlightening profile written from the perspective of an employee of an agency ringing and requesting staff to work. He stated "when I said 'we're really desperate', as I tried to fill a shift, I was not telling fibs" (Williams, 1992, p. 47). Changing a request to work into a plea was seen by some as making the hospital's problem the nurse's problem, an approach which was disliked especially if a degree of reciprocity between the staff involved had not been developed.

The alteration in commitment of casual staff, from the hospital as a whole, to a focus on their own nursing practice, and the way in which having a choice whether or not to work was seen as one of the few positive factors associated with casual nursing, meant that **responding to reciprocity** was a situation by situation response, which could not be anticipated or guaranteed.

COMPROMISE TO ENABLE PRACTICE

Responding to reciprocity and linking both emerged as important strategies within the process of decision making by prioritizing. Its relationship to the process of living with intrusion is contained within the necessity of casual nurses to manage the relentless uncertainty and the individual consequences which resulted from their employment status. Managing relentless uncertainty and its interrelated processes provide a description and analysis of the way in which casual nurses engage in **compromise within their personal lives to enable them to practise nursing.**

Casual nurses engage in many strategies which enable them to work as casual employees. Central to all of these strategies is the need for the individual nurse to create and engage in an ongoing process of compromise, which facilitates the changes necessary within both the nurse's personal domain, and that of her family, so that she can undertake casual work and manage the special conditions that this form of employment imparts.

COMPROMISE FOR BALANCE: LINKING PERSONAL AND PROFESSIONAL DOMAINS

The processes of compromise to enable practice and compromise within practice are components in the central process occurring within the lives of casual nurses, that of **compromise for balance**. This central process constitutes, modifies and modulates the experience of being a casual nurse, providing the link between the personal and professional domains in the lives of the nurses. These processes have been integrated within a conceptual model (Fig. 1).

