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DISSERTATION

A MIXED METHOD STUDY OF FLEX NURSES' WORK-RELATED SOCIAL RELATIONSHIPS

Submitted by

Maura Stilson MacPhee

School of Education

In partial fulfillment of the requirements

for the degree of Doctor of Philosophy in

Education and Human Resource Studies

Colorado State University

Summer 1999

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COLORADO STATE UNIVERSITY

MARCH 22, 1999

WE HEREBY RECOMMEND THAT THE DISSERTATION PREPARED UNDER OUR SUPERVISION BY MAURA STILSON MACPHEE ENTITLED A MIXED METHOD STUDY OF FLEX NURSES' WORK-RELATED SOCIAL RELATIONSHIPS BE ACCEPTED AS FULFILLING IN PART REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY IN EDUCATION AND HUMAN RESOURCE STUDIES.

Committee on Graduate Work

Adviser

Department Head/Director

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ABSTRACT OF DISSERTATION

A MIXED METHOD STUDY OF FLEX NURSES' WORK-RELATED SOCIAL RELATIONSHIPS

The health care industry has undergone radical changes during the past ten years. To remain competitive, many hospitals have adopted nurse staffing models that accommodate patient census variability. One model, the Flex nursing model, is comprised of nurses who work without benefits and can be cancelled if not needed. In turn, the nurses design their own work schedules.

Little is known about individuals who choose flexible work arrangements. According to American business predictions, however, "flexible workers" are desired in times of change, and flexible work models are expected to increase in the future.

The purpose of this dissertation was to study the nature of social relationships at work for nurses within a Flex nursing model. The socialization process and its outcomes, social supports, are considered critical to the formation of job satisfaction, work commitment, and job retention. If flexible workers are going to be an important component of the organizational workforce, it is necessary to understand how these individuals meet their social needs at work.

A mixed method case study employed a standardized assessment tool, The Social Network Questionnaire, to contrast differences in social network composition and emotional and instrumental support needs between Flex nurses and Regular nurses. The

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qualitative component of the study consisted of Flex nurse interviews and observations of Flex nurses interacting with their co-workers.

There were no significant differences in overall network composition between Flex and Regular nurses. There were differences in the utilization of peers for different kinds of emotional supports. The qualitative portion of the study revealed four major themes for Flex nurses. These themes were: flexibility, safety, support, and commitment.

Triangulation between the qualitative and quantitative findings, and between the study's outcomes and the nursing and organizational psychology literature, identified some important training and development considerations for individuals who comprise flexible work systems.

Maura Stilson MacPhee
School of Education
Colorado State University
Fort Collins, CO 80523
Summer 1999

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CHAPTER 1

INTRODUCTION

Statement of the Research Problem

The purpose of this study was to explore the work-related social relationships of "Flex" nurses at The Children's Hospital of Denver. Many health care settings have employed Flex health care workers to increase staffing flexibility. Staffing flexibility has helped hospitals adapt to fluctuating patient census demands in the turbulent health care market (Warren & Rozell, 1995). Flexible staffing options have also become an important career consideration for nurses who desire more lifestyle flexibility (Brodell, 1996).

During the past decade, American organizations, including health care institutions, have "reengineered" in order to stay competitive (Hammer & Champy, 1993). Reengineering has included structural changes, such as eliminating middle management layers to "flatten" the organization. "Product quality" and "customer service" are business operative terms, and organizations look at service processes as well as outcomes.

The new process focus has changed the way industry views workers and the nature of work. Workers are given authority to analyze their work, and to make their work processes more efficacious and customer-friendly. Along with a paradigm shift in workplace responsibility and control, organizations have bolstered the recruitment and retention of talented people. Hospitals, for instance, are currently dealing with an

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experienced nurse shortage (Curtain, 1995), and recruitment and retention of experienced nurses has become a critical initiative in many health care organizations.

The paradigm shifts of reengineering require an examination of the underlying relational issues, such as workplace socialization, that affect service processes and outcomes. Workplace socialization, however, has never been well understood. Perhaps, because it is a process; it has been difficult to determine the critical, work-related variables to measure along its developmental course (Van Maanen, 1976). Van Maanen defined organizational socialization as the "process by which a person learns the values, norms, and required behaviors which permit him to participate as a member of the organization" (1976, p. 67). Measurement and evaluation of socialization have been compounded by the rapid changes occurring in the workplace (Herriot, 1995). Many work-related studies have focused on socialization outcomes, such as job satisfaction, job commitment, and intention to stay (Wanous & Colella, 1989).

In the nursing literature, there are numerous studies that have investigated relationships between job characteristics and socialization outcomes, such as job satisfaction. The majority of these studies were intended to address retention issues—how to retain talented people (Blegen, 1993). These studies confirmed that workplace socialization factors, such as group cohesion and team respect, positively influence professionals' satisfaction with work (Hinshaw, Smeltzer & Atwood, 1987). Other research studies also showed that positive work relationships among nurses positively affect patient outcomes, an important consideration with the health care industry's concern for the client.

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Although the outcomes of workplace socialization have demonstrated relevance, and many variables associated with socialization outcomes have been studied in detail, there is a dearth of nursing literature on how nurses become socialized to their work environment, or the process by which social support systems are established and implemented. In addition, the nursing research on social support has been confounded by different conceptual and operational definitions. According to Hupcey (1998), "Definitions tend to be vague and simplistic and rarely specify types of relationships, interactions between the provider and recipient, or the actual needs of the recipient for support" (p.1232).

Reengineering has wrought many changes in how organizations are designed and how they function, yet there is little known of how nurses are coping with change via work-related social support systems. In particular, reengineering has generated numerous nurse staffing models to adapt quickly to patient census needs. The basic model is a core-ring model (Atkinson, 1984). "Core," or Regular employees, are usually full-time or part-time nurses with fairly specific work schedules and access to benefits. "Ring," or Flex staff, are nurses who support the Core nurses on an as needed basis. Despite multiple permutations of this model, there have been few studies addressing the workplace issues of the Flex nurses who play an increasingly important role in the maintenance of hospitals' delivery systems (Hollabaugh & Kendrick, 1998). The business literature has speculated that as many as 50 percent of all American workers will be engaged in flexible working arrangements by the year 2000 (Nollen & Axel, 1996).

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This study, a mixed method case study approach, will present a picture of workplace socialization for Flex nurses at The Children's Hospital of Denver. The quantitative analysis will provide comparative information about social support network structures of Regular and Flex nurses at the hospital, and the qualitative analysis will provide Flex nurses' themes pertaining to socialization and social supports within the hospital system. The primary unit of analysis was the Flex nurses, since Flex nurses may represent the types of workers necessary for adaptive organizational change.

"Triangulation," or combined methodologies, helped verify findings from the different methodologies, and this approach uncovered unique case qualities or variances not apparent via one method.

The Research Questions

Qualitative studies pose general research questions to guide the inquiry. Although quantitative research begins with specific hypotheses or research questions, qualitative research employs a "grand tour" question and a few subquestions. The grand tour question represents the broadest line of inquiry, and the subquestions are more specific topics to be covered during interviews and observations (Creswell, 1994). Qualitative research questions also contain language that "encodes" the type of tradition (ethnography, biography, et cetera) being employed, and "foreshadows" the study's methods and analyses, since each qualitative tradition has specific approaches to collecting, analyzing, and presenting data (Creswell, 1998). For this case study, I examined two grand tour questions: "What is it like being Flex at Children's?" and "What work relationships are important to you as a Flex nurse?" The former question provided detail about the Flex nurses' perception of themselves in their work

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environment. The latter question offered detailed information about the nature of Flex nurses' work-related social relationships. Subquestions included explorations of work-related relationships with regards to helpfulness or lack of helpfulness. As themes emerged in the conversations with Flex nurses and observations of Flex staff in their work environments, other questions were addressed to delineate what was going on. For instance, Flex nurses were asked about their definitions of emotional and instrumental supports, and their thoughts and feelings about "commitment." Although a series of open-ended questions guided the interviews, they were constantly and spontaneously revised to capture what was being addressed by the nurses in their interviews. The qualitative research questions, therefore, were used to create a description of the Flex nurses' work relationships—primarily the composition and function of their social networks at the hospital. The process of developing social connections at work was also revealed.

A quantitative portion of this case study utilized a standardized assessment tool, The Social Network Questionnaire (Antonucci, 1986), to elicit information about similarities and differences between Flex and Core nurses' work-related social support networks at Children's Hospital. In addition to descriptive data, there were a series of comparative and associational questions.

The major quantitative research questions were:

1. Is there a relationship between demographic variables (Regular/Flex nursing status, hours worked per pay period, months worked at Children's, number of nursing units worked), and social network variables (number of network members, and proportions of peers and managers per three closeness rings)?

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2. Is there a relationship between demographic variables and social network variables with regard to emotional support variables (reassurance, confiding, respect,upsets, major life decisions)?

3. Is there a relationship between the demographic variables and social network variables with regard to satisfaction variables (wanting more people in the network, wanting more people for emotional support, and wanting more people for instrumental support)?

Definitions of Terms

A case study is a qualitative approach that explores a bounded system (bounded by time and place) through an in-depth collection and analysis of qualitative and quantitative data. The multiple sources of information may include interviews, focus groups, direct and participant observations, surveys, document analyses, and audio-visual analyses. The context of the case involves an overview of the social, historical and economic settings of the case. The focus of this case was an instrumental one, where the case (Flex nurses of Children's Hospital of Denver) was used to illustrate workplace socialization. A detailed description of the case and its emergent themes is called a within-case analysis (Creswell, 1998).

A mixed method approach uses "at least one quantitative method and one qualitative method to collect, analyze, and report findings in a single study" (Creswell, 1997, p. 3). Foster (1997) recommended that triangulation of methods should occur at the conceptual level. Conceptual triangulation involves: a) conducting research according to the paradigmatic assumptions of the respective method (qualitative or quantitative); b) identifying pertinent results within each approach; c) verifying

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confidence in the results from each method; and d) constructing a conceptual model that respects the patterns of relationships and meanings within and between methods. "Integration across method occurs only after qualitative and quantitative results have been achieved and examined within method" (Foster, 1997, p. 4).

Organizational socialization is a process and sequence of stages that begins with an awareness of the organization's purpose and one's place/roles within the organization, and culminates with "certain signposts of successful socialization" that indicate passage from newcomer to insider (Wanous & Colella, 1989, p. 99).

Social support is also a dynamic process that depends on characteristics of the recipient and the provider, and the reasons for providing support. Social support typically implies "various, reliable forms of tangible and intangible assistance which enable an individual to feel affection, esteem, and part of a network" (Zunz, 1998, p. 42). Some social support researchers have addressed negative or unsolicited types of social support (Hupcey, 1998).

An individual's social support network is her network of relationships that can include family, friends, workplace colleagues, community members, et cetera (Bandura, 1997; Cohen & Willis, 1985). Social networks can provide a variety of material and emotional resources, but they can also be conflictual (Cramer, Riley, & Kiger, 1991). The dimensions of social networks include overall size, degree of closeness among members, degree of contact, types of support (typically described as emotional or instrumental), and density, or degree of familiarity among network members (MacPhee, Hoffenberg, & Feranchak, 1998).

Other terms associated with social support in the nursing literature include

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collegiality, which implies "some degree of networking, and interdependency...(Collegiality) within a discipline enables its members to function collaboratively with members of other disciplines" (Hansen, 1995, p. 11). Social intimacy, a new term in the nursing literature, has been defined as "the sharing of an individual's appraisal of stress and the unloading of troublesome thoughts"(Moore, Kuhrick, Kuhrick, & Katz, 1986, p. 28). Social interdependence is Bandura's (1997) term for the relationship between individuals and their social environments. This relationship is "reciprocally deterministic" (p. 31).

Social/socialization needs and nontechnical needs are used interchangeably. Social, nontechnical needs are individual needs fulfilled through social interactions. The "needs" terminology derives from Maslow's human needs hierarchy (Maslow, 1954). Theorists, such as Argyris (1964), Herzberg (1968), and Likert (1961) analyzed organizational systems and management styles in terms of meeting the needs of employees.

Flex or flextime represents self-scheduling flexibility. Nurses are able to specify the shifts they will work and the units where they will work. Although Flex arrangements vary by institution, most Flex nurses get paid more per hour than Regular nurses, but they do not receive benefits, and they are the first to be cancelled when patient census drops. Flexible staffing allows institutions to increase nurse numbers during peak census times and to decrease the number at low workload times (Wulff, 1994).

Reengineering is a business concept that signifies "the fundamental rethinking and radical redesign of business processes to achieve dramatic improvements in critical,

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contemporary measures of performance, such as cost, quality, service, and speed" (Hammer & Champy, 1993, p. 32). Reengineering starts with customer needs and works backwards. Individuals in direct contact with the customers are encouraged to enhance customer outcomes by replacing obsolete service processes with new, more revolutionary processes. There are close links between reengineering and Total Quality Management (TQM). TQM tends to be more incremental. If there are problems with a process, the direct line workers are expected to remove the waste or non-valued added activities from the process. With reengineering, individuals are allowed to replace whole processes. Restructuring and downsizing are predecessors of reeningeering introduced in the 1980s, that are other, incremental ways to eliminate non-valued added work, such as unnecessary management layers. All of these approaches, incremental or radical, are expected to increase organizational flexibility.

Delimitations

Although an in-depth case study includes multiple sources of information, due to time and resources constraints, this case study relied predominantly on one-on-one interviews with Flex nurses, participant observation, and convergent data from the quantitative assessment tool. It would have been ideal to do one-on-one interviews or focus groups with Regular nursing staff, nurse managers, nurse educators and human resource personnel to glean their appreciation of Flex nursing at Children's Hospital, but this was not feasible to do within the confines of this doctoral study.

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Assumptions and Limitations

Mixed method approaches pose unique problems, especially for solo researchers who must operate concurrently from two paradigms. In an ideal world, there would be multiple researchers with well-funded research support and unlimited time to do such a study. Nevertheless, I chose to use a mixed method approach, because I wanted to benefit from looking at a phenomenon from within and between two different paradigms. This was a learning experience for me, and I realize that by adopting a mixed method approach, given my personal and professional circumstances, my data have considerable limitations.

There are certain assumptions underlying the mixed method approach. Although some researchers refer to the relative "weights" of methodologies based on their contributions to study objectives, this may create "paradigmatic tension" and threaten the credibility of the mixed method approach (Foster, 1997). Instead, Foster recommends that a) The researcher equally values qualitative and quantitative methodologies, and b) The researcher has no a priori conclusions about the methodologies' contributions to the study. My assumption was that a mixed method approach would enrich my qualitative and quantitative research skills; I anticipated learning from both paradigms. How we search for meaning is less important than our conviction to find meaning.

Significance of the Study

Reengineering took hold in the health care industry over a decade ago. Health care providers realized that incremental systems changes were not sufficient to compete, to innovate, or to meet public expectations (Blancett & Flarey, 1995). To stay

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viable in the health care market, Children' Hospital underwent reengineering several years ago. The Flex nursing model (and its evolution) is a byproduct of reengineering. This case study of the Flex nursing situation at Children's will highlight the negative and positive aspects of reengineered health care systems.

One aspect of Flex nursing, the social interdependencies of its members, was chosen for closer scrutiny, because a driving force behind reengineering is the people and how they relate to one another (Kofman & Senge, 1995). The human resource development literature refers to "communities of commitment" and "learning organizations," but as Kofman and Senge pointed out, no one is clear about "commitment to what?" Although people and the quality of their interactions seem to determine organizational success, no one has taken an in-depth look at the social relationships of people at work. How do people relate to one another in the workplace? How did reengineering affect cooperation or competition among people? Such exploratory questions will help us understand the social processes that underlie successful organizational reengineering.

This case study will provide a rich description of Flex nurses' work-related social relationships. Quantitative research studies have yielded information about socialization outcomes, such as job satisfaction and organizational commitment (Blegen, 1993; Tett & Meyer, 1993). A few quantitative studies have investigated outcomes of reengineering, such as performance efficacy and customer satisfaction (McCloskey et al.,1994; Kinneman, Hitchings, Bryan, Fox, & Young, 1997). These statistical portrayals have been helpful, but to understand the whole picture, where the sum is greater than the parts, qualitative inquiry is necessary to understand how the

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"nuance, setting, interdependencies, complexities, idiosyncrasies, and context" all fit together (Patton, 1990, p. 51). This is particularly true with regard to people and their social interactions. Hastings and Waltz (1995) applied a mixed method approach to assessment of professional practice redesign, and Kovner et al (1993) used a qualitative format to investigate reengineering initiatives, but these studies did not include flexible staffing.

Flexible staffing is a relatively new phenomenon in nursing (Wulff, 1994). Little is known about the specific, work-related needs of this nursing population. For instance, over the course of one year (1996-1997), Flex nurse coverage of Children's Hospital nurse staffing needs increased by 30 percent. Despite an increased demand for this type of nursing coverage, there have been no systematic assessments of these nurses' training and development needs for over five years (personal communication, Kersey, May 1998).

This will be the first study to examine Flex nurses' work relationships in the work context. This will add depth to our understanding of how these nurses represent reengineered work environments. Previous research on Flex nurses has focused on surveys or questionnaires of job satisfaction and employee morale (Buckley, Fedor, Kicza, 1988; Cooperrider, 1980; Miller, 1984). These studies revealed that the Flex model was appealing to many nurses, but they did not provide descriptions of the internal dynamics that drive work relationships and affect the outcomes reflected through the surveys and questionnaires. In addition, many of these quantitative studies were conducted at the beginning of the reengineering movement, when the concept of

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flexible staffing was new and exciting to nurses and management. How has it changed in the perspectives of the nurses since its inception many years ago?

Case studies provide in-depth descriptions that allow people not familiar with a phenomenon, such as Flex nursing, to understand what it is all about (Patton, 1990). The intricacies of work-related relationships can be better defined through the words and actions of the nurses themselves. This qualitative methodology will provide detailed documentation of the commonalities and unique variations that exist for Flex nurses within one system.

The mixed method approach will increase confidence in the results by converging data from two different paradigms. "Conceptual triangulation allows the researcher to highlight strengths of each method" (Foster, 1997, p. 6). Convergence will take place between method-specific findings, and between study findings and the research literature. What we know of behavior is intimately tied to the research methods we use to study a problem. Although more complicated, the mixed method approach should provide a check and balance for the human tendency to "force the problem to fit the method" (Plante, Kiernan, & Betts, 1994, p. 52).

This case study, therefore, is a step towards providing a holistic appreciation of a reengineered situation from the perspectives of a Flex group of nurses within one system, The Children's Hospital of Denver.

Researcher's Perspective

When a researcher enters the setting under study and personally engages in activities or events within the setting, she is called a "participant observer" (Patton, 1990). There is a continuum of degree of engagement or participation. These types of

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observations are considered an asset in qualitative research; the researcher is able to get close to the people and situations being studied, and personal reflections provide richer portrayals of everyday life. For this to work, however, the researcher must practice "empathic neutrality," or the ability to empathize with the multiple perspectives of the setting in a non-biased way. "The investigator does not set out to prove a particular perspective or manipulate the data to arrive at predisposed truths...Rather, the investigator's commitment is to understand the world as it is" (Patton, 1990, p. 55).

Empathic neutrality is difficult to achieve. The researcher must be capable of "empathic introspection and reflection based on direct observation of and interaction with people" (Patton, 1990, p. 57). There are qualitative strategies to assist with this process, but for a solo researcher, there is always the risk of personal ideologies getting in the way.

In my case, I received graduate training in naturalistic observation studying aggression among and between two wolf packs. I also worked as a psychologist's research assistant, videotaping and micro-analyzing prosocial behaviors in toddlers. My specialty in nursing is the assessment of feeding interactions between mothers and their infants. This has depended on trained observation skills. Throughout my professional careers I have achieved comfort with doing field or naturalistic observations and recording behaviors systematically. I have not, however, tested my capabilities in situations personally close to me--my peers.

I have worked as a staff nurse and clinical specialist at Children's Hospital for 15 years. During that time, I have prided myself on my ability to be caring but objective towards my clients: I consider empathic neutrality an important component of

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expert nursing. This is different though, from undertaking a case study as participant observer. I am a part of the network of nurses I studied. I had thought that I might do my study in another, unfamiliar institution, but those professional ties of potential bias also provided me with a special degree of access to people, situations and resources that would have taken me considerable time to match in any other institution. I have had to be especially careful, therefore, to practice empathic neutrality and to honor confidentiality during my exploration of Flex nurse work relationships at my institution.

I have experienced some unusual emotions over the past few years. I used to do clinical nursing care three days weekly (full-time) on a medical unit. I had a strong identity as a regular staff member with a great deal of expertise, and I enjoyed this status. I made a decision, however, to undergo a role change, and I competed for and trained to be a medical case manager for my unit. Case management has been an essential tool of the reengineering movement, and I wanted to be a part of the action. It was a hard transition for me, however, because all of the sudden, I was at a desk with a phone, and the staff's behavior towards me changed. There I was, rounding with the doctors, talking with insurance companies, arranging care conferences for families--but not doing patient care. I felt an emotional distance develop between myself and my peers (doctors and nurses), and I did not like being treated in an "outcast" fashion. I decided that the case management position was not for me, and I turned my career towards academics and teaching.

The emotional contact with other health care professionals "in the real world" is very important to me. I also appreciate the contact with the children and their families;

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at present, I maintain these contacts by acting as a clinical instructor for nursing students one day a week. I supervise the students' direct care of patients, and this has allowed me continued contact with nursing unit activities. My decreased contact with the staff has taken a toll. I feel less close to the nurses, even those individuals I have known for a long time. We still work well together, but much of the personal intimacy is gone. My sensations of "detachment" made me wonder about the Flex nursing experience: These nurses work so many units and shifts under variable conditions. When I first learned about the Flex concept, I became curious about the nature of social relationships between these nurses with their peers at work.

My personal bias is that we all need to have a place, and we all need to feel secure and attached through others. I've always been a student and proponent of attachment theory. I have worked with infants who do not thrive and grow because they are not securely attached to their primary caregivers. I have seen the devastating effects of non-attachment on self-esteem and self-identity. My proclivity for studying social relationships of nurses stems from my belief that these connections matter.

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CHAPTER 2

LITERATURE REVIEW

Reengineering

The classical school of management in the early 1900s viewed people as objects or producers. This mechanistic approach measured organizational success in terms of efficient outputs: The social aspects of work were either ignored or viewed pessimistically. This management approach became known as Theory X. (Rothwell, Sullivan, & McClean, 1995).

Human relations came in vogue during the mid-1900s. The Hawthorne experiment, although flawed, focused attention on the organization as a social system. Environmental manipulations did not affect worker productivity. Instead, congenial relations with peers and managers significantly affected worker output. "Each individual, highly variable and complex due to a unique genetic composition and family, social, and work experiences, becomes even more valuable and complex when placed in interaction with other unique individuals" (Wren, 1979, p. 348). This optimistic view of workers became known as Theory Y (Kreitner, 1995).

In psychology, Carl Rogers and Abraham Maslow focused on the intrinsic qualities of human motivations and needs. In education, Cyril Houle and Malcolm Knowles researched adults' learning needs and found that adults' primary reasons to learn are love of learning, a desire to find solutions to problems, and a desire for social relationships. In business, McGregor and Argyris argued that traditional bureaucratic

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structures foster dependence and passivity. To awaken human innovation, they proposed Theory Y management approaches that respect people's capacities to share, and to create with others (Rothwell et al., 1995).

Participative or Theory Y organizations use as little authoritarian control as possible. Employees are granted considerable freedom and responsibility, and they are expected to work collaboratively to get the job done (Benton, 1995). Although Theory Y approaches have been lauded by the business world, the implementation of this management style has been problematic. Our society is a competitive one, and it has been difficult to promote people's attitude changes. People intrinsically believe in competition, although human relations strategies promote cooperation (Kofman & Senge, 1995). According to Keys (1998), "It seems clear that Theory X is well rooted in American culture and American management. While participatory principles have been espoused by numerous management systems, the notions inherent in Theory X are quite comfortable to far too many American managers" (p.15).

There has been a slow drift back to Theory X management strategies, despite the superior performance of Theory Y organizations. "The (Theory Y) techniques harness some powerful and intrinsic human forces on behalf of an organization" (Keys, 1998, p. 17). The Theory Y approach appeals to people. For nurses, Theory Y promotes factors that are considered most important to job satisfaction, such as ability to practice autonomously (Blegen, 1993). Nevertheless, with the escalation of health care costs, governmental financial and regulatory controls and managed care, organizations have focused on cost-driven concerns despite a symbolic commitment to patient-driven quality care. In the mid-1990s, for instance, many organizations ignored

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human relations issues while cutting costs through downsizing. "Neo-Theory X" management behaviors created employee distrust and work stress (Keys, 1998).

Reengineering is a revolutionary business process that embraces Theory Y management philosophy. It focuses on the "people" aspects of organizations. Reengineering happens at the customer level where employees transform obsolete processes to better meet client expectations. Reengineering involves an employee-oriented approach to organizational governance, culture and climate, standards of performance, measurements of customer satisfaction, and overall service delivery. Reengineering can result in a 20 to 50 percent change in processes with emphases on quality, timeliness and satisfaction (Hammer, 1996; Hammer & Champy, 1993).

The major precepts of reengineering rely on human relations constructs, such as respect for the individual, teamwork, lifelong learning, and trust. Many of these constructs have become organizational reengineering goals incorporated within vision and mission statements. There are a few case study evaluations of reengineered organizations that indicate favorable outcomes for the organizations and their employees (Flarey, 1995; Smith & Flarey, in press).

The major problem with most organizations' implementation of reengineering is a subtle encroachment of Theory X mentality. Theory X represents an old paradigm of task orientation with people as objects/producers. In the reengineering paradigm, employees are respected as professionals. According to Kanter:

> Professionals share a knowledge base, methodology, and standards of excellence that characterize a community of practitioners. Elaborate training, peer review, and ethical codes encourage application of knowledge to high standards with minimal supervision. Furthermore, professionals generally advance in their careers by adding knowledge, not by climbing a job ladder (1997, p. 159).

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Curtain (1995) claimed that the reengineering paradigm has created a shift away from organizational loyalty to professional loyalty, or a self-commitment to provide quality service.

> Employees must learn to redirect their loyalty from their employer to their work, commit themselves to self-development and skills enlargement and see employment contracts that provide enough stability to enable them to do their best work, free from unproductive anxiety. As they invest in themselves, they become more valuable (Curtain, 1995, p. 52).

Nursing is a profession amenable to reengineering strategies. Nursing has always been a process-driven profession, and it has always focused on patient outcomes (McCloskey, 1990). Recent reengineering initiatives for nurses have included process-focused reorganizations of nursing activities, such as shared governance, case management, and flexible staffing (Kovner, Hendrickson, Knickman, & Finkler, 1993). New, computerized information systems (informatics) have been instituted to reduce documentation tasks and to address communication efficacy (Patterson, Blehm, Foster, Fuglee, & Moore, 1995).

Shared governance models have granted nurses varying degrees of control over their standards of practice within institutions. Some models include nurses on hospital governing bodies where staff nurses have equal representation, while other models are restricted to unit-based nursing councils (Porter-O'Grady, 1987).

Nurse case managers are expert nurses who coordinate patient care for complex patients. With managed care, hospital patients are usually sicker and they require more coordination of services during hospitalization and after discharge to home. Coordination efforts can be time-consuming and frustrating, especially for clinical care

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staff. Case managers provide smoother care delivery for patients, and relieve the responsibilities of clinicians (Zander, 1988).

Other nursing practice innovations indicate paradigmatic shifts. For instance, professional development programs within institutions encourage nurses to identify their learning interests and to master skills sets and proficiencies for certification and career advancement. Nurses are being encouraged to develop professional portfolios (Flynn, 1997). Institutions are also creating peer networks to share clinical expertise within and across disciplines (Kaye & Jacobson, 1996).

Flex nursing is a product of reengineering that works best under participative management. It is a staffing model that allows nurses to choose their schedules in exchange for professional care of clients. There are few controls in the new paradigm. Flex nurses are held accountable for maintaining professional standards of practice with minimal supervision. They are also held accountable for providing quality care in a timely manner (Kutash & Nelson, 1993; McLaughlin, Thomas, & Barter, 1995).

Although there have been favorable reports of organizational reengineering, nurse-specific reengineering strategies have not been well-investigated. McCloskey and colleagues (1994) found that systematic evaluation strategies have been lacking, providing equivocal evidence for reengineering innovation outcomes. For instance, with regard to shared governance models:

> There is a lack of standardization of shared governance models and the specific structures and processes that are implemented are usually not clearly specified. Studies to evaluate shared governance tend to lack rigor, yield mixed results, leave questions as to what has been evaluated, and produce little opportunity for comparing results (p. 40).

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Kovner and colleagues (1993) used interviews with institutional executive officers and professional staff to assess the implementation of several nurse reengineering projects, including shared governance and computerized documentation. The interviewees were asked about their assessment of these innovations as well as their involvement in their implementation. Site visits and interviews were conducted at 37 hospitals throughout New Jersey where reengineering strategies had been instituted based on monetary awards from the New Jersey Department of Health. These hospitals were charged with developing innovative models to attract and retain nursing staff. The models were instigated in 1989 and qualitative evaluations were done in 1991.

Many hospital executives stated that although they had implemented the formal elements of nurse reengineering, there were still "implementation crises." Changing the mind-set of nurses was reported to be a major implementation difficulty. After two years, however, some institutions reported that nurses were "thinking on a different level," and "were more involved in making decisions." Executives made specific implementation recommendations: "take sufficient time to plan; involve staff early on and emphasize education; involve all the relevant ancillary departments; start with strong units as pilots; investigate variations on the theme; and get the philosophy in place first" (Kovner et al., 1993, p. 28).

Shared governance was evaluated positively by the majority of staff and executives. The nurses appreciated the increased autonomy and felt more satisfied with their work environments, but they also felt that this was a time-consuming, emotionally intensive process. Some nurse managers had trouble ceding authority to staff, and there

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was residual skepticism among some staff--"Are they really going to let me decide this?" (p. 31).

Computer documentation met with some resistance at the beginning, but after dealing with vendor delays and developmental bugs, the majority of nurses and executives felt that documentation and communications were improved through new informatics systems.

Overall, organizational executives reported that staff were requiring at least two years to accept and accommodate to change. In many respects, implementing more than one change at a time was overwhelming to everybody. The executives felt that the changes had positive impacts on nursing professionalism. They viewed the change as healthy for nurses, because there were more opportunities for nursing staff to assume leadership roles and to exercise autonomy over their practice. Of note is that this article had few quotations or direct reports from the nurses themselves. The focus was predominantly on the executives' perspectives of reengineering.

Brannon (1996) critiqued another reengineering strategy that reoganizes nurses' work activities, the re-introduction of "nonprofessional nurses" (nursing aides, practical nurses). In the 1980s, nonprofessional nurses were eliminated as hospitals adopted all-professional (registered nurses) nursing staffs. Nurses were expected to do everything for their patients. "Primary nursing" was a means to get nurses back to the bedsides where they could get to know their patients well and respond more quickly to patient needs. Professional nurses became responsible for mundane tasks, such as bed baths, and bed making. The latest trend has been to re-implement a stratified work force with nonprofessional staff available to relieve nurses of less technical tasks.

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Brannon's critique was based on political issues that have arisen between hospitals and the American Nursing Association (ANA), particularly its California branch, the California Nursing Association (CNA). ANA and CNA members have been involved in federal and state legislative hearings, and legal disputes with hospitals over the re-introduction of nonprofessional health care providers. Many ANA/CNA members have voiced their resentment of reengineered work designs that displace them from the bedside and potentially reduce the quality of patient care.

Parker & Slaughter (1994), and Schiff and Goldfield (1994) argued that managerial work redesign methods focus exclusively on cutting labor costs and increasing productivity. Brannon (1996) and these other critics of reengineering presented nursings' views of change via large, organized groups, such as the ANA and the CNA.

Forte and Forstrom (1998) also addressed the problems with "skill mix" (using nonprofessionals), particularly the negative reactions from nurses. They stated that these types of work redesigns are doomed when management neglects to plan for how professionals think about their work. Nurses, however, need to recognize that they are ultimately in charge of task delegation decisions. They possess the professional knowledge to know what different patients need, and they have the authority to determine which nursing interventions will make the greatest difference. These authors argued that how change is communicated to nurses, and how nurses view their extended roles are serious issues that have not been adequately addressed in many, reengineered organizations.

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The nursing literature suggests that reengineering strategies have had mixed implementation success. According to Keys (1998), the essential difference between positive and negative reengineering outcomes may reside with Theory X or Theory Y approaches to implementation. The management literature forcefully argues that reengineering empowers people by shifting authority to workers and encouraging cooperation (Hammer, 1996). On the other hand, there are critics of reengineering who are concerned with management's ability to support Theory Y principles.

Flex Nurses

There are few studies that address work attitudes and issues from the perspectives of Flex nursing staff. Most research has contrasted work attitudes of part-time versus full-time nurses (LeGrow, 1993; Werbel, 1985; Wetzel, Soloshy, & Gallagher, 1990). Werbel (1985) investigated the relationship between part-time and full-time nurses and their primary life involvements as measured by two, 3-item scales (work involvement, family involvement). There was no significant relationship between work as a primary life involvement and nursing status. This study was limited by the instruments used, and similar to other studies of the 1980s, this research had a narrow focus.

Wetzel et al (1990) examined demographic factors, job characteristics, and work attitudes of a large group of Canadian nurses whose job status was categorized as full-time or part-time.The part-time nurses tended to be older, had greater tenure, were more likely to be married, to have more nursing experience, were paid less, and had less supervisory experience. Nursing status did not significantly differentiate between groups with regards to work attitudes except that part-time nurses reported less job

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involvement. Other attitude measures included: satisfaction with extrinsic job factors, satisfaction with intrinsic job factors, assessments of immediate supervisors, thoughts of leaving the organization, power perceptions, professional commitment, and organizational commitment. Based on a single attitudinal difference for part-time nurses, the authors stated: "The fact that this lower job involvement does not coincide with less satisfaction with the job is consistent with the theory of `partial inclusion'. It holds that those less involved in the organizations' functioning lack information about its problems that leads to the development of negative work-related attitudes" (p. 84).

LeGrow (1993) found that most work attitudes research through the 1980s focused on one predictor variable and one outcome variable, usually job satisfaction. LeGrow (1993) attempted to further delineate nursing status by examining another concept, "job peripherality." Job peripherality refers to employees who possess low organizational commitment, career commitment and job involvement, irrespective of their employment status (part-time or full-time). Legrow did a survey study with 583 nurses. Peripheral and non-peripheral nurses were identified via responses to a job involvement questionnaire, an organizational commitment questionnaire, and a career commitment scale.

Peripheral employees scored below the 45th percentile on each of the questionnaires. Employees who did not fall above or below this percentile for all three scales were excluded from the study. Work attitudes included: overall job satisfaction, satisfaction with supervision, promotion opportunities, pay, coworkers, work, role conflict, intentions to turnover, responsibility for work outcomes, and intrinsic work motivation. LeGrow controlled for the covariates of marital status, parental status, job

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position, and reason for working. LeGrow selected these attitudinal measures "due to their high frequency of occurrence throughout employment status investigations and in order to facilitate meaningful integration of results and conclusions across employment status investigations" (p. 55).

LeGrow found that there were no significant main effects or interaction effects for attitude differences based on employment status or peripherality. He concluded that nurses are guided by a common set of values that determine their overall satisfaction, regardless of work status or degree of peripherality. What is important to note about LeGrow's research is that he surveyed members of the Ohio Nursing Association. Organizational membership may have been a significant confound with regards to individuals' professional views and involvement.