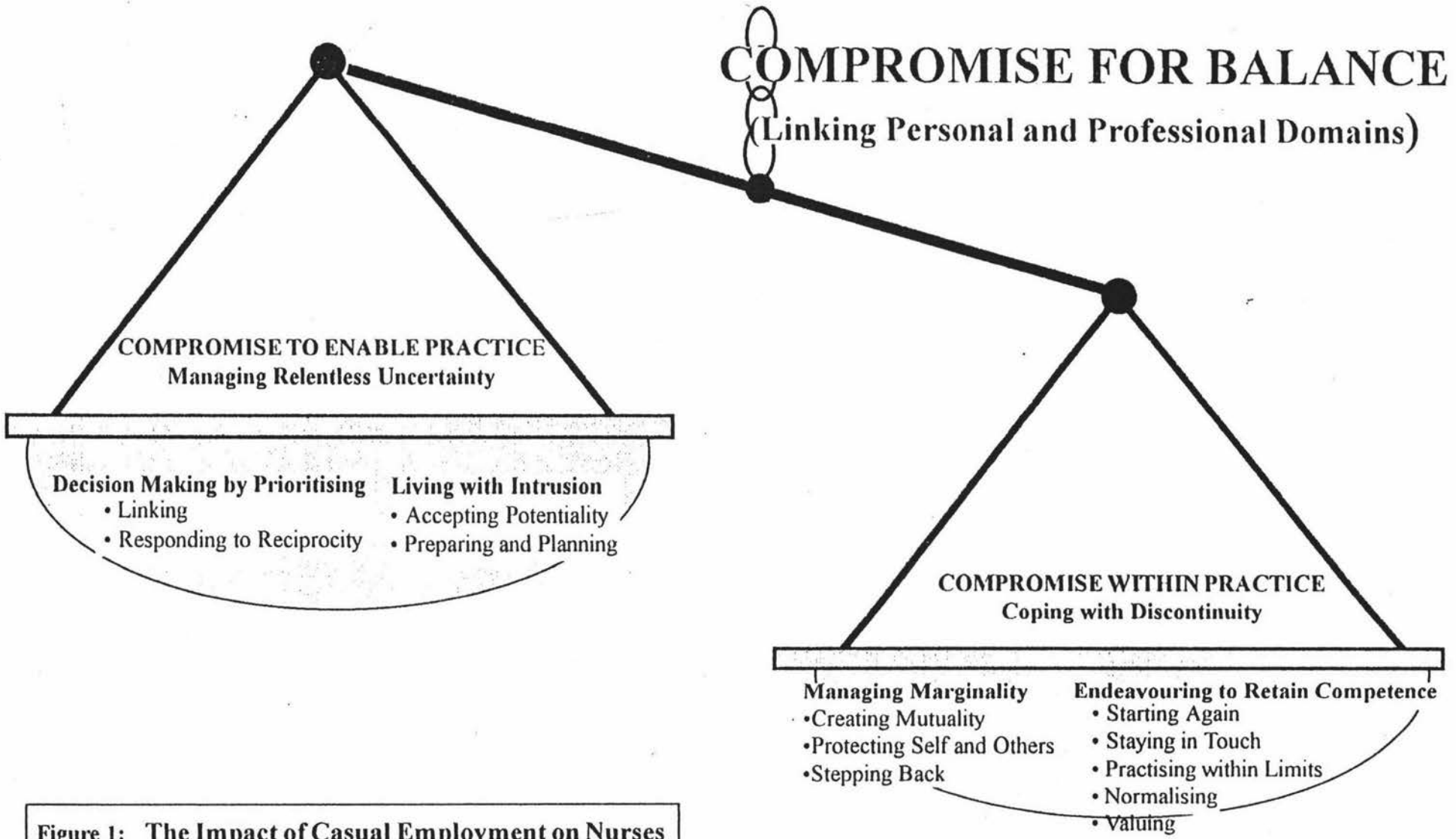

Figure 1: The Impact of Casual Employment on Nurses and their Practice of Nursing

The degree of compromise varies between individuals and over time, as personal and professional circumstances change. Balance, as an individually defined experience, reflects the degree of success of the processes, compromise to enable practice and compromise within practice, to link the personal and professional domains of the nurse's life in a satisfactory way.

Balancing always involves a process of compromise, whereby mutual concessions are made, enabling the maintenance of stability within both the individual's professional and personal arenas. Without compromise, and with a resultant imbalance, continued employment would be difficult.

The potential for imbalance results directly and indirectly from the mode of employment. Associated with the uncertainty of when the next work day will be is the uncertainty of income, an uncertain future and therefore a resultant presencing in the here and now, without the luxury of a future perspective or plan. For those who are reliant on the income, or who are in search of more permanent employment, the impact can be marked and the degree of compromise to retain a sense of balance, significant.

It would be artificial to separate an individual from her actions and, in this way, the impact of casual employment on the individual nurse is inseparable from its influence on her nursing practice. The process of compromise for balance provides the key to how employment as a nurse on a casual contract impacts on the nurse and her nursing practice.

SUMMARY

This chapter has explored and analysed the way in which casual employment results in nurses making changes within their personal lives to enable them to practise nursing. These changes all include a component of compromise and particularly, a response to the uncertain nature of casual nursing and the way in which this uncertainty impacts on the individual. The two interlinked processes of decision making by prioritizing and living with intrusion were examined, as were the components of linking, responding to reciprocity, accepting potentiality and preparing and planning.

Finally, the conceptual model, with its central process of compromise for balance, was presented. Compromise for balance identifies the pivotal process in which casual nurses engage, responding to the way that casual employment causes changes within both their personal and professional lives. Chapter Seven will further discuss this model and develop the implications of this research on nursing practice and the nursing profession.

CHAPTER SEVEN

DISCUSSION, RECOMMENDATIONS, AND LIMITATIONS

INTRODUCTION

Within this research casual nursing, from the perspective of the casual nurse, has been explored and a critique offered. Grounded theory, as the research methodology, has been used to analyse and finally encapsulate the experience of casual nurses within a conceptual model, the pivotal process of which emerged as a process of compromise for balance.

Although the number of participants in this study was small, and attempts to provide a representative sample covering a wide variety of locations where casual staff are employed were not made, each participant provided meaningful insights into the lives of casual nurses. By using the grounded theory methodology, an overarching perspective has been obtained, encapsulating the individuality, diversity, and commonalities within the experiences of the participants. Arising from within the participants' stories and the data analysis have been a number of implications for nursing practice and nursing research. Within this chapter these implications, combined with recommendations, will be discussed, as will the limitations of this research.