Davis-Blake and Uzzi (1993) examined the use of temporary workers by over 2,000 business organizations that participated in the Department of Labor's Employment Opportunity Pilot Project. Their data analyses were based on survey results from 1982. Their findings were also reported from the perspectives of managerial executives. They found that organizations employed temporary workers on the basis of their technical and informational knowledge; the interpersonal dimensions of the work did not affect their use of temporary workers.

In the nursing literature, the only studies on Flex nurses have focused on the managers' perspectives of staffing utility, although the personal, lifestyle advantages of scheduling flexibility are mentioned as benefits of this work redesign approach. Warren and Rozell (1995) surveyed managers' perceptions of the costs, benefits, quality of care delivery, and knowledge bases of Flex nurses ("supplemental staff"). Although the

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majority of the managers rated Flex nurses' clinical care skills as satisfactory, they indicated problems with Flex nurses' knowledge of hospital and unit-specific policies and procedures. Opinions on the financial incentives for using this staffing model were mixed.

As a precursor to this study, I conducted a survey study of 46 Flex nurses at Children's Hospital. Regardless of hours worked per pay period, months worked as a Flex nurse, or months worked at Children's, the nurses were satisfied with their general orientation to the hospital. The only significant finding for unit-specific orientation satisfaction was based on hours worked per pay period. Nurses working an average number of hours, 25 to 48 hours a pay period (two-week period), were less satisfied with their unit orientations. I concluded that people who work the least number of hours may be satisfied with the unit knowledge they have because of their limited time in the hospital. Those with the most hours know the unit facilities as well as regular staff. The people who work an average number of hours, however, may feel in-between with regards to unit culture and expectations. This pilot survey raised issues about how the amount of time spent with people can influence attitudes about work.

Socialization

Numerous theories examine how people acquire the values, norms, and behaviors of their social group. Parsons (1953) believed that people learn about each other in three distinct ways: 1) through cognitive perception and conceptualization; 2) through attachment or aversion; and 3) as the integration of cognitive and affective meanings. More recent applications of this social-interactional theme have examined the cognitive, affective, and/or motivational components of how we "fit in" (Bandura,

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1997; Billett, 1998; Vann, 1996). Some scholars have returned to humanist-existential discussions of how we derive meaning from life or what is the essence of our existence (Merriam & Heuer, 1996). All of these theories share one commonality: We are socially, contextually bound by others. Regardless of theoretical orientation, our socialness, being around others, is a key ingredient to understanding human behavior. Many of these theories are developmental: People developmentally progress (cognitively, affectively, motivationally) over time, and these developmental processes are an intrinsic part of human nature (Billett, 1998; Maslow, 1954; Nelson, Quick, & Joplin, 1991; Rogers, 1980).

According to Billett (1998), people engage in ongoing, moment-to-moment problem-solving. "Problem-solving is inherent in the routine and non-routine goal-directed activities in which individuals constantly engage" (p. 21). This cognitive process is influenced by affective matters of preference, morality, and aesthetics, and the social setting functions as a type of gatekeeper. A specific social context "provides for the construction of knowledge in different ways through the privileging and access to different forms of knowledge" (p. 21). With regard to the workplace, the "social practice" of individuals determines access to information, activities, and the quality of guidance and support. Factors, such as sex, gender, ethnicity, and race, are inherent aspects of the social context that can influence individuals' developmental outcomes.

Vann (1996) focused on how social experiences, particularly those in the workplace, can "serve as catalysts in a conditioning process that facilitates development of a self-directing orientation" (p. 121). Throughout our lives, we learn the attitudes and behaviors that are socially sanctioned and those that are taboo. There are groups

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of intimates (primary groups) that directly shape our attitudes and behaviors, and there are reference groups that influence our behavior indirectly through observational learning. We see the outcomes of reference group activities and decide whether to join or decline.

Workplace socialization tactics, such as peer mentoring programs, often result in either self-direction or conformity (Vann,1996). Although individual choice is heavily determined by primary group socialization, the workplace environment and its socialization tactics can influence whether employees will value the use of initiative and innovation, versus the security of job routinization.

Jones (1986) investigated the effects of six types of socialization tactics on newcomers' adjustment to organizations. Social tactics were significantly related to lower levels of role conflict and role ambiguity and to higher levels of job commitment and satisfaction. These social tactics included the provision of experienced organizational members as role models, and positive feedback from peers on an ongoing basis. Other socialization tactics, such as providing content/informational background during orientation were less significant. These findings reinforced Van Maanen and Schein's (1979) original research on workplace socialization where they found that "in the social, interpersonal sphere, interpretations offered by other organizational members may more strongly influence newcomers' perceptions of contexts than do objective characteristics of contexts" (Jones, 1986, p. 265).

Bandura (1997) stated that "occupations structure a large part of people's everyday reality and provide us with a major source of personal identity and self-worth" (p. 422). An individual's performance at a task is determined by his/her self-

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efficacy, or the belief that he/she can do the task. Actual skills per se, are less significant to task performance than personal efficacy beliefs. These efficacy beliefs are socially shaped or constructed. Bandura's research has shown that when people benefit from helpful modeling, guided practice, and corrective feedback, they achieve a higher sense of work efficacy, regardless of their initial belief in their efficacy to learn and master new skills. Social reinforcement in the workplace, therefore, can supplant old belief systems and promote individual development. In addition, Bandura's work has shown that when people are interacting as teams or groups in the workplace, a "collective" efficacy evolves among the members. "In such instances, people's sense of collective efficacy determines their well-being and what they can accomplish as a group" (p. 422).

Jones (1986) and Saks (1995) demonstrated that self-efficacy significantly moderates the effects of socialization on workplace adjustment. Individuals with low self-efficacy benefited more from social supports at work than newcomers with high self-efficacy. Their work and Bandura's (1997) research indicated that there may be a cyclical-developmental process going on. The social context of the workplace with its reference groups, mentors, peer feedback, can significantly influence self-efficacy. Self-efficacy, in turn, can affect individual performance and contribute to collective efficacy, or ultimately, group and organizational performance. Consequently, group feedback can enhance individual members' self-efficacy, and the cycle continues.

Bandura (1997) contended that "multilinked" relationships, such as social support networks, raise adoptive behavior by conveying more information through multiple modeling. He also suggested that these multiple links may "mobilize stronger

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social influences, or it may be that people with close ties are more receptive to new ideas than those who are socially estranged" (p. 519). A social network of co-workers, therefore, may boost personal and collective efficacy and enhance the opportunities for change and innovation. Social network research has supported a "buffering hypothesis" where networks function to decrease stress and increase cohesion and cooperation (Cramer, Riley, & Kiger, 1991). There are, however, negative aspects to social networks as well as positive ones (Hupcey, 1998).

Vachon (1998) studied nurses in acute care and palliative care oncology settings. She found that participating in a network of caring and reciprocal relationships with peers helped transcend multiple work stressors. She also reasoned that when work-related networks are insufficiently supportive, individuals are forced to rely on individual coping strategies. Although personal coping strategies, such as a sense of competence, control, and pleasure from work help manage work-related stress, they may be moderated by support from the work network. In support of Bandura's self-efficacy research, Vachon concluded that "the development of supportive, collaborative work relationships may be fundamental to an enhancement of self-efficacy and self-esteem" (p.155). Personal support mechanisms therefore, are helpful but not sufficient to buffer work-related stressors. Pines, Aronson, and Kafry (1981) also found that nurses need colleagues who can share the reality of their professional roles and the nature of their work.

Nelson, Quick, and Joplin (1991) suggested that attachment is the foundation of effective socialization. Their research investigated the types of "psychological contracts" that form between organizational newcomers and insiders. When individuals

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initially join organizations, there is a period of uncertainty for the individual and the organization: "Will this work out?" Socialization, therefore, is a reciprocal process of uncertainty reduction. Newcomers form work attachments with people, and the quality of these attachments determines whether a secure attachment (commitment and satisfaction) will transpire. Similarly, newcomers are viewed as "unknown quantities" until they have met certain, informal and formal acceptance criteria established by organizational members.

Although Bowlby (1982) initially proposed that attachment in infancy and early childhood provides a secure base for worldly exploration, Nelson et al. (1991) advocated that this is a developmental process that continues throughout the lifespan. Adult attachments are equally significant in terms of providing protective and regulatory functions. They developed a three-phase model of newcomer socialization based on attachment theory. Unfortunately, the empirical evidence they cited does not exclusively support an attachment theory foundation.

For instance, Nelson et al. (1991) cited the work of Fisher (1985). Fisher studied the relationship between social support and work adjustment, as measured by such variables as job satisfaction and commitment. Her survey of 210 nurses found that social support from peers and supervisors was positively related to workplace outcomes. Competing socio-cognitive theories could also be used to explain the results of Fisher's study.

Self-in-relation theorists, such as Judith Jordan and Jean Baker Miller, have suggested an approach to socialization that draws upon feminist theory and psychotherapy. Our culture has emphasized masculine ideals of individualism and

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competition. Self-in-relation theorists have proposed an alternate, feminine approach to self development and socialization that "involves an important shift in emphasis from separation to relationship" (Surrey, 1991, p. 53). The ability to be in relationship with others rests on the capacity for empathy in all persons involved.

> The ability to experience, comprehend, and respond to the inner state of another person is a highly complex process, relying on a high level of psychological development and learning. Accurate empathy involves a balancing of affective arousal and cognitive structuring. It requires an ability to build on the experience of identification with the other person to form a cognitive assimilation of this experience as a basis for response. Such capacities imply highly developed emotional and cognitive operations requiring practice, modeling, and feedback in relationships (Surrey, 1991, p. 54).

Relationship implies "a sense of knowing oneself and others through a process of mutual relational interaction and continuity of 'emotional-cognitive' dialogue over time and space" (Surrey, 1991, p. 62). Socialization rests on interaction and dialogue, and the quality of social connections depends on degree of empathy. Developmentally, an individual moves from a relationship with primary caregivers to a "more comprehensive and flexible adult form of relationship" (Surrey, 1991, p.63).

The emphasis on connections with others has always been more prominent at all stages of life for females (Surrey, 1991). Research and clinical observation have shown that most women have a greater ability for emotional closeness and flexibility than do men, and the capacity for empathy is more highly developed in women (Kohut, 1971; Surrey, 1991; Winnicott, 1971).

Feminists are concerned with the impact our majority culture and ideology has had on men and women. "In our culture we too readily equate a need to be related to other people with dependency" (Stiver, 1991, p. 226).

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Jordan (1991), a psychotherapist wrote:

> The elaboration and development of empathy as a means of interacting is central to my work with women in therapy. Many modern women initially see their empathic attunement to others as a burden; they wish they could be more like men--singleminded, able to turn off feelings in the interest of logic; they wish all the important areas of their lives, especially love and work, did not feel so interconnected and entwined...part of the problem is living in a world which cannot clearly acknowledge the important contribution of emotional reaction and interpersonal sensitivity to thinking, to work, to all aspects of life (p. 284).

These theorists, therefore, have raised an issue of self development and socialization that significantly affects nurses, who are predominantly women, and who reside in a profession of empathy and caring.

Research studies on women and workplace culture demonstrated that "enabled" women are able to resist traditional conditions of employment and create their own culture (Lamphere,1985; Lundgren & Browner, 1990; Zavella, 1985). Women participate actively in creating a work culture of empathetic care and mutual support when they have the opportunity to do so. Lundgren and Browner (1990) suggested that this acculturation process requires certain organizational/workplace conditions. They conducted an ethnography of a group of predominantly female health care workers caring for institutionalized mentally retarded adults.

The women's work provided them with opportunities to informally socialize on the job, relative freedom from supervision, and opportunities for co-worker solidarity. In the latter instance, health care professionals identified with their assigned units, versus the larger treatment program. "Each unit's identity grew out of the type of residents assigned to it and the personalities and work styles of supervisors and staff. The residents' physical and functional characteristics that differentiated units also encouraged group cohesion" (Lundgren & Browner,1990, p.161).

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Identity with others/place was explored in another ethnographic study of nursing homes and health care providers (Diamond, 1988). Diamond found that many of these nursing homes were converting to "business models." Managers planned and controlled "operations" by reducing work relationships between staff and clients to series of measurable tasks and cost-benefit ratios. In these instances, profit maximization undermined the staff members' attempts to create value through their work for themselves and others.

Transformative learning theory (Mezirow, 1991) has attempted to integrate motivational, cognitive, and affective components within a developmental framework. Although Mezirow applied the theory to adult learning, the theory is applicable to socialization as a learning process.

According to Mezirow (1991), as people encounter experiences that do not make sense to them, they engage in critical reflection and create a new meaning that "transforms" old, cognitive representations of the world. This transformative process creates affective responses, such as anxieties and fears of the unknown. These emotions can block the process unless the social environment provides a sense of support and security. Providing support (affective) and challenging unknowns (cognitive) raises the question: "What for?" Mezirow claimed that people are intrinsically motivated to move from a narrow frame of reference, to a more inclusive, universal worldview.

Maslow (1954), Rogers (1980), and Adler (Corey, 1996), were three theorists who discussed the importance of intrinsic, motivational forces. They believed that humans have the innate potential to grow intrapsychically. Maslow referred to "higher needs;" Rogers described the "self-actualization" of individuals as a natural, unfolding

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process; and Adler trusted people to set goals for themselves based on their need to belong to community, a sense of "social interest". This aspect of socialization, the urge to join in socially, is considered a universal, human "given" in theories that pursue cognitive-affective explanations of how people make sense of their world.

The motive to self-actualize, the cognitive capability to recognize dissonance and transform mental schema, and the emotional triggers to respond to uncertainty and to seek social support, are interwoven dimensions of how we become socialized. More research is necessary to differentiate the contributions of cognitive, affective, and motivational factors to the socialization process.

Social Supports

Socialization, social supports, and social networks are often intermingled. An example is Bandura's (1997) discussion of social networks as social supports and avenues for the development of individual and collective self-efficacy.

Hupcey and Morse (1997) argued that social support research is muddled by lack of definition. "Any potentially positive interaction, no matter who this interaction is with, has been considered social support" (p. 270). It is important to define the nature of the resource (emotional, material) and the relationship of the providers and recipients. Based on a review of the social support literature, they identified six characteristics of social support that distinguish it from other types of support. They were particularly concerned with differences between professional support provided as a service versus support obtained through individuals' social networks.

They distinguished between social and professional supports by the types of services obtained, relationship duration, trust, obligation, reciprocity, and relationship

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expectations. Social support is "open" and may include anything to aid the recipient. Social support relationships are "durable," or there is an expectation that they will endure through repeated contacts: They convey shared trust in social relationships, there is sense of social obligation. "This obligation stems from kinship or through bonds of friendship" (p. 274). With social support, network members know who will be able to provide different types of support. Pearlin (1985) called this "specialized fit" between network supports and problems. Because of this knowledge of network members, recipients often expect certain kinds of support without directly requesting it. Support is delimited by policy and standards of practice

Professional relationships have less expectations for continuance, and they are often unilateral in nature. For instance, patients are often in vulnerable positions because of their unilateral trust in health care providers. There is also an asymmetric obligation in professional relationships. Professionals are expected to provide certain types of support services, and patients are not expected to reciprocate. With professional support, professionals act on the basis of their professional role responsibilities.

Laireiter and Baumann (1995) described social support as interpersonal relationships of reciprocal trust and expectations. More emotionally distant network members, however, are not expected to perform the same types of social support as members within the "close core."

Heller, Price, and Hogg (1990) viewed social support as a process that depends on exchanges between people. Reciprocity of social exchanges maintain relationships over time. "Individuals need opportunities both to provide and to receive support in

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order to maintain equity in relationships" (p. 485). DePaulo (1982) found that people were more willing to enlist the help of strangers when they believed that they could reciprocate the help on a future occasion. Reciprocity considerations are especially important in work-related situations, and less prominent among family members where the nature of support relationships are more complex.

Antonucci (1985) also noted that social support is a series of recipcrocated social exchanges that occur over time in which individuals build up a "bank." "One does not have to pay back immediately or with the same type of support" (p. 120), but there are expectations that a balance will be achieved.

Dunkel-Schetter and Skokan (1990) reviewed the literature of unsolicited support provided to distressed recipients. They also included their pilot work on this research area. They identified four variables that influence the degree of offered support: stress factors, recipient factors, relationship factors, and provider factors. Individuals in self-reported high stress situations perceived more social support, especially when the stress was threatening their self-esteem or a loved one's well-being.

Three important recipient factors are the perceived level of distress, recipient coping mechanisms and recipient resources. Perceived acute distress elicited more support, especially at low to moderate levels. Of note is that chronic distress, such as distress reported by depressed individuals, resulted in diminished support over time. Individuals who manifested active coping strategies received more support. Active coping is defined as an individual's efforts to solve her own problems. Examples of active coping included support seeking. "One of the strongest predictors of amount of support was the extent to which it was requested" (p. 441). Another factor, recipient

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personal resources, was represented through research that showed that people with high self-esteem and high mastery receive more social support. In addition, individuals with personal qualities such as locus of control, hardiness, dispositional optimism, and sense of coherence, also elicited more support from others (Dunkel-Schetter & Skokan, 1990).

Relationship factors covered degree of intimacy, satisfaction with the relationship, social norm acceptance, reciprocity norms, and history of past exchanges. These factors are positively associated with social support. For instance, historically, people who consistently refuse support are less likely to receive support over time, whereas, support acceptance and appreciation increase the probability of continued support.

From the provider standpoint, attributions about the controllability of the recipient's situation affect social support provision. Providers were less likely to help individuals who were responsible for their situations, and conversely, individuals in situations they could not control elicited more empathy and support. Dunkel-Schetter and Skokan (1990) also cited research that found that when providers empathized with people in need of help, an "altruistic motivation" to help was triggered.

Dunkel-Schetter and Skokan (1990) conducted a pilot study with college students who were asked whether they would help a hypothetical 'victim.' Provider perceptions of acute distress significantly, positively correlated with intentions to provide support. Personal experiences with the stressful event significantly increased willingness to help, suggesting the importance of empathy. Of interest, however, is that this effect varied by type of personal experience. For instance, scenarios of

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bereavement and drug abuse were positively associated with support, but experiences with eating disorders were negatively associated, and alcohol and sexual abuse were not related to support intentions. There were also no significant associations between attributions (whether the victim had control or not) and willingness to provide support. As noted by the authors, specific psychological paradigms may represent different combinations of social support variables (stress factors, recipient factors, provider factors, relationship factors) that interact to elicit unique and varied support responses.

Coyne and DeLongis (1986) provided another critique of the social support literature. Their focus was on research tactics and research applications. They argued that social support research is often based on survey methods. Contextual problems result when these research findings are translated into clinical interventions.

> Perceptions of support do not arise invacuo, and we should be careful not to localize what is more appropriately a feature of that person's transactions with his or her typical environment. We need to learn more about how people find, build, maintain, and end relationships; how they are constrained by their personal characteristics, their circumstances, and the pool of people available; and the costs and benefits that they incur. Existing survey methods need to be supplemented by indepth interview studies of the nature of supportive relationships...If such a knowledge base develops, social support may be viewed as a general rubric for understanding the potential benefits of social relationships (p. 45).

The Workplace

Karasek (1979) developed a workplace model to characterize the nature of occupations in the United States and Sweden. His model classified jobs according to two dimensions—job control of decisional autonomy and psychological job demands. Karasek also created a self-reporting questionnaire to categorize people's occupations along these two dimensions. Karasek showed that people in different quadrants were

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associated with different degrees of job satisfaction, physical illness, psychological depression, absenteeism, productivity, and a variety of other work-related outcomes (Karasek & Theorell, 1990). For instance, individuals with high psychological demands at work and high decisional latitude were in "active" jobs. Karasek (1979) showed that individuals in active jobs had the highest levels of job satisfaction. Workers in passive jobs with low decision latitude suffered the most from depression, low self-esteem and physical illnesses. Increased psychological demands on this latter group compounded strain symptoms.

Karasek (1981) applied his model to analyze productivity among five firms in Michigan, including a hospital. Demand and control were measured with his standardized questionnaires, and productivity was operationalized as supervisors' ratings of employee effectiveness on a combined scale of quantity and quality. There was an interactive association between job characteristics and productivity: Productivity was associated with high job demands when job control was high. When job control was low, higher levels of job demands resulted in decreased productivity. Karasek and Theorell (1990) suggested that Karasek's productivity studies illustrated how Theory X management "may lead to underutilized skills, and furthermore, that motivational energy that might otherwise be available to accomplish tasks is transformed into adverse stress reactions when workers are not free to exercise reasonable levels of decision making" (p. 176).

Seago and Faucett (1997) used Karasek's model to investigate various job titles in an acute care hospital. Nurses's questionnaire responses placed them in an "active

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job" category. Unfortunately, associations between nurse job categorization and outcomes, such as job satisfaction, were not investigated.

The Karasek model has been used primarily to investigate the importance of workplace control in the job satisfaction literature (Karasek & Theorell, 1990). The dimension of psychological demands has been least investigated, and there are few studies that reflect the effects of social relationships on work. Johnson (1986) added a social support dimension to Karasek's demand/control model. These three dimensions were capable of predicting 41% of the variance in depressive symptoms for his study population of U.S. workers. For example, Johnson found that U.S. males low on decision latitude and high on psychological demands were the most depressed. Johnson's study showed a clear demand/control association within each level of social support (low-high), supporting the validity of Karasek's original model.

Kopelman (1985) reviewed 32 work redesign projects over a period of twenty years within the U.S. and Sweden. Work redesign strategies included job "enrichment," "work groups," and "responsibility for the complete product." These projects demonstrated significant increases in job satisfaction. Significant decreases in absenteeism were only associated with "social feedback" Kopelman suggested that this absentee finding provided indirect evidence for the importance of social support on work –related factors.

Research investigating the control dimension of Karasek's model showed that during an active period of Swedish business reorganization in the 1980s, the negative effects of job changes were offset by giving people more control over the job change process (Karasek, Gardell, & Lindell, 1987). Karasek and his colleagues also found

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some concerning findings. During this reorganization period deemed a "humanization phase" in Sweden, some organizations reduced, rather than increased job control—a situation especially pronounced among older workers and women. In situations where employees did not have influence over the job change process, organizational and individual worker outcomes were less favorable. These researchers also found that employee involvement in participative processes ended negatively if these participative processes did not produce desirable task outcomes. Participative management, therefore, is not a simplistic management issue.

Schabracq and Cooper (1998) presented a phenomenological framework of the workplace. They based their framework on consulting activities in several organizations. In this framework, the workplace is comprised of "situations" that become known to workers through repetition and familiarity. These situations are also cultural building blocks or socialization tools. "Socialization here means actively discovering, getting acquainted with, and lastly, identifying with a limited set of situations and their inherent ways of thinking, feeling, and acting. In this way, one becomes a member of one's culture, maintaining and reproducing it by enacting its realities" (p. 627).

People are selective: They choose environments to suit their own preferences and skills. Selecting and adapting to specific environments allows people to operate most of the time on an "automatic" level. This frees individuals to focus on specific, task-related problems or learning new skills. People also learn a set of operational rules and assumptions that allow them to act in "meaningful and morally responsible ways." Shabracq and Cooper (1998) referred to this as a system of "integrity." "There are

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substantial individual differences in the degree to which people strive towards fixed rules and procedures. Some need a completely structured environment, others need more spaces and challenges. In both cases, the intended outcome is an environment adapted to their specific configuration of abilities, values, and needs, which is conducive to well-being and health" (p. 630).

Schabracq and Cooper (1998) borrowed from Gestalt psychology to compare integrity to a figure-ground problem: The figure is the task, and the ground is environmental expectations. System integrity is disrupted when the task or the environment gets out of control. People employ coping strategies to manage integrity disruptions. People never act in isolation, however. The social context has a significant affect on outcomes.

Schabracq and Cooper (1998) proposed a bipolar continuum of figure-ground control where "the golden road of the middle" is preferred. Tasks should not be too boring, or be too overwhelming. The environment should not attract too much attention and break the focus on the task, or be taken for granted. Most people continously scan the environment for signs of disruption; ideally, a sense of trust and control over environmental factors allows individuals to maintain their focus on tasks. When the figure or ground (task or environment) approaches bipolar extremes, work performance is affected cognitively and affectively, and people usually report such disruptions as "stress."

Typically, compatibility of values affects task orientation. If an organization requires task performance that is incompatible with a worker's values, integrity is disrupted. Safety issues most affect orientation to the environment. Schabracq and

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Cooper (1998) suggested that certain reorganizational outcomes can affect safety: downsizing, new working conditions and equipment, withdrawal of rights and privileges, and perceived bad intentions and conflicts from fellow workers. They also proposed that social networks help orient and stabilize people within their figure-ground context. They believed that an adequate social network is essential to integrity.

The workplace literature has identified some components that add success to workplace adjustment; an interesting job with self-control, and a supportive network are important facets are the work environment to consider when addressing individuals'adaptation to work.

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CHAPTER 3

METHOD

Research Approach and Rationale

A mixed method case study was conducted at The Children's Hospital of Denver. The focus was the work-related social relationships of Flex nurses. Flex nurses were interviewed, and participant observations were conducted of Flex nurses in their work environments. Concurrently an assessment tool was administered to gather quantitative data for convergence at the interpretive or conceptual phase of data analysis.

Participants

Qualitative Population

The interview population consisted of the Flex nurses at Children's Hospital. There were 200 Flex nurses who were all Bachelor-of-Science prepared. The average length of time on the Flex staff was 30 months, and the average length of time at Children's Hospital was 80 months. Most of the Flex nurses were female and Caucasian (personal communication, Kersey, May 1998).

There were two types of Flex nurses, Flex Is and Flex IIs. Flex I nurses only worked on one unit. Flex I nurses were considered "decentralized," and their work arrangements were negotiated with their unit's staff: There were 100 of these nurses.

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Flex II nurses covered two or more units. They were "centralized," or scheduled through the main, Flex staffing office: There were 100 Flex II nurses.

A Flex staff nurse chose the units she covered, the number of hours she worked per pay period, and the shifts she worked, although Flex I nurses were more dependent on individual unit demands. Due to Flex I and Flex II differences, a decision was made to focus on Flex II nurses. Only Flex II nurses were interviewed for the qualitative portion of the study.

Quantitative population

There were 600 inpatient nurses, including the 200 Flex staff. The theoretical and the accessible population included all the inpatient nurses of The Children's Hospital of Denver.

Setting

Children's Hospital is a 200-bed, pediatric, tertiary care facility located in Denver, Colorado. The hospital cares for the age ranges of infancy through young adult. It has trauma designation and there are two intensive care units. The hospital is affiliated with The University of Colorado Health Sciences Center, and it serves as a referral center for thirteen surrounding western states.

Sampling Procedures

Qualitative sampling

Qualitative inquiry purposefully samples a small number of information-rich cases or interviewees. For this case study, Flex nurses were approached on different units and shifts to provide "different moments, in different places, with different

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people" (Miles & Huberman, 1994, p. 29). As themes began to emerge, other interviews and observations were selected to confirm or disconfirm the themes. As mentioned by Miles and Huberman (1994):

> within case sampling has an iterative or 'rolling' quality working in progressive waves as the study progresses...We observe, talk to people, and pick up artifacts and documents. That leads us to new samples of informants and observations, new documents. At each step along the evidential trail, we are making sampling decisions to clarify the main patterns, see contrasts, identify exceptions or discrepant instances, and uncover negative instances (p. 29).

Seven Flex nurses were interviewed, and four managers were interviewed for background information. Observations took place on three inpatient units, including two units that were frequently staffed with Flex nurses.

Quantitative sampling

For the questionnaire portion of the study, the selected sample was all the inpatient nurse employees of Children's Hospital. This population was selected, because typically, Flex nurses only covered inpatient units at the hospital. The questionnaire was intended to compare Flex nurse social networks with Regular nurse social networks.

Inpatient nurses were accessed by delivering questionnaires to all nursing, unit-based mailboxes throughout the hospital. Three hundred questionnaires were distributed via individual nurse mailboxes. These mailboxes included the Flex I, unit-based Flex nurses. Additionally, 100 questionnaires were sent to Flex II (multi-unit based) nurses' homes via the Flex staffing office. This mailing was done at the recommendation of the Flex nursing director to expedite Flex nurse returns. Outpatient, day treatment, and home care nurses were excluded from the study. All

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total, 400 questionnaire packets were successfully distributed or mailed to inpatient nursing staff at Children's Hospital.

168 questionnaires were returned: The return rate was 42%. Only two Flex I nurses returned their questionnaires. It is possible that Flex I nurses, who were unit-based, identified themselves as "Regular" nurses on their questionnaires. To simplify analyses, these Flex Is were eliminated from the study. The final N=166 consisted of 46 Flex II nurses and 120 Regular nurses.

Measures

Qualitative measures

Case studies rely on multiple sources of data. This study was based primarily on interviews with Flex nurses and participant observations. Approval for this study was obtained from the Children's Hospital Investigational Review Board and Colorado State University's Human Subjects Committee. Potential interviewees were contacted on the nursing units, and arrangements were made to do the interviews in a private, confidential fashion. At the time of the initial contact, the purpose of the study was explained to the individuals, as well as their rights to refuse participation or to withdraw at any time. Risks and benefits were also explained. See Appendix B for a copy of the consent form.

A general interview guide was used to ensure that all relevant topics were discussed with the interviewees. This interview approach allowed me to address similar Flex concerns with all the interviewees while adapting the questions to individual respondents' thoughts and feelings. See Appendix B for a copy of the interview guide.

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Participant observation is derived from anthropological fieldwork: The researcher records notes from personal observations while being fully engaged in the activities of the setting. This provides an "insider's view" of the case (Patton, 1990). Observations were made while I served as clinical nursing faculty for nursing students on the inpatient units. In a nursing instructor's role, I was able to make unobtrusive observations of nursing interactions.

Patton (1990) recommended a "sensitizing framework" to organize observations and notations according to the "sensitizing concepts" of the study, and Miles and Huberman (1994) used "contact summary sheets." Important basics of field data typically include the setting (context), the participants in the social environment, what they are doing and saying (actions), interactional outcomes, and any highlights--omissions or commissions. Particular slang/dialect and nonverbal communications are also valuable to record. I used contact summary sheets to record my reactions to noted field events, particularly the nature and intensity of my own feelings around social interactions involving Flex nursing staff. See Appendix B for an observation contact summary sheet.

Quantitative measures

For the quantitative portion of the study, the Social Network Questionnaire (SNQ) was used (Antonucci, 1986). The SNQ was developed to assess social networks and supportive relationships. It includes a hierarchical mapping procedure of concentric rings. The circles provide a framework for individuals to diagram their social network. "The technique seems to transcend culture, age, life situation, and crisis" (Antonucci, 1986, p. 11). For this study, the SNQ questions and wording were adapted to nurses'

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social networks at work. See Appendix A for a copy of the questionnaire and its cover letter.

The cover page of the SNQ asks general demographic questions, such as gender of respondent, and written and visual examples are provided for completing the network ring portion of the questionnaire.

There are different sections to the SNQ. In the first section, respondents are asked to place members of their social network into one of three concentric rings according to closeness: The center of the concentric rings is designated as "You," being the most important person. The 1st ring= "people you feel closest to at work." The 2nd ring= "people you feel less close to at work, but they are still important to you." The 3rd ring= "People you feel least close to at work, but they are still important to you". Respondents are allowed to diagram as many people as desired within the three closeness circles. Respondents are then asked to designate the relationships (peer, manager, et cetera) of the first 15 individuals of their network. Respondents generate their own relationship categories. Other researchers (MacPhee et al., 1996), have been able to sort relationship responses into a limited number of relationship categories.

In addition to numbers of network members per relationship category in each of the rings, proportions were used in the analyses. Proportions are considered to be a more accurate representation of support availability according to other social network researchers (MacPhee et al., 1996). For instance, it makes a difference whether there are 3 peers out of 3 people in the 1st ring (100% peers in the 1st ring), or 3 peers out of 12 people in the 1st ring (25% peers in the 1st ring).

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This first section of the SNQ, with its closeness rings and relationship categories of the first 15 members, yielded information on total network size, the numbers of network members in each closeness ring, the proportions of network members in each closeness ring, the number of members per relationship category in each ring, and proportions of members per relationship category in each ring.

The second section of the SNQ is a series of questions to determine which members of the network meet different types of emotional support needs such as confiding, providing reassurance, providing respect, providing support for emotional upsets, and providing advice for major life decisions. For each type of emotional support, respondents are asked to circle the number of the person from their first 15 members if that person provides that type of support. For instance, if the respondent receives reassurance from members 6 and 8 out of their first 15 network members, they circle numbers 6 and 8 out of a list of 1 through 15.

For the analyses, respondents' circled numbers were matched to their self-generated relationship categories. For instance, it was possible to determine how many peers provided reassurance. In addition, proportions were calculated. It is important to know whether there are 3 peers of 3 people total providing reassurance (100% reassurance provided by peers), or 3 peers of 12 people total providing reassurance (25% reassurance provided by peers).

The second section yielded information about total numbers of network members providing different types of emotional support, numbers of members from each relationship category providing different types of emotional support, and

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proportions of members from each relationship category providing different types of emotional support.

The final section of the SNQ asks about respondents' satisfaction with their social network. The questions are posed as Yes/No responses to: a) "Would you want to have more people in your network?" b) "Would you want to have more people in your network for emotional support?" and c) "Would you want to have more people in your network for instrumental support?" Emotional support is implied to be confiding, reassurance, respect, helping with emotional upsets, and providing advice for major life decisions. Instrumental support is defined for the respondents as: "Assistance with nursing tasks and information."

For this study, the SNQ independent variables were attribute variables covering employee demographics. The demographic variables included: gender, nursing status (Flex or Regular), number of hours worked per pay period, number of months employed at Children's, and number of units worked.

The dependent variables of the SNQ included:

1. Social network variables: total number of network members, numbers of people in each of the three closeness rings, and proportions of peers and managers in each of the closeness rings. A further explanation of these relationship categories is provided in Chapter 4.

2. Emotional support variables: reassurance, respect, someone to confide in, someone to talk to when depressed or upset, and someone to talk to about major life decisions.

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3. Satisfaction variables: wanting more people in the total network (Y/N), wanting more people in the network for emotional support (Y/N), and wanting more people in the network for instrumental support (Y/N).

For a summary of the study's quantitative independent and dependent variables, see Table 1.

Table 1.

Independent and Dependent Variables for the Social Network Questionnaire

Variables	Type	Scale of Measurement
DEMOGRAPHICS		
Gender	IV	Dichotomous
Nurse status: Flex/Regular	IV	Dichotomous
# Hours per pay period	IV	Ratio
# Months at Children'ss	IV	Ratio
# Units worked	IV	Ratio
SOCIAL NETWORK		
Total # in network	DV	Ratio
# per ring	DV	Ratio
% peers per ring	DV	Ratio
% managers per ring	DV	Ratio
EMOTIONAL SUPPORT		
%peers/managers for confiding	DV	Ratio
%peers/managers for reassurance	DV	Ratio
% peers/managers for respect	DV	Ratio
%peers/managers for emotional upsets	DV	Ratio
% peers/managers for major life decisions	DV	Ratio
SATISFACTION		
Wanting more people in network	DV/IV	Dichotomous
Wanting more emotional support	DV/IV	Dichotomous
Wanting more instrumental support	DV/IV	Dichotomous

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Validity and Reliability of Measures

Qualitative validity and reliability

In qualitative inquiry, research validity is conceptualized differently from quantitative inquiry. According to Creswell (1997), in the past, qualitative researchers tried to conform to quantitative conceptions of validity and reliability. More recently, qualitative researchers have developed their own vocabulary of "trustworthiness" and "authenticity."