IMPLICATIONS FOR NURSING PRACTICE

The central process of compromise emerged from this research and provided us with an insight as to how employment on a casual contract impacts upon the nurse and her nursing practice. As has been described in Chapters Four, Five, and Six, the breadth of influence of this form of employment is widespread, and has implications for the nurse, her nursing practice, and her family. Although this study has remained focused on the perspective of the casual nurse, and intentionally, the way in which the presence of casual nurses in the work setting impinges on the practise of permanent staff, or upon patients, has not been investigated, it is obvious that there are corollary implications for nursing as a whole.

Many of the current moves within nursing, which are associated with development and maturation of the profession, are irrevocably linked and interconnected with the ideal of a permanent, stable and organised nursing work force. Discussions within nursing literature of topics such as continuity of care, primary nursing, clinical career pathways, and specialist nursing practice, frequently exclude contingency workers, such as casual nurses, because their existence is incompatible within the philosophies which underpin these developments. But casual nurses, bureau nurses and agency nurses are now well integrated into the nursing work force in New Zealand and worldwide. If these professional developments are seen as being vital to the profession of nursing, how can we as nurses exclude so many of our number from these developments?

On the other hand, constantly publicised are also concerns about how changes within the organisation of the nursing work force, and specifically those brought about by health reforms, impact on issues of patient safety (O'Connor, 1994/1995) and quality of nursing care (Alsweiler, 1994; Mullinix, 1991). Also associated are concerns about the way in which these changes can also place individual nurses at risk of legal liability (Fiesta, 1990; Moroney, 1994/1995). Casual nurses, and the casualisation of the nursing work force, are always cited in these contexts. If nursing and nurses are to support each other and work together for the good of the profession, the provision of quality nursing care, and the benefit of all nurses, then some middle ground must be reached. Styles (1991) stated:

> our responsibility as a profession is to ensure that the right nurse is at the right place at the right time with the right knowledge and skills and the right motivation (p. 354).

It is appropriate that these comments were made within the context recognising the need to bridge "the gap between competence and excellence" (Styles, 1991, p. 353) within nursing practice. The question of where do casual nurses fit within the push for nursing excellence must be asked.

It is obvious that the need for some contingency workers, such as casual nurses, will continue, but it is also appropriate that there are concerns raised about the widespread use of casual staff as replacements for permanent staff. The participants within this study were very aware of the multiplicity of ways in which

their employment on a casual basis influenced their nursing practice. Although no measures were used to evaluate the nursing care provided by the participants, their own perception of their nursing practice was reflected within their experiences of self satisfaction, their self evaluation, and reflection on their practice. Providing competent, and at times excellent nursing care, was possible, but limitations imposed by the casual nature of their employment, such as the discontinuous character of their practice, frequently impinged on their ability to do so, and forced them to compromise their personal standards of nursing care provided. These standards were set against their own, individualised measure of the quality of nursing care the nurses were able to provide. Attree (1991), in discussing the concept of quality nursing care, described how often quality is seen as a value judgement. This was definitely reflected within the perceptions of the casual nurses who participated in this research. Hogston (1995) further defined the concept of quality in nursing practice and commented:

> From this standpoint it would appear evident that quality is a term depicting favour to those people who judge it. Quality of care thus becomes a subjective phenomenon because it means different things to different people, patients and nurses alike (p. 117).

Employing nurses on casual contracts has broad implications, not only for the individual nurses but for all nurses and nursing as a profession. The participants in this study worked within a number of limitations, some of which directly reflected their employment contract conditions. Other limitations were indirect effects, resulting from the way in which the casual nurses were utilised. Some nurses chose casual employment and accepted these conditions as a compromise associated with allowing them to work. Other nurses had no choice as other employment options were not available. The limitations included less access to orientation, less access to paid in-service education, no sick leave, and limited or no performance appraisal. Also obvious was the impact of prolonged job uncertainty, underemployment, and financial insecurity.

Concerns also must be raised about the way in which accepted employment conditions, and especially rostering regulations are not always adhered to for casual employees. It appears to be up to the individual nurse to monitor the regulations and apply them to her work schedule, something which can be difficult

when a nurse feels unable to refuse work for financial or other reasons. The incidences of casual nurses working three different shifts in quick succession, having split days off, and working double shifts appear to be becoming more common (Moroney, 1994/1995) and these occurrences are largely invisible if the nurses are not rostered, and work in many different clinical areas. Branthwaite (1990) called for nurses to be aware of the hours of work clause within their nurses' award and to enforce these regulations. She stated "by not enforcing this clause and by agreeing to be rostered in an illegal way you are weakening the argument for setting down working conditions" (Branthwaite, 1990, p. 9).