Lincoln (1995) discussed relational criteria that must be met when conducting qualitative studies. These criteria address rigor of the study as well as ethical considerations. "Voice" refers to the decision of the researcher to include or exclude what is said by participants. The context selection process should be judged on "openness, engagement, and the problematic nature of the text" (p. 283). Another condition is called "critical subjectivity," or the researcher's capacity for self-reflection and self-awareness. Since the researcher's observations and insights are so important in every phase of the qualitative process, critical subjectivity enables the researcher to begin to uncover dialectic relationships, array and discuss contradictions within the stories being recorded" (Lincoln, 1995, p. 283).

"Reciprocity" is another qualitative construct that denotes the relationships that exist between the researcher and the participants. Qualitative research is a "personal form of relating," and the researcher must be aware of the introspective and interactional nature of inquiry.

Rigor, therefore, in qualitative inquiry, refers to the researcher's ability to account for self and for self in relation to others. The process of establishing qualitative

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rigor depends on the skills of the researcher and the researcher's ability to demonstrate the whole picture of a phenomenon through documentation and illustration of the raw data. "Trustworthiness becomes a matter of persuasion whereby the scientist is viewed as having made those practices visible and, therefore, auditable; it is less a matter of claiming to be right about a phenomenon than of having practiced good science" (Sandelowski, 1993, p. 2).

Guba (1981) and Krefting (1990) provided comparative criteria (qualitative/quantitative) for research validity. Credibility (qualitative) and internal validity (quantitative) pertain to truth value, or how confident the researcher is with the "truth" of the findings. Transferability (qualitative) and external validity (quantitative) refer to a study's applicability or generalizability. Can the findings be generalized to other settings or groups? Dependability (qualitative) and reliability (quantitative) indicate the consistency or replicability of the research findings. Confirmability (qualitative) and objectivity (quantitative) concern the neutrality of the researcher towards the research. Guba and Krefting's criteria will be applied to the qualitative approaches I used to establish credibility, transferability, dependability, and confirmability.

Credibility can be ascertained by several approaches, including triangulation. I used a mixed method approach with triangulation of data sources within-method (observation, interviews) and conceptual triangulation between-methods. Other credibility approaches included time sampling, or taking samples over time. I conducted interviews and did unit observations over a five month period. Prolonged and varied field experiences contribute to research credibility, and I have been doing

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clinical care at Children's Hospital for over 15 years. Reflexivity refers to the researcher's efforts to critically reflect and memo: I kept extensive notes and logs with my objective observations and subjective impressions. Member checking is a technique used to continually check back with interviewees: I asked interviewees and key informants to check the accuracy of my analyses and interpretations based on their initial statements. Peer examination involves a discussion of findings with individuals who have qualitative research experience. I asked one of my committee advisers, an expert in qualitative analysis, to review my analyses and conclusions at various stages of qualitative analysis. Protocols for interviews/observations provide an account of the techniques used, or validity of the data-gathering techniques: I employed interview/observation protocols to help sort and organize my data. Structural coherence indicates that there are no loose ends or inconsistencies in the data interpretation: This depends on the data reduction and interpretation process. I maintained a "data trail" to document how data were organized, categorized, thematically arranged and reported.

Transferability can be determined by using nominated samples, or samples recommended by key informants versus self-selection: I had intended to do this, but instead, I identified Flex nurses working on units where I did my observations. Throughout qualitative analysis, I sought out confirming and disconfirming cases to the emerging themes. In Chapter 4, I provide basic demographic information for comparative purposes, and numerous quotations to facilitate transferability. Qualitative data from this study are unique representations of a single, bounded system. "The point of generalization occurs when the reader recognizes some elements or features that may carry over to other situations" (Plante, Kiernan & Betts, 1994, p. 54).

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Dependability relies on the quality of the data trail, dense description of the research process, triangulation, peer examination, and stepwise replication. Stepwise replication is similar to split-half reliability. After a certain number of interviews and/or observations, the data are reduced, analyzed, and interpreted. Another set of interviews and/or observations are completed and compared with the first set. Rather than splitting data chronologically, I employed constant comparative analysis.

Confirmability also depends on the data trail (audit), triangulation, and researcher reflexivity. In general, qualitative research validity relies most heavily on researcher skills and the relational qualities detailed by Lincoln (1995).

Quantitative validity and reliability

Antonucci and Akiyama (1985) used the Social Network Questionnaire (SNQ) on a national study of the mature adult population: Their sample findings were consistent with other empiric work on mature adults. The SNQ has been used to study the elderly (Heller & Mansbach, 1984; Prucho & Faletti, 1984), a three-generation sample of Hispanic women (Levitt, 1985), a three-generation sample of women in Tokyo (Campbell, 1985), children's social networks in childhood and early adolescence (Levitt,Guacci-Franco, & Levitt, 1993), ethnic variations in social networks and parenting (MacPhee et al,1996), and adolescents and their families coping with a newly diagnosed chronic illness (MacPhee, Hoffenberg, & Feranchank, 1997).

Levitt et al. (1993) found excellent 12-week stability coefficients for total number of persons in children's networks: .72 at age 7, .76 at age 10, and .79 at age 14. Another study reported one year stability for network members as $r = .60$, with stability for closeness of $r = .47$ over one year (MacPhee et al., 1996).

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MacPhee et al. (1996) asked parents to indicate the types of support they received from social support members. Factor analysis suggested two composite support variables: emotional support was the proportion of the network providing reassurance, respect, confiding, and providing care during times of illness (alpha=.83); instrumental support consisted of assistance with child care and monetary support (alpha=.76).

MacPhee et al. (1996) used four relationship categories in their parenting study: domestic partner, friend, extended kin, and immediate kin. They computed the number of individuals listed by relationship category and the number of different support functions provided by category. The instrumental and emotional functions were highly correlated within relationship categories (median $\underline{r}$ =.65), but not across relationship categories ($\underline{r}$ =.15). Participants also completed a series of yes/no items assessing satisfaction with types of support (MacPhee et al., 1996). The composite score (alpha=.80; stability $\underline{r}$=.71) ranged from 6 to 12, with a positively skewed distribution indicating the desire for more support.

Procedure

Qualitative procedure

At the beginning of each interview, the interviewee was asked to sign a Human Subjects consent form. An audiotape was used to record entire conversations. The majority of interviews were recorded via phone. A special phone recording device was used, but in-depth notes were also taken during the interviews to help highlight particular topics of interest. The nurses preferred to talk from their homes. Interviews were not successful in the hospital because of the pace of care: Nurses were too busy to

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talk for extended periods during shifts, and they did not want to come in early or stay late for interviews. Most initial interviews lasted one to two hours. Follow-up interviews were typically 30 minutes to one hour. The nurses were also amenable to sitting down for brief conversations during shifts, and a few impromptu discussions took place among small groups of Flex nurses during my unit observations. After each interview and note-taking session, my impressions were recorded in a log on computer disk.

Participant observations were outlined on observation summary sheets, and detailed notes were memoed on a computer disk as soon after the observations as possible. The computer log was also used for frequent discussions with myself about possible codes/themes and their implications. Most observations occurred during my supervisions of nursing students. I tried to return to units during different periods in a 12-hour shift (7am-7pm) to observe Flex nursing interactions. I was usually on a unit for 30 minutes at a time. In addition, I made observations and took notes on occasions when I was visiting units to recruit Flex staff, or to check on questionnaires in the study's drop boxes. This also gave me the opportunity to visit units on off-shifts.

Most of my off-shift observations were made during the evening shift from 3pm to 9pm, but I also made unit visits and observations from 5am to 7am. The observations were primarily used to reinforce interview themes from the Flex nurses. I made 50 observation entries in my computer log and took more in-depth notes (summary sheets) on 10 specific incidents observed between Flex nurses with peers (Flex and Regular nurses) and managers.

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Quantitative procedure

The Social Network Questionnaire (SNQ) was placed in the mailboxes of all inpatient nurses at Children's Hospital except Flex II nurses who received their questionnaires via mail. A cover letter explained the purpose of the study (See Appendix A). An envelope (without identifiers) was included so that the completed questionnaire could be sealed and placed in drop boxes located in the nursing lounges. Colored flyers were posted around the inpatient nursing lounges asking nurses to check their mailboxes and to participate in the study. Drop boxes were left in the lounges with additional questionnaires for a total of four weeks. Contents were collected on a weekly basis. The drop boxes were sealed (except for a drop slit) to ensure confidentiality.

Data Analysis

Qualitative analysis

Qualitative analysis occurs simultaneously with data collection, data interpretation, and narrative writing (Creswell, 1994). According to Stake:

> There is no particular moment when data analysis begins. Analysis is a matter of giving meaning to first impressions as well as to final compilations. Analysis essentially means taking something apart. We take our impressions, our observations, apart...How is this part related to that part? Analysis goes on and on...Two strategic ways that researchers reach new meanings about cases are through direct interpretation of the individual instance and through aggregation of instances until something can be said about them as a class...The caseworker sequences the action, categorizes properties, and makes tallies in some intuitive aggregation (1995, pp. 71-74).

Qualitative data analysis and representation follow specific research traditions. For instance, for case studies, Creswell (1998) defined the phases of case study

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analysis as "descriptions, themes, and assertions" (p. 65). He depicted qualitative analysis as a spiral. After data collection, the first loop of the spiral is a management loop: Data are organized into files or units. The second loop, a reading and memoing loop, requires the researcher to read through all the data and record reflections or notes within the margins of interview/observation texts. At the third loop, the researcher develops a description of the context, identifies patterns or categories within the data, and aggregates categories across interviews and observations: This is the "thematic" phase. The final loop is the representation and visualization of the data, as well as a final narrative report: The researcher makes "assertions" about the data.

I used Creswell's approach, and I also used Strauss and Corbin's constant comparative analysis scheme to organize my different levels of codes (1990). Each taped interview was transcribed. Interview transcriptions and observational notes were coded (Level I coding) by meaning segment. Relationships among the Level I codes were given theme names at the Level II coding. At Level III, themes were presented in a narrative account with an overall "storyline."

The audit trail consists of original tapes, transcriptions, disk and hard copies of observational notes, Level I codes stored in Hyperresearch©, and disk and hard copies of each of the coding level summaries.

Although I had intended to build within-case displays throughout the analysis process, I found that it was more meaningful for me to write in-depth narrative accounts of each of the nurses' interviews with illustrative quotations and anecdotal observations.

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Quantitative analysis

Chapter 4 contains descriptive data of the study's independent and dependent variables. Chapter 4 also provides a table of the inferential research questions. SPSS 7.5 for Windows was used to analyze research data, as well as Morgan and Griego's (1998) interpretative manual.

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CHAPTER 4

RESULTS

Quantitative Analyses

Gender was eliminated from the analyses because only four males responded to the SNQ (2.4% of the sample). Although participants were allowed to create their own relationship categories for the SNQ, the majority of nurses used the two categories provided as examples by the researcher: peers and managers. Because there were only small numbers of network members in other relationship categories, inferential analyses were limited to peers and managers. Other categories generated by the nurses included: Physician (n=15); Secretary (n=17); Friend (n=10); Associate (n=8); Technical Assistant (n=9); Patient or Family member of patient (n=4); and Mentor (n=10).

Table 2 provides an overview of the inferential research questions with types of analyses employed. Refer to Table 1 in Chapter 3 for a list of the specific variables found within the broader category headings.

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Table 2.

Quantitative Inferential Research Questions and Analyses

Research Question	Analysis
1a. What is the association between demographic variables and social network variables?	Associational: Pearson correlations
1b. What is the association between demographic variables and emotional support variables?	Associational: Pearson correlations
2a. Is there a statistically significant difference in group means between Flex and Regular nurses for demographic variables?	Comparative: Independent samples t-tests
2b. Is there a statistically significant difference in group means between Flex and Regular nurses for network variables?	Comparative: Independent samples t-tests
2c. Is there a statistically significant difference in group means between Flex and Regular nurses for emotional support variables?	Comparative: Independent samples t-tests
2d. Is there a statistically significant difference in group means between Flex and Regular nurses for satisfaction variables?	Comparative: Chi squares
3a. Is there a statistically significant difference in group means for each of the satisfaction variables[1] in regard to the demographic variables?	Comparative: Independent samples t-tests
3b. Is there a statistically significant difference in group means for each of the satisfaction variables in regard to the social network variables?	Comparative: Independent samples t-tests
3c. Is there a statistically significant difference in group means for each of the satisfaction variables in regard to the emotional support variables?	Comparative: Independent samples t-tests

[1] "Difference in group means for each of the satisfaction variables" = differences in means for nurses who wanted more (total network members, emotional supports, instrumental supports) versus those nurses who did not.

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Due to large sample size, there may have been some statistical findings of unimportant significance. For correlational analyses, effect size was determined by r squared, and for t-tests, simple effect size was calculated by dividing the difference of group means by a pooled standard deviation. Chi square effect sizes were computed with another formula utilizing the chi square values and actual sample size (Lipsey & Wilson, 1999). Because some of the analyses may have been due to chance alone, hypothesis-specific Bonferroni tests were done to adjust significance levels. Some interesting trends at lower significance levels are also reported.

The descriptive data in Table 3 demonstrate that for Flex (N=46) and Regular nurses (N=120), peers represented a larger proportion of network members than did managers for all three closeness rings. For both nursing groups, peers also provided a larger proportion of different types of emotional support than did managers. For both nursing groups, 40% of the nurses wanted more network members. For emotional support, 40% of Flex wanted more support, and 50% of Regular nurses wanted more support. For instrumental support, 50% of both groups wanted more support.

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Table 3.

Descriptive Statistics for Major Independent and Dependent Variables

	Nursing Status			
	Regular		Flex	
Variables	Mean	SD	Mean	SD
DEMOGRAPHICS				
#Units worked	1.0	0.0	3.3	1.8
Hours/pay period	55.6	18.4	41.8	21.6
Months at TCH	120.1	94.1	99.5	72.3
NETWORK				
# People in network	13.8	8.3	11.4	6.5
# People in 1st ring	4.7	3.2	3.8	2.9
# People in 2nd ring	5.6	4.5	4.6	3.5
# People in 3rd ring	3.5	3.8	3.0	2.4
% Peers in 1st ring	81.7	29.3	69.1	38.1
% Peers in 2nd ring	73.3	32.2	72.5	33.4
% Peers in 3rd ring	49.7	44.7	42.1	43.5
% Managers in 1st ring	12.7	23.4	11.6	20.7
% Managers in 2nd ring	18.6	27.3	19.1	28.1
% Managers in 3rd ring	17.3	30.7	27.9	37.3
EMOTIONAL SUPPORT				
# People for confiding	4.0	2.5	3.3	2.7
% Peers for confiding	83.1	27.3	67.9	37.3
% Managers for confiding	12.5	22.0	13.5	22.0
# People for reassurance	4.1	3.1	3.4	3.2
% Peers for reassurance	82.2	29.9	63.9	38.7
% Managers for reassurance	12.1	23.2	14.9	24.1
# People for respect	6.7	4.7	6.3	4.3
% Peers for respect	76.1	30.0	69.4	31.4
% Managers for respect	16.4	22.8	19.9	23.2
# People for handling upsets	3.7	2.9	2.8	3.5
% Peers for upsets	78.6	33.6	57.9	42.0
% Managers for upsets	10.5	20.8	10.5	17.2
# People for major decisions	1.5	1.8	1.3	1.7
% Peers for major decisions	52.0	47.6	38.3	43.2
% Managers for major decisions	8.6	23.5	10.6	21.7
SATISFACTION 1=No, 2=Yes				
Want more people in network	1.4	.5	1.4	.5
Want more for emotional support	1.5	.5	1.4	.5
Want more for instrumental support	1.5	.5	1.5	.5

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Associational Analyses

Associations among network composition variables

A Bonferroni test set the significance level at .001. The total number of people in the network significantly correlated with the numbers of people in each of the closeness rings: 1st ring $r(166)=.587$, $p<.0001$; 2nd ring $r(166)=.815$, $p<.0001$; and 3rd ring $r(166)=.737$, $p<.0001$. As network numbers increased, individuals were added to all three closeness rings.

With regard to ring patterns, there was a trend towards positive correlations between total network size and proportions of peers in the first and second rings. There were no significant associations between total network size and proportions of managers in the three rings. The correlations are summarized in Table 4.

Table 4.

Correlations for Total Network Size and Ring Composition

	%Peers in 1st Ring	%Peers in 2nd Ring	%Peers in 3rd Ring	%Manager in 1st Ring	%Manager in 2nd Ring	%Manager in 3rd ring
Total#	.182*	.227**	-.137	.086	-.127	-.174

*Correlation is significant at $p<.05$ (2-Tailed significance).
**Correlation is significant at $p<.01$ (2-Tailed significance).

Associations among nursing demographic variables

Among the nursing demographic variables, there were no significant associations at the Bonferroni test's significance level of .001. There was one weak negative correlation between number of nursing units worked and number of hours worked per pay

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period, $r(166) = -.187$, $p < .05$. This was applicable to Flex nurses who worked multiple units.

Research question 1a

Pearson correlations examined the associations between the nursing demographic variables and social network composition variables. The Bonferroni test set the significance level at .001 for this series of correlations. See Table 3 for the specific variables. There were no significant associations between the number of units worked and social network composition variables.

There were no significant associations between the hours worked per pay period and social network composition variables.

Months worked at the hospital did not correlate with total network size, numbers of people in the closeness rings, or the proportions of peers and managers in the closeness rings.

Research question 1b

Correlations between demographic variables and emotional support variables were next investigated. The significance level was set at .001 using the Bonferroni test. Trends and significant associations are summarized in Table 5. One trend showed that as the number of units worked increased, there was a decrease in the proportion of peers utilized for reassurance and dealing with upsets. Since Flex nurses worked multiple units, these associations were due to them. Another trend showed that as hours worked per pay period increased, the proportion of peers utilized for confiding and respect increased. There were no significant associations between months worked at the

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children's hospital (TCH) and the proportions of peers utilized for the five different types of emotional support.

Table 5.