NZNO's Industrial committee presented draft standards for rostering, linking safe rostering with health service moves towards accreditation and quality management. Their draft standards included:

> Standard 1: The roster meets legal requirements and is in line with the relevant employment contract.
> Standard 2: The roster will be fair and equitable.
> Standard 3: The roster takes into account 24-hour biological rhythms and/or nurses' lifestyles (Industrial Report, 1994, p. 11).

These standards would be difficult to apply to casual employees and if the working conditions are being eroded for casual nurses, at what stage will permanent staff also feel the impact?

Davidson and Bray (1994) have presented New Zealand based research on the area of women and part-time work and their study supports the findings of this research. Their study of women part-time workers, including those in the health sector, recognised the increasing job insecurity experienced, the lack of advancement and training opportunities for part-time staff, and the underemployment component of part-time work for some. Also identified was the way in which many women "thought that full time work was seen as superior to part time work" and they went on to say that the part-time workers:

> wanted to be valued and appreciated by full time workers, especially given that many part time workers fulfil roles of 'fill-ins' or 'support staff for full time workers (Davidson & Bray, 1994, p. 19).

Shuttleworth (1994) also raised the issue of part-time nurses being discriminated against in terms of their access to in-service education when compared to full-time staff, a finding reflected within the experience of the participants in this study. Casual staff, with less job security than their part-time colleagues, are even more vulnerable to discrimination within working conditions.

Although not directly researched within this study, a concern raised by participants was the employment of new nursing graduates as casual nurses. The professional appropriateness was questioned, as was the availability of professional support and the impact of casual work on inexperienced nurses, who in the future may be required to perform as experienced staff. If experienced casual nursing staff constantly compromise within their nursing practice to enable them to cope with the discontinuous nature of casual nursing, are we, as nurses, compromising within our profession by allowing new graduates to be employed in this way? It begs the question, as to whether it is possible to be a casual professional or a professional casual.

The importance of the development of collegial relationships between casual and ward staff, as well as between casual staff, to enable and support nursing practice have been explored within this research. Henneman, Lee and Cohen (1995) have recently explored the concept of collaboration as it relates to nursing practice. They state:

> Collaboration requires many types of sharing: shared knowledge, shared values, shared responsibility, shared outcomes and shared visions (Henneman, Lee & Cohen, 1995, p. 106).

Collaboration is only possible if there is an understanding of what it is like for the other group involved in the collaborative process. The concept of creating mutuality in this research highlighted the attempts made to develop this understanding so that nurses could work together, for the benefit of both groups of nurses and the patient. If casual employees are to continue to be utilised, then efforts to decrease casual nurses' experience of marginality, and increase the degree of collaboration, would be beneficial to all.

> Individuals who are involved in collaboration benefit from the supportive and nurturing environment it creates. Collaboration substantiates the unique and important contribution made by an individual, hence reinforcing feelings of competence, self-worth and importance. The 'win-win' attitude which accompanies collaboration promotes a sense of success and accomplishment in meeting individual as well as team objectives (Henneman, Lee & Cohen, 1995, p. 107).

These implications have a widespread impact which must be addressed by the profession as a whole. Casual nurses, who are voiceless because of their vulnerability, deserve and require the support and valuing of their work by their own profession. Fierman (1994) provides a thought provoking comment on American industry when she states the:

> drive for flexibility and cost cutting runs head-on into another key imperative: the growing belief that competitive advantage hinges upon retaining a work force that is motivated, creative, and independent - empowered, in the current jargon. That goal will never be achieved by companies operating with a largely disposable work force" (p. 29).

The nursing profession, as a whole, needs to address these issues in a proactive way and on behalf of the most vulnerable members of its profession, or will labels such as "a wasted asset" as have been applied to part-time nurses (Jackson, 1991, p. 49), soon be applied to casual nurses?

CASUAL NURSES: AN ENIGMA?

The label casual nurse, innocuous as it may seem, has the ability to conceive many, mainly negative, connotations about the casual nurse as an individual, and her nursing practice. It is hoped that this research has challenged and dispelled some of the myths surrounding casual nurses and their practice, by making their experiences visible. Collegial relationships, which enable nursing practice, are reliant on the development of a degree of empathy and an understanding of what it is like to stand in the other person's shoes, and this is only possible if both perspectives are visible.

Casual nurses have become an integral part of our health services, and yet, they remain an enigma within the nursing profession. Their existence is recognised mainly as a sign of the detrimental changes occurring with health reforms, but with an absence of part-time nursing positions available, many nurses are prepared to accept the limitations of casual work so that they can continue working while integrating their other responsibilities.

Casual nursing is also an enigma, a paradox, for many of the casual nurses themselves. Parts of the experience suit, whereas others are seen as very detrimental to the nurse's nursing practice. Coping with the enigma is only possible by compromise.

LIMITATIONS OF THIS RESEARCH

While this study has explored the experiences and perceptions of a group of casual nurses and these experiences have been encapsulated within a conceptual model, there are limitations of this research which must be acknowledged.

Artificial temporal boundaries were placed on this study, by its nature as a piece of academic work, and this resulted in a number of limitations as to the sample size and breadth of geographical locations involved in this research. The need to negotiate access with multiple levels of management was time consuming, and if other geographical sites, involving other Regional Health Authorities and their Ethics committees, had been included, there would have been greater restriction rather than expansion of the study. These limitations have the potential to limit the generalisability of this research.

Although the process of theoretical sampling was utilised, access to other casual nurses whose conditions of employment and usage within their hospital was different than those within the study, could have led to the emergence of different codes, and altered the data analysis. As stated in Chapter Three, the general rather than specific applicability of a grounded theory study is important, as is its acceptance by participants and other nurses, of it being generally representative of their experience.

The imposition of an artificial time frame also prevented a more in-depth study of changes occurring and experiences over time. Although all of the participants had experience as casual nurses before the study, the experience of being a casual nurse changed over time and detailed study of this aspect was not always possible.

The participants involved, and their employing organisations, deserve and require total confidentiality. The need to safe guard nurses' employment, by confidentiality and anonymity, has been seen as paramount within this study, and therefore many identifying details which may have enlightened the reader about different nursing practice, and organisational differences, have been omitted.

As with any research, and with a constant focus on the emergent data analysis, research decisions were made as to how processes, such as theoretical sampling, would be undertaken. Although these decisions flow from the data, they are ultimately personal and subjective decisions, with the power to change the focus of the research at any point.

Finally, it is impossible to deny that my own personal interest and experience as a casual nurse has shaped my perception of the experiences of casual nurses. I have constantly questioned my own stance and have attempted to raise underlying assumptions which have developed from those experiences. I have been surprised and amazed at the frequency which participants have shared insights into their experiences which I had previously not connected in any way with the experience of being a casual nurse. I believe that my own experiences provided me with a sensitivity and starting point which enabled, rather than directed, this research.

IMPLICATIONS FOR FURTHER RESEARCH

This research has specifically focused on casual nurses and their perceptions because, up until now, their stories were largely unknown and unheard. It was therefore necessary to undertake preliminary and tightly focused research which could provide a base on which other studies could develop. Many more questions than answers have emerged from within this research, a number of which were directly raised by the participants.

Nurses working within hospital services work collectively. Any changes occurring for any group will automatically impact on others within the group. In this way those nurses employed permanently are likely to experience changes within their practice because they work with colleagues employed on a casual basis. There is also the potential for patient care to be affected. These effects and influences need to be examined, especially in the light that the cost effectiveness of using casual staff has not been researched within the New Zealand context.

A potential research question, which arises from the current economic outlook, is the long term impact on the individual and the nursing profession of unemployment or underemployment of experienced and qualified nurses. Although a shortage of experienced nurses has been mooted in many quarters (Underwood, 1994/1995), most of the participants in this study, who wanted either full-time or part-time employment, of a regular nature, within a ward or unit, had accepted casual work as all that was available.

Other questions which need to be explored to provide a wider perspective on casual nurses, include an analysis on the different conditions of employment under which contingency or casual nurses are employed, and an exploration of the different ways of utilising and organising casual nurses. For some participants the intrusive nature of being on call for casual work appeared to have been modified by the systems in place in different hospitals and the methods used to contact and book casual staff. Research, and the resultant sharing of information, could impact greatly on how some casual nurses experience this part of their employment.

Many unanswered questions have arisen during the process of this research. This study has provided a beginning stance, from which the experience of being a casual nurse can be further explored, and the impact of this form of employment on the health services as a whole, can be examined.