Correlations for Demographic and Emotional Support Variables

	#Units worked	Hours per pay period	Months at TCH
%Peers for Confiding	-.093	.180*	-.030
%Peers for Reassurance	-.191*	.123	.025
%Peers for Respect	-.037	.156*	-.039
%Peers for Upsets	-.217**	.078	.099
%Peers for Major Decisions	-.020	.034	.063
%Managers for Confiding	-.009	-.107	.008
%Managers for Reassurance	.056	-.128	.016
%Managers for Respect	.118	-.061	.036
%Managers for Upsets	.009	-.003	.029
%Managers for Major Life Decisions	-.025	-.053	.027

*Correlation significant at $p < .05$ (2-Tailed).

** Correlation significant at $p < .01$ (2-Tailed).

Associations Between Social Network and Emotional Support Variables

The Bonferroni test set the significance level at .0001. For the variable, total network size, there was only significant, but weak positive association between the

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total number of people in the network and the proportion of peers utilized for respect with $r = .228$, $p < .0001$. Otherwise, there were no significant associations between total network size and the proportions of peers or managers utilized for different kinds of emotional support.

Table 6 shows that as the proportions of peers in the 1st ring increased, the proportions of peers utilized for all types of emotional supports increased. As the proportions of 1st ring managers increased, the proportions of managers utilized for all types of emotional supports increased. As the proportions of 1st ring peers increased, the proportions decreased of managers utilized for confiding, reassurance, and handling emotional upsets. There was a trend for respect, and there was no significant correlation or trend for helping with major life decisions. Similarly, when the proportions increased of managers utilized for confiding, reassurance, and handling emotional upsets, there was a decrease in these types of emotional support provided by peers: There were trends for providing reassurance, respect, and helping with major life decisions.

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Table 6.

Correlations for Emotional Support Variables and 1st Ring Network Composition

Emotional Supports	% Peers in 1st Ring	% Managers in 1st Ring
% Peers for Confiding	.599**	-.296**
% Managers for Confiding	-.426**	.593**
% Peers for Reassurance	.559**	-.258*
% Managers for Reassurance	-.395**	.502**
% Peers for Respect	.506**	-.243*
% Managers for Respect	-.251*	.292**
% Peers for Handling Upsets	.403**	-.090**
% Managers for Handling Upsets	-.304**	.470**
% Peers for Major Life Decisions	.287**	-.129
% Managers for Major Life Decisions	-.185	.359**

*Correlation significant at $p < .005$ (2-Tailed).
** Correlation significant at $p < .0001$ (2-Tailed).

At the 2nd ring level, as the proportions of peers in the 2nd ring increased, the proportions of peers utilized for reassurance and respect increased. As the proportions of 2nd ring managers increased, the proportions of managers utilized for reassurance and respect increased. A trend showed that as the proportion of peers utilized for respect increased, the proportion of managers utilized for respect decreased. Another trend showed that as the proportion of managers utilized for respect increased, the proportion of peers utilized for respect decreased. Table 7 illustrates these correlations.

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Table 7.

Correlations of Emotional Support Variables and 2nd Ring Network Composition

Emotional Support	% Peers in 2nd Ring	% Managers in 2nd Ring
% Peers for Confiding	.160	.065
% Managers for Confiding	-.040	.122
% Peers for Reassurance	.293**	-.063
% Managers for Reassurance	-.170	.271**
% Peers for Respect	.405**	-.215*
% Managers for Respect	-.259*	.472**
% Peers for Emotional Upsets	.153	.054
% Managers for Emotional Upsets	-.029	.109
% Peers for Major Life Decisions	.106	.012
% Managers for Major Life Decisions	-.009	.034

* Correlation significant at $p < .005$ (2-Tailed).
** Correlation significant at $p < .0001$ (2-Tailed).

Table 8 depicts the associations among emotional support variables at the 3rd ring level. At this farthest level, there were two trends: As the proportion of peers increased, the proportion of peers utilized for respect increased. And as the proportion of managers increased, the proportion of managers utilized for respect increased.

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Table 8.

Correlations of Emotional Support Variables and 3rd Ring Network Composition

Emotional Support	% Peers in 3rd Ring	%Managers in the 3rd Ring
%Peers for Confiding	-.063	-.032
%Managers for Confiding	.020	.064
%Peers for Reassurance	.069	-.094
%Managers for Reassurance	.006	.106
%Peers for Respect	.201*	-.115
%Managers for Respect	-.106	.194*
%Peers for Dealing with Upsets	.046	-.098
%Managers for Dealing with Upsets	-.052	.077
%Peers for Handling Major Life Decisions	.024	-.073
%Managers for Handling Major Life Decisions	.020	-.022

*Correlations significant at $p < .05$ (2-Tailed).

Comparative Analyses

Research question 2a

A series of independent samples t-tests were executed with the independent variable, nursing status (Flex, Regular), and the demographic variables as dependent variables. The significance level was set at .001. Since Flex nurses worked multiple units and Regular staff were based on one unit, there was an expected significant difference between groups for number of units worked ($t = 14.094$, $df = 164$, $p < .0001$). There were no other significant differences between Flex and Regular staff.

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Research question 2b

There were no significant differences between the means of the two nursing groups for any of the social network composition variables.

Research question 2c

The t-test results are summarized in Table 9 for the differences in means of the two nursing groups for the emotional support variables. The Bonferroni test set the significance level at .002. There were significant differences between Flex and Regular staff for proportions of peers utilized for reassurance and handling emotional upsets, and there was a trend for confiding. Regular nurses identified significantly higher proportions of peers in their networks for these types of emotional support than did Flex nurses. There were no significant differences or trends between groups for peer respect or for peer help with major decisions. There were no significant differences between groups in regard to proportions of managers providing the five types of emotional support. The effect sizes for the t-tests on proportions of peers providing emotional support ranged from .3 to .6. The effect sizes for the t-tests for managers providing emotional support ranged from .04 to .15.

Research question 2d

Chi square analyses were used to compare Flex and Regular staff on wanting more network members, wanting more emotional support, and wanting more instrumental support. There were no significant differences detected. For network size, χ^2 (1,N=166)=.166,ns. For emotional support, χ^2 (1,N=166)=.136,ns. For instrumental support, χ^2 (1, N=166)=.024,ns. The effect sizes were small.

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Table 9.

Comparison of Flex and Regular Nurses Using Independent Samples t-tests

	Regular		Flex			
	Mean	SD	Mean	SD	t	Significance
%Peers Confiding	83.0	27.3	67.9	37.3	-2.9	.005
%Peers Reassure	82.2	29.9	63.9	38.7	-3.2	.001
%Peers Respect	76.0	29.9	69.4	31.4	-1.3	.210
%Peers for Upset	78.6	33.6	57.9	41.9	-3.3	.001
%Peers for Major Decisions	52.0	47.6	38.3	43.3	-1.7	.090
%Managers Confiding	12.5	22.0	13.5	22.0	.260	.796
%Managers Reassure	12.1	23.2	14.9	24.1	.694	.489
%Managers Respect	16.4	22.8	19.9	23.2	.883	.378
%Managers for Upset	10.5	20.8	10.5	17.2	.001	.999
%Managers for Major Decisions	8.7	23.5	10.6	21.7	.488	.626

Research question 3a

T-tests were used to examine differences between levels of the variable, "wanting more network members"(1=No, 2=Yes), on the demographic variables. There were significant results for months worked at the hospital ($t=4.4, df=164, p<.0001$). The two group means were: No ($M=138$, $SD=90.1$) and Yes ($M=80$, $SD=75$). The effect size was high (.7). The dependent variable was recoded into more specific time categories to ascertain the possibility of an "adjustment period." Time categories were created with expected cell counts greater than 5. A chi

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square analysis was significant: χ_2 (3, N=166) =15.7, p <.0001. The effect size was high (.64). Table 10 provides a summary of the cell counts.

Table 10.

Cell Counts for Wanting More People in Network

	Wanting More People in Total Network		
Months Split into Categories	No	Yes	Total#
0-24	14	22	36
25-48	4	10	14
49-90	13	6	19
>91	67	30	97

A series of t-tests were conducted between the levels of the variable, "wanting more people for emotional support" (Yes/No), and the demographic variables. Months at the hospital yielded significant results. The means of the two groups were significantly different (Yes: M=92.9, SD 85.2; No: M=132, SD=88) with t=2.93, df=164, p<.004. The effect size was moderate (.45).

There were no significant differences between levels of the variable, "wanting more instrumental support" (Yes/No), and the demographic variables.

Research question 3b

Another series of t-tests investigated differences between group means for "wanting more people in the network" and the social network composition variables. There were no significant findings. There were also no significant differences on group means for "wanting more people for emotional support" and "wanting more people for instrumental support" with regards to the network variables.

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Research question 3c

The differences in means for each of the satisfaction variables were also tested for the emotional support variables. There were no significant findings.

Supplemental Findings

A series of additional statistics, paired samples t-tests and independent samples t-tests, were performed to further analyze the nature of the Flex and Regular nurses' social networks. The effect sizes for the paired samples t-tests were calculated using a modified pooled standardized deviation for comparison groups with the same sample size (Lipsey & Wilson, 1999).

Paired Samples t-tests on Social Network Composition

To supplement the correlational findings on social network composition variables, a series of paired samples t-tests were done between the proportions of peers in the three closeness rings, and between the proportions of managers in the three closeness rings. Comparisons were also made between proportions of peers and proportions of managers within the three rings. Table 11 summarizes these results. The significance level for these paired samples t-tests was set at .001 after the Bonferroni test.

There was no significant difference in group means between the proportion of peers in the 1st ring and the proportion of peers in the 2nd ring. There was a significant difference in group means between the proportions of peers in the 2nd ring and those in the 3rd ring, with a higher proportion of peers in the 2nd ring versus the 3rd ring.

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Table 11.

Paired Samples t-tests of Peers and Managers Within the Closeness Rings

Pairs	Means	SDs	t	Significance
% Peers in 1st Ring	78.3	32.4	1.6	.11
% Peers in 2nd Ring	73.0	32.4		
% Peers in 2nd Ring	73.0	32.4	6.8	.0001
% Peers in 3rd Ring	47.6	44.4		
% Managers in the 1st Ring	12.4	22.6	-2.3	.023
% Managers in the 2nd Ring	18.7	27.4		
% Managers in the 2nd Ring	18.7	27.4	-.49	.625
% Managers in the 3rd Ring	20.2	32.9		
% Peers in the 1st Ring	78.2	32.4	17.4	.0001
% Managers in the 1st Ring	12.4	22.6		
% Peers in the 2nd Ring	73.3	32.4	12.7	.0001
% Managers in the 2nd Ring	18.7	27.4		
% Peers in the 3rd Ring	47.6	44.4	5.5	.0001
% Managers in the 3rd Ring	20.2	32.9		

For the managers, there were no significant differences between group means for the proportions of managers in the 1st, 2nd, or 3rd rings. There were significant differences between group means for the proportions of peers in the 1st ring and the proportions of managers in the 1st ring: There was a higher proportion of peers in the 1st ring. A similar significant difference was found between group means for the proportions of peers and the proportions of managers in the 2nd and 3rd rings, respectively. For both ring levels, there were significantly higher proportions of peers than managers. For the significant findings, effect size was large (> .65).

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Paired Samples t-tests on Proportions of Peers Used for Emotional Support

Paired samples t-tests were used to discern differences in proportions of peers utilized for different types of emotional support according to their ring location. The Bonferroni test set the significance level at .001. Table 12 summarizes these results. The proportions of 1st ring peers utilized for most types of emotional support were significantly greater than the proportions of 2nd ring peers utilized for emotional support: There was a trend for respect. The proportions of 2nd ring peers utilized for most types of emotional support were significantly greater than the proportions of 3rd ring peers utilized for these types of support with a trend for major life decisions. Effect size was large >.65.

Table 12.

Paired Samples t-tests of Proportions of Peers Offering Emotional Support

	Mean	SD	t	Significance
% Peers in 1st Ring Confiding &	77.9	35.4	12.2	.0001
% Peers in 2nd Ring Confiding	23.9	40.2		
% Peers in 2nd Ring Confiding &	23.9	40.2	5.3	.0001
% Peers in 3rd Ring Confiding	5.7	22.9		
% Peers in 1st Ring Reassuring &	75.7	38.2	10.1	.0001
% Peers in 2nd Ring Reassuring	28.8	43.8		
% Peers in 2nd Ring Reassuring &	28.8	43.8	6.3	.0001
% Peers in 3rd Ring Reassuring	6.9	25.1		
% Peers in 1st Ring Respect &	70.2	39.9	2.8	.005
% Peers in 2nd Ring Respect	56.9	45.3		
% Peers in 2nd Ring Respect &	56.9	45.3	7.1	.0001
% Peers in 3rd Ring Respect	28.1	42.9		
% Peers in 1st Ring Upsets &	70.4	41.9	9.9	.0001
% Peers in 2nd Ring Upsets	24.4	41.0		
% Peers in 2nd Ring Upsets &	24.4	41.0	5.7	.0001
% Peers in 3rd Ring Upsets	5.5	22.2		
% Peers in 1st Ring Life Decisions &	50.4	48.2	10.2	.0001
% Peers in 2nd Ring Life Decisions	8.1	27.1		
% Peers in 2nd Ring Life Decisions &	8.1	27.1	3.2	.002
% Peers in 3rd Ring Life Decisions	1.3	11.1		

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Paired Samples t-tests on Proportions of Managers Used for Emotional Support

Table 13 shows that for managers, unlike for peers, there were no significant differences in proportions of managers providing types of emotional support with regard to their ring location. For example, the proportions of 1st ring managers utilized for reassurance were not significantly different from the proportions of 2nd ring or 3rd ring managers utilized for reassurance. There was a trend for the proportion of 2nd ring managers utilized for confiding to be greater than the proportions of 3rd ring managers utilized for confiding. Effect size was low <.1.

Table 13.

Paired Samples t-tests on Proportions of Managers for Emotional Support

	Mean	SD	t	Significance
% Managers in 1st Ring for Confiding &	10.9	22.8	.91	.365
% Managers in 2nd Ring for Confiding	8.5	24.2		
% Managers in 2nd Ring for Confiding &	8.5	24.2	2.9	.004
% Managers in 3rd Ring for Confiding	2.1	13.9		
% Managers in 1st Ring for Reassuring &	9.1	21.2	-.264	.792
% Managers in 2nd Ring for Reassuring	9.7	27.3		
% Managers in the 2nd Ring for Reassuring &	9.7	27.3	2.4	.015
% Managers in 3rd Ring for Reassuring	3.9	19.1		
% Managers in the 1st Ring for Respect &	12.1	23.9	-.892	.374
% Managers in the 2nd Ring for Respect	14.7	29.1		
% Managers in the 2nd Ring for Respect &	14.7	29.1	2.1	.041
% Managers in the 3rd Ring for Respect	9.3	25.6		
% Managers in the 1st Ring for Upsets &	10.1	24.2	1.0	.302
% Managers in the 2nd Ring for Upsets	7.5	22.6		
% Managers in the 2nd Ring for Upsets &	7.5	22.9	1.5	.137
% Managers in the 3rd Ring for Upsets	4.2	19.3		
% Managers in 1st Ring for Life Decisions &	8.6	24.6	1.3	.182
% Managers in 2nd Ring for Life Decisions	5.1	21.8		
% Managers in 2nd Ring for Life Decisions &	5.1	21.8	2.3	.023
% Managers in 3rd Ring for Life Decisions	1.2	10.9		

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Paired Samples t-tests Comparing Peer/Manager Emotional Support

Paired samples t-tests also showed that within ring levels, the proportions of peers utilized for all types of emotional support were significantly greater than the proportions of managers utilized for emotional support. Table 14 illustrates the results of paired comparisons for the 1st ring. Paired comparisons between proportions of peers and managers at the 2nd ring level and the 3rd ring level also revealed significant differences in utilization for all types of emotional support. For example, proportions of 2nd ring peers were significantly greater than proportions of 2nd ring managers utilized for confiding, reassurance, respect, handling emotional upsets and helping with major life decisions at $p < .0001$. The effect size ranged from .3 to .6.

Table 14.

Paired Samples t-tests for 1st Ring Peers/Managers Offering Emotional Support

	Mean	SD	t	Significance
% Peers Confiding &	78.0	35.4	17.1	.0001
% Managers Confiding	10.9	22.8		
% Peers Reassuring &	75.7	38.2	17.0	.0001
% Managers Reassuring	9.1	21.2		
% Peers Respect &	70.2	39.9	14.6	.0001
% Managers Respect	12.1	24.0		
% Peers for Upsets &	70.4	41.9	13.9	.0001
% Managers for Upsets	10.1	24.2		
% Peers for Life Decisions &	50.4	48.2	9.5	.0001
% Managers for Life Decisions	8.6	24.6		

Independent Samples t-tests on Nursing Groups for Peers/Managers' Emotional Support

Additional independent samples t-tests were performed to determine whether there were differences between Flex and Regular nurses with regards to proportions of

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peers and proportions of managers utilized for emotional support from within the different closeness rings. The Bonferroni test set the significance level at .001.

Within the 1st ring, there were significant differences between Flex and Regular nurse group means for proportions of peers providing confiding, reassurance, and help with handling emotional upsets: Significantly greater proportions of peers were utilized by Regular nurses for these types of support. There were no significant differences in nursing group means with regards to respect or helping with major life decisions. Effect size for significant results was large (>.6). Table 15 reports these results.

Table 15.

Independent Samples t-tests for Flex and Regular Nurses on Emotional Support Variables

Emotional Supports Provided by % Peers in 1st Ring	Nurse Status: Flex (N=46) Regular (N=120)	Mean	SD	t	Significance
Confiding	Flex	61.8	43.5	-3.78	.0001
	Regular	84.2	29.8		
Reassuring	Flex	59.5	44.3	-3.5	.001
	Regular	81.9	33.8		
Respect	Flex	60.9	42.2	-1.9	.062
	Regular	73.8	38.5		
Helping with Emotional Upsets	Flex	51.6	47.4	-3.7	.0001
	Regular	77.6	37.3		
Helping with Major Life Decisions	Flex	40.5	46.4	-1.6	.100
	Regular	54.2	48.6		

At the 2nd ring level and the 3rd ring levels, there were no significant differences between Flex and Regular nurse group means for proportions of peers utilized for emotional supports. There were no significant differences between Flex and Regular

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nurse group means for proportions of managers utilized for emotional supports at the 1st, 2nd, and 3rd ring levels.

Summary

An overview is provided of the key, significant findings from the quantitative portion of the study:

1. Descriptive findings: There were more peers and proportions of peers in both types of nurses' overall networks and in each of the closeness rings. For both types of nurses, proportionally more peers were utilized for all types of support than were managers. For both groups 40% wanted more people in their overall networks, 40 to 50% (Flex/Regular) wanted more people for emotional support, and 50% of both groups wanted more instrumental support.

2. Associations among the network variables: As total network numbers increased, numbers of people increased in all three rings. There was a trend towards positive correlations between total network size and proportions of peers in the first two rings. There were no significant associations among network variables and manager variables.

3. Associations among the demographic variables: There was one weakly significant negative correlation between number of nursing units worked and number of hours worked per pay period.

4. Associations between the nursing demographic variables and social network composition variables (1a): There were no significant associations between the number of units worked, the hours worked per pay period, the months worked at the hospital and the social network composition variables.

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5. Associations between demographic variables and emotional support variables (1b): Although there were a few trends, there were no significant associations between the number of units worked, hours worked per pay period, months worked at the hospital and the emotional support variables.

6. Associations between social network composition variables and emotional support variables: There was a weakly positive association between total network size and the proportions of peers utilized for respect.

In the 1st ring, as the proportions of peers increased, there was a significant increase in the proportion of peers utilized for all types of emotional support. This pattern also existed for managers in the 1st ring. In addition, as the proportion of peers in the 1st ring increased, the proportion of managers utilized for most types of emotional support decreased (except for respect and helping with major life decisions). Similarly, as the proportions of managers providing emotional support increased, there was a decrease in the proportions of peers providing support, particularly with regards to confiding and handling emotional upsets: There were trends for the other types of emotional supports.

In the 2nd ring, there was a positive association between proportions of peers and proportions of peers utilized for reassurance and respect. A similar positive association existed between proportions of managers and the emotional supports, reassurance and respect. Two trends indicated that as the proportion of peers providing respect increased, the proportion of managers providing respect decreased, and vice versa. There were no significant associations at the 3rd ring level.

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7. Comparisons between Flex and Regular nurse group means for demographic variables (2a): There were no significant differences, except that Flex nurses worked more units (M=3.3, SD=1.8) versus Regular (M=1.0).

8. Comparisons between Flex and Regular nurse group means for social network composition variables (2b): There were no significant differences.

9. Comparisons between Flex and Regular nurse group means for emotional support variables (2c): Regular nurses utilized greater proportions of peers for reassurance and handling emotional upsets, and there was a trend for confiding. There were no significant differences for respect or handling major life decisions. There were no differences between groups for proportions of managers providing different kinds of emotional support.

10. Comparisons between Flex and Regular nurse group means for satisfaction variables (2d): There were no significant differences between groups for wanting more network members, wanting more people for emotional support, or wanting more people for instrumental support.

11. Comparisons between satisfaction variable levels (Yes/No) on demographic variables (3a): Nurses who worked fewer months at the hospital wanted more people in their network, and they wanted more emotional support. The observed cell counts for "wanting more people in network" suggested that nurses who had been at the hospital less than 4 years wanted more people in their networks, but nurses who had been at the hospital over 4 years did not.

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12. Comparisons between satisfaction variable levels revealed no significant differences on the social network composition variables (3b), or the emotional support variables (3c).

13. Supplemental findings on network composition: There were no differences in proportions of peers in the 1st and 2nd rings, but there were significantly greater proportions of peers in the first two rings, versus the 3rd ring. There were also significantly greater proportions of peers in the first two rings compared with proportions of managers. For managers, there were no significant differences in proportions of managers between the three closeness rings.

14. Supplemental findings of emotional support variables: The proportions of 1st ring peers were utilized significantly more for most types of emotional support than were 2nd ring peers: There was a trend for respect. Proportions of 2nd ring peers were utilized significantly more for most types of emotional support than were 3rd ring peers: There was a trend for major life decisions. These patterns did not exist for managers in the nurses' social networks. At each ring level, the proportions of peers utilized for all types of emotional support were significantly greater than the proportions of managers utilized for emotional support.

15. Supplemental findings of nursing group comparisons for peer and manager emotional support at each ring level: At the 1st ring level, there were significant differences between Flex and Regular nursing group means for proportions of peers providing confiding, reassurance, and help with emotional upsets. The Regular nurses utilized significantly greater proportions of peers for these types of emotional support than did Flex nurses. There were no significant group mean differences for respect or

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handling major life decisions. At the 2nd and 3rd ring levels, there were no significant differences between group means for proportions of peers utilized for emotional support, and at all three ring levels, there were no significant differences in nursing group means for utilization of proportions of managers for emotional support.

The qualitative analysis section will provide more descriptive and explanatory details, and hopefully, hone some of the conclusions from the quantitative portion.

Qualitative Analysis

The original research question sought to provide description of a special population of nurses within one institution. The Flex nurses of Children's Hospital comprised about 20% of the nursing staff. They were a buffer for patient census changes, and they covered multiple units and worked on short notice: They were not pre-scheduled, and they were cancelled if they were not needed. Conversely, the Regular nurses at Children's had continuity and predictability to the routines, the expectations, and the social surroundings. The original research question, therefore, focused on understanding how these Flex nurses socialized and adapted to their noncontinuous and unpredictable work environments.

This topic was chosen because the business management literature suggests that flexibility is wanted and needed by contemporary organizations and their employees. This study was designed to find out how a flexible group of nurses managed within their work environment. How did they get along with their work colleagues? What was helpful to them? What was not helpful to them? Hopefully, answers to such questions will be useful when planning orientation programs and providing ongoing professional supports for Flex individuals.

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What evolved during the course of this study was a realization that I was dealing with layers of culture—each layer socialized to meet its cultural members' needs. Culture, therefore, became a backdrop for this study without my recognizing what was happening. Perhaps it dawned on me when I began identifying with Flex nurses'statements about pride in being a nurse--a sense of professionalism; and when I appreciated Flex nurses' comments about Children's Hospital—what a great place it is for children; and when I recognized and admired distinctly different features of the Flex nurses I had not sensed or felt as a Regular staff person at the hospital.

There are three cultures imbedded in this study: The culture of nursing as a profession, the culture of Children's Hospital with its own mission and vision, and the culture of Flex nurses within Children's Hospital. A brief overview of nursing culture and Children's Hospital will be provided as background. Although there are numerous definitions of culture, I will use this definition: "A useful way of thinking about where culture comes from...culture is the way in which a group of people solves problems" (Trompenaars, 1994, p.7). I prefer this definition, because it is active. or it focuses on an ongoing process of how people socially interact with each other in order to get something done. A culture comes into being. This seems like a suitable definition to frame a group of Flex nurses created through the needs of an institution to solve its problems.

The traditional way of thinking of culture includes layers. The explicit or outer layer is the one we know best, because it is what we can observe. The language, food, structures, and rituals are the culture's accoutrements that represent the deeper levels. The outer layer reflects people's norms and values. Norms are the group's mutual

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sense of right and wrong ("I should do this"), and values are the group's ideals ("I aspire to do this").The deepest layer, the core, has to do with basic assumptions, perhaps universal assumptions about human existence. All humans need certain things to survive—Maslow's hierarchy of needs. We unconsciously go about meeting our basic needs as these core problems of survival fuel the other cultural layers about us.

The majority of this presentation will focus on the middle layer of the Flex culture. During the course of this study, something happened at Children's Hospital. The hospital administrators encountered a problem with the Flex nurse staffing model and redesigned it to better suit the needs of the hospital. This created problems for many of the Flex nurses, and they were seeking solutions during the time I was interviewing them and making observations. What I witnessed was Flex culture in action. I looked through a window at these nurses' norms and values, and despite the many avenues I pursued to answer my initial questions about work-related social relationships, our conversations always returned to norm and value issues pertaining to the "redesign."

During the interview and observation process, I also learned how impossible it is to disentangle the multiple cultures to which we belong. I struggled with this—trying to ask questions about cultural allegiances. I asked multiple questions about "loyalty" to the organization, to the profession, to peers. It was difficult to distinguish cultural demarcators between the cultures of nursing, the hospital, and peers: Loyalty issues to one affected the others. So I will give you my construction of Flex nursing culture, imbued with nursing culture and Children's Hospital culture.

Chronology

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I spent five months collecting my qualitative data. I began in September 1998 by attending a clinical nursing directors' meeting to introduce my research to the clinical directors (head nurses) of the hospital's inpatient units. At this meeting, the redesign issue was also discussed, and some of the clinical directors asked me how this would affect my research. At that time, I was worried about the redesign, particularly with regards to the quantitative portion of my dissertation: I worried about skewed results on my questionnaire once Flex staff knew about the redesign. I sensed that the clinical directors believed the redesign would create negative reactions from Flex nurses. I also became nervous that Flex would be upset by the redesign and not do my questionnaire. I expedited the questionnaire and distributed it within a week of the clinical directors' meeting!

After the initial clinical directors' meeting, the redesign process moved quickly. A redesign committee of clinical directors used data from a variety of sources to draft a Flex redesign proposal: This happened within weeks. In October, the committee held focus groups with Flex nurses to discuss the draft proposals and solicit their input. The committee drafted a series of plans that were further discussed by the clinical directors, and a final plan was issued and circulated to Flex staff in December.

I attended two of the focus groups, and I spoke with redesign committee members. I kept copies of the proposal drafts and took notes of my impressions. In many respects, I tried to avoid too much contact with the clinical directors. I stopped going to meetings and took a few weeks to divorce myself from the directors' approach to the redesign process. I wanted to get close to the Flex nurses and their situation.

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Although I needed background information from the clinical directors, my real focus was the Flex nurses.

I began interviewing Flex nurses in January 1999. I had a sampling plan figured out. I was going to use a list of representative Flex nurses given to me by a key informant, the clinical director of the Flex team. Instead, I ended up going to the Flex nurse staffing office and asking for the whereabouts of Flex nurses on the days I was at the hospital to set up interviews and to observe. I went to units, watched Flex nurse interactions, and asked Flex staff to interview with me. I wondered if this was too haphazard an approach, but I ended up walking into interesting situations, and it gave Flex staff a chance to know me, too. It was acceptable to sit at the desk and talk about the day, how things were going. Casual contacts progressed to confidentially taped interviews or private discussions over the phone, and the Flex nurses I met were very willing to answer my questions. I felt better wandering the units and sitting down with the nurses, and the Flex nurses seemed to accept my presence and the purpose of my questions. I continued to remind them that my questions were directed at understanding their work relationships and their Flex nursing social issues.

Confidentiality became troublesome, because on some units, I would be talking with a Flex nurse and other Flex nurses would join us. Impromptu focus sessions arose, and some Flex nurses passing me in the hall would come up, pull me aside and share something new with me. I had to be careful to protect the confidentiality of Flex nurses who became more open in their approaches to me—more open in their inclusion of me.

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I began to feel camaraderie and respect for the nurses of my interviews and observations. I handled this by "debriefing" myself with a journal. After Flex nurse encounters, I wrote in this journal, and I tried to trace how I was feeling and thinking about Flex nurses at Children's. At the proposal phase of the study, I had recited a litany of Patton's themes to qualitative inquiry, one of those being "empathic neutrality" (Patton, 1990). Deeper into the study, I realized what that term meant, and how difficult it was to achieve. To maintain researcher credibility and to understand the Flex nurse situation, journaling was a necessary means for me to distance the data from my personal judgments of what was going on. A big part of this study's validity rests on my cognitive and my emotional participation with several Flex nurses during the redesign process, but during the analysis of the data, I carefully dissected their words from my insights by constantly comparing their transcriptions with my journal notes, and scrutinizing codes to avoid empathic "subjectivity".

I coded the transcriptions of my notes, journals, and interviews using HyperResearch©. I referred to Miles and Huberman's ladder of analytic abstraction (1994) and Strauss and Corbin's constant comparative analysis techniques (1990). I did sentence by sentence coding and chunked together segments with similar themes. I arranged these themes to reflect the relationships among them, and I wrote a draft of these Flex themes with key quotations. This interim theme summary was distributed to each of the Flex interviewees and two Flex directors. Several of the Flex nurses gave me feedback with additional comments and clarifications. I sat down with one of the Flex nursing directors, a key informant, to get her perspective on the summary piece—Did it make sense to her?

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After validating my thematic interpretations with the Flex nurses and the Flex nursing directors, I went through each of the Flex nurses' interviews and wrote out the majority of quotations from their interviews that substantiated my chosen themes. This was reviewed with one of my committee members. This data "immersion" prepared me to create narrative accounts of the themes of Flex nursing culture at Children's Hospital. My analysis will be presented as theme narratives with illustrative quotations. The last narrative is a redesign narrative that reflects the impact of the redesign process on each of the Flex nurse culture themes. The final section is a "storyline" to integrate the narratives, and to create a summary picture of Flex nursing culture at Children's.

Cultural Background

Nursing culture

The nurses at Children's Hospital share a common nursing culture. The majority of nurses have Bachelor of Science degrees, and to obtain those degrees, they attended accredited professional nursing programs. In nursing school, a primary focus of nurse educators is to assist students with accommodating to the nurse culture. Courses focus on nursing history, nursing issues and trends, nursing ethics, even the women's movement. Students are also expected to spend hundreds of hours in clinical settings, at patient bedsides and in clinics, watching and working with professional nurses.

I went through this acculturation process, and I have initiated and tracked students through their phases of becoming professional nurses. What (we) nurses end up sharing is a common understanding of what we are all about. Our discipline is based on caring, not curing. Every nursing textbook defines nursing as "an art and science by

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which people are assisted in caring for themselves whenever possible" (DeLaune & Ladner, 1998, p.4). There are even nursing theorists with caring theories to postulate the uniqueness of how and what we do.

We also share a professional code of ethics founded on philosophical precepts such as beneficence, justice, fidelity, and autonomy. Every one of us has encountered professional, ethical dilemmas, and many of us have been involved in ethics disputations involving our patients and/or our professional colleagues.

Our practice as nurses is bounded by state statutes, or "standards of practice" that legally define what is safe for us to do. Our nursing roles and scope of care are clearly delineated by legal regulation. Every nurse is accountable for knowing practice laws and adhering to them. Unfortunately, some of us have suffered through malpractice and negligence suits.

New words are creeping into our nursing vocabulary. Business slogans and business reality, such as "managed care," "downsizing," "Health Maintenance Organizations," are becoming common knowledge to nurses. Being a nurse also means providing efficacious care. Nursing is an art, a science, and a business. Nurses are also cognizant of change. It used to happen infrequently, but now it is an inevitability. Most nurses know they will have to adapt to changes and do it quickly. The core culture of modern society is changing, and it has wrought havoc on that perception of having one, stable, lifelong job and being loyal to that job forever and ever. Nurses are wrestling with the old perceptions, too, and nurse administrators, educators, and staff are scrambling to provide quality service that is caring, systematic, and cost-effective in the midst of constant change.

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All of us came out of school and entered nursing with a theoretical base of what we were supposed to do as professional nurses, but now, our core culture has impinged on our cultural definitions. We have all kinds of hybrids around us. Flex nurses are one of those hybrids. The Flex model was created in the business world and adapted to health care to manage patient census fluctuations. This model of business dollars and "sense" has been superimposed on a professional nursing foundation of ethics, legalities, art, and science.

Children's Hospital culture

The nurses will tell you that Children's is a great place to work: Professionals work together to provide the best, possible care for children. It has been a place where professional nurses can practice the art and science of nursing among other professionals who share their nursing definition, their sense of ethics, and their knowledge of legalities. There is the mission statement: "To improve the health of children in Denver, Colorado, and the region, through the provision of high quality, coordinated programs of patient care, education, research, and advocacy." Professionals who have been at Children's know that the mission is not empty rhetoric. Through an affiliation with the University of Colorado Health Sciences Center and numerous awards and grants, Children's has maintained an impressive array of interdisciplinary projects to improve children's health through all the avenues mentioned in the mission. Children's is a tertiary care center with specialists and cutting edge treatments and technology: The patients have complex needs. To provide cost-effective and humane care, the staff has to collaborate to minimize intrusion and to solve unknowns efficiently.

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There are messages and broadcasts everywhere of what Children's represents and what it does for children's health care. There are Children's Hospital magazines and newsletters, an Internet site, and an in-house television station announcing ongoing activities and projects at the hospital. The hospital is an exciting place to be. Every week, there are seminars or educational in-services to attend, and nationally and internationally acclaimed guest lecturers are at the hospital on regular bases. Celebrities also tour the hospital and visit with the families and the staff.

Nurses at Children's are surrounded by state-of-the-art care, new technology, new policies and procedures, and evolving professional expectations. Nurses do more than clinical care: They are directly and indirectly involved in educating new nurses, medical interns and residents, and they assist and/or direct research to support new clinical practices. Nurses at Children's, therefore, know that they have many opportunities to live the mission, and to fulfill what it means to be a professional nurse. In this often frenetic environment, they must also accept an increased accountability to each other and to the public.

Flex history

The nurses at Children's realize that business realities have afflicted health care, and nursing management has regular staff meetings to inform staff of the economic realities. For over two years, Children's Hospital has been booming while the industry has been imposing tighter and tighter restrictions on care management. The nurses have been stressed by an unending workload. At full census, or a maximum hospital capacity of very sick children, there have been few breaks in the hectic pace of care. There used to be seasonal peaks and valleys, and not too long ago, in 1993, the hospital was

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almost forced to lay off nurses. That was the origination of the Flex staffing model. People could join Flex and "keep their foot in the door." The program also served as a kind of cushion against census changes. If the census increased, Flex nurses could be brought in, and if the census dropped, Flex staff could be cancelled, while Regular staff were relatively protected from the up and down census buffets. According to the Director of Nursing, "We designed a team that at the drop of a hat would let us cancel 200 hours of nursing time. That got us through those years—having that type of staffing flexibility."