CONCLUDING STATEMENT

Grounded theory methodology has been used in this study to explore the experiences and perceptions of nurses employed on casual contracts. A conceptual model was developed, encapsulating how this form of employment impacted upon the casual nurse and her practise of nursing. The central process in which casual nurses engage, of compromise for balance, emerged through the process of data analysis, and was supported by two interlinked processes of compromise to enable practice and compromise within practice. Coping with the discontinuous nature of casual employment and the resultant employment uncertainty and insecurity of this form of work has special implications within both the personal and professional domains of the lives of casual nurses.

Casual employment is chosen by some nurses because of the flexibility it imparts when managing multiple responsibilities, especially those involving caring for children and dependants. Other nurses were employed on a casual basis because they were unable to obtain other forms of employment. Although this created differences within their experiences, casual nurses still, on the whole, had to engage in significant compromise within their nursing practice.

Casual nurses fulfil a vital function within our hospital based health services, enabling nursing services to be provided when staffing levels are otherwise inadequate. This research has provided an initial study into casual nurses' experiences. Other research, exploring different perspectives of the utilisation of casual nurses is needed, so that the nursing profession, as a whole, can decide on how best to professionally support these nurses and manage the impact of this form of employment on the delivery of health services.

APPENDICES

APPENDIX ONE

LETTER OF INTRODUCTION

11 April 1994

[Home Address Edited]

Hi

My name is Lesley Batten and I am a student at Massey University and also a registered nurse. I am interested in talking to registered nurses who work on "casual" to find out what their experiences of being a casual nurse are. This study is part of my Masters Degree. [...] management have given me permission to do this study but are not otherwise involved.

If you are interested in talking to me about your experiences, please phone me and we can discuss what is involved in the study.

My home phone number is [...]

Looking forward to hearing from you.

Lesley Batten

APPENDIX TWO

MASSEY
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Telephone 0-6-356 9099
Facsimile 0-6-350 5668

FACULTY OF
SOCIAL SCIENCES

DEPARTMENT OF
NURSING AND
MIDWIFERY

INFORMATION SHEET

Title

The Enigma of the Casual Nurse. A Grounded Theory Study Exploring the Experiences of Registered Nurses Employed on Casual Contracts

Researcher

Lesley Batten

You are invited to participate in a research study which is examining how casual employment affects nurses and their nursing practice. I would like to hear your experiences so that I can gain a better understanding of how casual work helps or hinders you. This research is being completed as part of the requirements of a Master of Arts degree.

If you agree to participate in this study, you will be asked to take part in 1-3 personal interviews with the researcher. I would anticipate that the interviews would last approximately one to one and a half hours, and would occur at a place and time convenient for you. These interviews would be tape recorded and then the tapes would be typed onto computer disks and printed. I would then analyse the information. This information will all be coded so that no information which could identify you would be included and will only be available to myself, the typist and academic supervisors. The information (tapes, transcripts and disks) will be kept in a locked place and tapes and disks will be wiped at the end of the study. If required, you can have your interview tape returned to you.

The study will be written up in the form of a thesis and the findings will be shared with other nurses and health professionals. Some extracts from interviews will be quoted but no information which could identify you or where you work would be included. I will supply you with a summary of the findings at the end of the study and you can read the full thesis if you wish.

You may refuse to answer a particular question or ask for a section of the tape to be wiped. You can also ask that the tape be stopped at any time during the interview. I will answer any questions you have before or during the interviews as they arise.

I hope you will consider participating in this study. I am happy to answer any questions you have either on the phone or I can meet you in person.

Yours sincerely

Lesley Batten

Research Supervisor: Professor Julie Boddy, Ph (06) 35 69 099 Extn 4333

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FACULTY OF
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DEPARTMENT OF
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MIDWIFERY

APPENDIX THREE

CONSENT FORM

Title

The Enigma of the Casual Nurse. A Grounded Theory Study Exploring the Experiences of Registered Nurses Employed on Casual Contracts

Researcher

Lesley Batten

I have read the Information Sheet for this study and have had the details of the study explained to me. My questions about the study have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I also understand that I am free to decline to answer any particular questions or to withdraw from the study at any time. I agree to provide information to the researcher on the understanding that it is completely confidential.

I voluntarily agree to participate in this study under the conditions set out in the Information Sheet.

Signed _____

Witnessed _____

Date _____

Name _____

Address _____

_____

_____

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