But things changed in 1996-1997. The inpatient census started rising up and up, and since then, there have been few census valleys. The hospital has remained budgeted for 80% census with Regular staff, and the other staffing needs have been met by Flex nurses—for over two years. The present dilemma is a shortage of Regular staff, and Flex have been able to work full-time hours at extra hourly pay rates with few schedule restrictions, because they have been in demand at all times. Instead of filling in as needed, Flex have even become an integral part of some units with chronic staffing problems. Despite recruitment efforts, sufficient numbers of experienced Regular staff are lacking. As stated by the Director of Nursing: "We have the reverse of '93. Instead of a downsize, we need an upsize."

When this reverse trend began, the clinical directors convened annual task force sessions to figure out what to do with the situation, including, "What should we do about Flex?" Unable to bolster the Regular staff numbers, attention turned to Flex. Was there a more effective way to manage Flex and to meet nurse staffing needs?

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In 1996, the task force decided to add requirements to the Flex program. Flex staff were asked to do 10% off-shifts (evenings and nights), and a tracking program was instituted to ensure that Flex nurses met their off-shift requirements. In 1997, Flex off-shift requirements were increased to 25%. In these instances, management's intention was to ease the burden of Regular staff by requiring Flex staff to work some of the less popular shifts.

The latest Flex task force recently issued a redesign with five plans from which to choose. The explicit intention of this redesign proposal was to meet the nursing needs of the hospital, and to fill in the staffing gaps that Regular staff nurses were unable to fill. The majority of the five plans required 50% off-shifts, weekend and holiday coverage. The final proposal packet is contained in Appendix C. In December 1998, Flex nurses received a copy of this proposal with a cover letter explaining the steps taken to provide a careful evaluation of the Flex situation. Flex nurses were asked to choose a plan and return their plan choice/agreement to the Flex staffing office by January 25, 1999. Flex clinical directors were available to answer questions and to address concerns after the proposal was distributed to Flex nurses. The Flex directors were hoping to finalize their tracking plans and formalize the redesign by early March. As of early February, the Flex directors were still waiting for half the Flex staff to return their proposal packets.

Flex nursing culture

All the interviewees were females, Caucasian, with an average age of 31 years. All the interviewees were experienced pediatric nurses with an average of 7 years' clinical practice (range of 4-15 years). Months worked at Children's Hospital ranged from 6 months to 6 years with an average of 3 years' practice at the hospital. Although

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the majority of the interviewees worked straight 12-hour day shifts, two interviewees worked straight night shifts. All the interviewees were Flex II nurses working among four or five units, except one nurse who worked predominantly between two units. Half of the interviewees worked part-time (a maximum of 48 hours per two-week pay period), and half of the interviewees worked full-time (72 hours per two-week pay period). Months as a Flex nurse ranged from 6 months to 3 years with an average of 2 years' Flex nurse experience.

To illustrate the variety of interviewee responses while preserving confidentiality, the nurses are designated by Arabic numerals, Nurse 1 through Nurse 7, throughout the qualitative analysis.

Themes

Flexibility

Flexibility was the primary reason for nurses to do Flex. Flex interviewees stated that they wanted and needed flexibility in their work schedules because of their lifestyles. "I don't know from week to week what I need to be doing with my family" (Nurse 1). For staff with family responsibilities, Flex was an attractive alternative. "I was a Regular staff and went to Flex after having a child. I need to design my own schedule" (Nurse 2). For nurses without family obligations, flexibility was still a key concern. "I was getting frustrated as a Regular staff. I wanted to do spontaneous things, and I couldn't do them. I didn't know a month ahead what would be happening in my life" (Nurse 7). For some of the nurses, flexibility was expressed as variety of work opportunities. "I like the freedom of going to different units" (Nurse 6), and "I went to Flex for the challenge—I was getting bored on one unit and dreaded going to

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work" (Nurse 4). Another nurse indicated that the flexibility saved her from burnout: "I wanted to get off one floor. I was getting too attached to one of my patients, and I needed a change" (Nurse 5).

Flex staff denied that extra hourly wages were the primary consideration in their choice to work Flex. Flex nurses were paid more per hour than Regular staff in exchange for their lack of benefits. The Flex clinical director, however, indicated that when Regular staff benefits were added in to the Regular hourly wage rate, there were only a few cents' difference between Flex and Regular staff salaries. Nevertheless, there was a perception among the Flex nurses and Regular staff nurses that Flex made a lot more money per hour than Regular staff. Flex nurses, however, did not rank money as the major reason for doing Flex. "When I was a new grad, the Flex money was really attractive, and I went after the money. But I soon realized that I wanted the flexibility-that matters more" (Nurse 2). "I like the extra pay because I have benefits with my husband, but I love the flexibility. I can call in when I want to work" (Nurse 5).

Underlying the theme of flexibility was the issue of control. None of the Flex nurses explicitly used the term, but it emerged as an important component of the flexibility theme. Both Flex clinical directors stated that Flex nurses "want control more than anything else. They want to control their schedules." One clinical director stated: "Flex attracts the nurse that wants to stay happy in the profession and is able to do that through an element of control. Control is the huge element."

Flexibility and control needs represent the differences between the traditional roles of nurses and the new Flex role. Because of 24 hour demands in hospital settings,

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nurses are expected to commit to schedules where management can adequately maintain staffing needs to meet patient needs. When Flex was created at Children's, certain nurses chose to go with Flex for a variety of reasons, but the Flex nurse role evolved in to a role synonymous with flexible lifestyle and more control. Managers perceived it as a control issue, but the Flex nurses described it as a flexibility issue.

Flex nurses had a shared rationale for their flexible schedules. "Flex is what it says. People choose their own schedules-there's the flexibility. We get nothing else-no benefits or security. I'm willing to have it that way" (Nurse 3). Some Flex introduced the importance of professionalism: "I'm a professional. Isn't that what a professional's supposed to be? You can work for yourself. You choose for yourself—what you want to do. I'm willing to move around to get my hours in. I'll go anywhere" (Nurse 6).

Flex nurses also described flexibility as the most essential trait Flex nurses must possess. "You have to be flexible when you're going all over. Sometimes it's hard, but I'm very flexible. I think it's different for other nurses who don't like to float or go to other places. Some people are comfortable in one place—they need a home to go to. I don't care about that: I like being flexible and having variety" (Nurse 6). "Flex is more willing to go other places—and without much orientation. We just have to do it" (Nurse 1). Some Flex nurses also described flexibility in terms of unit-to-unit adaptability.

"You are going to lots of different units with lots of different people. You need confidence to go to lots of different places" (Nurse 2). "You have to be able to go with

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the flow. You can't sweat what will happen, because you can't be sure where you will go or what will happen" (Nurse 3).

Communications and performance evaluations were other examples of Flex nurses' flexibility. Hospital and unit-based communications help staff connect with each other, and they also channel important information about policies and procedures, and other issues that impact nurses' standards of practice. For regular staff at Children's Hospital, there were unit-based staff meetings. There were also Intranet communications, and Regular staff had e-mail access. Although the Flex nursing directors had staff meetings, communications were usually routed through minutes and written announcements posted on a bulletin board in the Flex staffing office.

When asked about communications, Flex nurses indicated that they made it their responsibility to find out what was going on, but they typically relied on the grapevine, or informal communications. When they were on units where they were not sure of specific policies and procedures, they went directly to resource people, such as charge nurses, although they also used the unit-based procedure manuals as needed. "I get sufficient housewide communication by talking to people on the units and reading what is posted" (Nurse 4). "I ask people when I don't know something. I don't know if anything formal would be very helpful" (Nurse 6). Flex nurses, therefore, seemed to prefer informal means of staying apprised of hospital activities. They were very flexible (and spontaneous) with regards to finding out what they needed to know.

The same was true of evaluations. Regular staff had fairly routinized , annual evaluation requirements. They had to do peer reviews and meet with their manager-supervisors for merit raise purposes. Flex nurses, however, did not have formal

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evaluation procedures, because they did not receive merit raises. They were only required to meet basic safety and competency requirements. When asked whether they wanted or needed performance, there were mixed responses. Some nurses missed having feedback on the quality of their work, but most Flex did not think that an impartial, constructive process was possible with their multi-unit situation. "Our salary is not based on merit, and there is no consistent person to evaluate the effectiveness of what we do. I think in the beginning, when I was first doing Flex, feedback on how I was doing would have been helpful, but not now" (Nurse 1). "We don't have much of an evaluation. No news is good news. That's hard to swallow sometimes. I personally would like more, but I'm not sure how they (Flex managers) would do it" (Nurse 4). "I hate peer evaluations. You have all those little boxes to mark off, and you get your friends to fill them out. What does that tell you? If you are a professional you should be able to decide for yourself what you are doing well and what you need to change—and be able to sit down with a manager and talk about it. If you're a professional, you should be doing a self-evaluation every day. When I go to different units, I'm constantly learning, and I'm constantly re-evaluating where I am after I have had new experiences" (Nurse 7).

Flex nurses, therefore, were expected to be flexible with regards to communications and evaluations. Regular staff had formal systems in place for both, but Flex nurses relied on themselves to stay informed, and to evaluate their own professional performance and progress. As stated by one Flex nurse, these are professional behaviors. Flex nurses operated with few controls in a flexible environment where they were allowed to determine their own needs. This differed

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markedly from Regular staff, who had fairly formal controls in place, especially in communications and evaluations.

Summary. Flex nurses defined themselves according to their ability and their willingness to be flexible. They saw their work flexibility as an exchange for a flexible work schedule. Flexibility was their primary reason for doing Flex, and it was an umbrella term for all their reasons: "wanting spontaneity," "not knowing my kids' schedules," "wanting challenge and variety at work," "needing to avoid burnout," "avoiding all the committee work and politics on the units." Managers described this same situation as a control issue, where "Flex want to be in control of their own schedules." Flex nurses, however, preferred operating in a flexible environment where there were few controls, even in areas where Regular staff had quite a few, such as communications and evaluations.

Safety

The Flex nurses acknowledged that flexing to multiple units was a hard thing to do. In fact, "floating" was an acknowledged, stressful situation for Regular staff, and Children's Hospital had a float team of regularly-scheduled nurses who went to other units for an hourly rate differential. For floats, and for Flex nurses, it was "part of the job." Because it was part of their role definition, I asked Flex nurses how they dealt with the unknowns. Flex nurses provided a number of traits Flex nurses must possess to be "safe" on different units.

"You have to be able to ask for help. You have to ask. You can't be an expert everywhere. If I wanted to be an expert, I'd stay on one unit and get to know it well. But I want my freedom, so I move around. You have to be prepared to ask for help,

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otherwise you won't be safe and effective" (Nurse 7). "You need to be able to say when something isn't safe or appropriate for you to do. They don't know you or what you can do. You have to be able to say when you need help" (Nurse 3).

The safety issue was also a source of distress for some of the Flex nurses. "They really needed someone on oncology, and they said, 'We'll give you a safe assignment.' But I got a newly diagnosed cancer patient, and I didn't know what to say to the parents. You have to be able to speak up for yourself when the situation's not safe" (Nurse 5). "My least comfort level is the Newborn Center. I got oriented there, but I had stable kids. My first day off orientation, I had a really sick kid. That got to me. I don't go there much, and they don't know me. You have to be assertive, because people don't know what you know or don't know"(Nurse 4).

Flex nurses considered safety as a creed between themselves and Regular staff. In many respects, their reputation on different units with Regular staff depended on their ability to be safe with the unit's patients. Nurse 4 added to her comments about the Newborn Center: "I don't like to go there. Sometimes I think the people doubt you. It would help to go there again and again—to establish connections with the nurses so that they'll know what you can do or not do." Nurse 6: "I ask a lot of questions. I never stop asking questions. That actually helps a lot. Regular staff like that, too, because when you ask questions, they know what you don't know, and they won't worry about you or what you're doing on their unit. They know you'll be safe when you ask for help when you need it. People get into trouble by not saying anything."

During one my of unit visits, a confrontation occurred between a Flex nurse and a unit manager. Other Flex and Regular staff were present, observing the interaction.

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The Flex nurse challenged the safety of her assignment and asked for help. There was tension between the manager and the nurse: The manager initially became defensive towards the Flex nurse, but she agreed to provide extra assistance. Although it was difficult for this nurse to address the manager with an audience of peers, her safety concerns outweighed a risk of embarrassment. After this confrontation, Regular and Flex peers went to her and asked her if she needed any more help. I sensed that the other nurses appreciated this nurse's forthright admission of need for help and empathized with her situation. Later, I spoke with the manager about the incident. She felt that she (and the nurse) could have handled the situation differently, but she said: "She is an excellent nurse. I trust her judgment. I just don't like the way she addressed her concerns."

Summary. Flex nurses considered it their professional responsibility to set limits as part of their role definition: To stay within the scope of their personal practice capabilities. To "be safe" implied "letting people know when the assignment's not safe," and "asking for help when you need it." "Asking questions," and "admitting when I don't know something," were important mechanisms for Flex nurses to establish themselves on units with Regular staff, and they were less comfortable on units where this process was hindered.

"Safety" in nursing has many professional and personal overtones—physical and psychological. Legally, nurses are required to stay within their scope of practice to protect their patients (and themselves) from physical and psychological harm. Many ethical principles, such as nonmaleficience, or "Do No Harm," weigh on nurses' decisions to act or not to act. Failing to act in a safe and prudent manner has resulted in

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damage to patients and loss of licensure as well as professional censure. Safety, therefore, was a paramount concern for Flex nurses who flexed to multiple units with countless unknowns.

Flex nurses were pragmatic about this situation. Their feelers were always out, determining whether the assignment was "safe." They developed "safety" mechanisms or checks and balances to protect themselves and their patients. They actively sought to make "safe" connections on their flex units. Psychological distress occurred in patient care situations where Flex staff did not have safe connections established with their peers. The nature of these connections will be discussed in the next theme.

Of note is that I discussed safety issues with a Flex clinical director. At Children's Hospital, when errors occur or safety is breeched, either patient or professional safety, a report is filled out and investigated by the appropriate clinical director. According to the Flex director, "We get very few reports, especially considering the number of nurses we have." The Flex nurses, therefore, found ways to compensate for their multi-unit flexing, and they found ways to maintain safe, professional standards of care.

Support

Providing safe care was an interpersonal activity. Flex nurses had to ask for help as needed. The Regular staff scrutinized and gauged Flex nursing performance as safe or competent when Flex nurses were on their units. Flex nurses were aware of this scrutiny, and in many instances, they welcomed the attentions and concerns of Regular nurses. Unfortunately, a few Flex nurses also shared negative encounters when their professionalism had been questioned, perhaps unfairly. In most respects, however, Flex

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nurse interviewees described positive working relationships with all their professional colleagues, and during my observations, I saw professional give-and-taking between Flex and Regular nurses. When I did not know the nurses, it was impossible for me to tell who was Regular staff and who was Flex.

I asked a series of questions about work-related relationships, and these questions led to a series of inquiries about emotional support and instrumental support. What I discovered is that Flex nurses viewed their relationships at work in terms of support, particularly support they required to provide safe and effective care. Flex nurses defined emotional and instrumental support as "the help you get when you need it. Emotional support happens when people know you're Flex and will help you when you need it. Instrumental support is the routine help you'd expect when doing procedures-or asking where to find things" (Nurse 2). "Emotional support is when I go to a unit and feel as if I'm included by the staff. They know I'm there and that I'm Flex—that I might need help. I expect the same thing with instrumental support, but emotional support is—emotional! It means showing concerns and interest in someone else. It matters when people can see that you're having a bad time and need help. They'll help you any way they can. Instrumental support is task-oriented. It is something that has to be done.You have to help hold an infant to start an IV"(Nurse 3).

To Flex nurses who worked on multiple units, emotional support was also other nurses' willingness to acknowledge their presence and "find out how you're doing. Nothing intense. I don't need someone like a puppy dog to follow me around and ask me all the time how I'm doing. Just someone who will periodically ask me how things

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are going. I don't like to feel alienated. I want people to know that I'm there and check on me once and a while" (Nurse 1).

How were support relationships established? Flex nurses stated that they had to be assertive and let others know about their skills levels by asking questions. Flex nurses also stated that some nurses and some units were better about establishing support relationships than other units. "It depends on the unit—how the nurses treat you. Most of the nurses are great. But ( ) is a rough crowd. They're quick to point out when they've done something to help you" (Nurse 1). "I get along with most of the nurses. For the most part, people will try to help you out. I like most floors, but I prefer floors where they know you're Flex and will help you out. One unit is bad because they are always short, always stressed. It's that way every day—I think it has taken its toll. Some nurses will say, 'Give ( ) a harder assignment, because she's Flex and she gets paid more. But it's just there, and it doesn't happen often. Most people are great, especially other Flex and Floats around because they know what it's like" (Nurse 5).

Flex nurses developed individual styles of interacting on the different units with different staff, but they all took an active approach by asking questions and soliciting help (to be safe), if help was not offered. One Flex nurse described the technique she used for obtaining help: "In general, there are two types of people. People who love their jobs and people who hate their jobs. Lucky for Children's, most of the people here love what they do—and they let you know it. They'll answer questions and help you out. You can tell. All you have to do is say, 'Can somebody help me?' Somebody will jump up and come with you. That's the person who loves what they're doing, who

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knows what's going on and wants to help. Take for instance, ( ). She loves the kids, and she loves her unit. She's a jumper-upper. She won't let you mess up. That's true when I went to the PICU, too. The first time, I was so terrified. Then I realized, 'These women are not going to let you fail.' They won't let anything happen. If an alarm goes off, they check it. If it's crazy and no one can help anybody else, you have group chaos and you bond because you've all had such a miserable night!"(Nurse 7).

I was intrigued by the amount of time it took to establish support relationships. Flex nurses based length of adjustment time on learning routines and scoping out the helpers. "You need to get your bearings. When I came new to the hospital, it took me about a week. I had to figure out where things were, how they do things on the different units"(Nurse 1). "You catch on pretty quick—who you can trust to answer your questions. It took me a couple of days" (Nurse 6). Flex nurses cited adjustment times of a few days to a few months .

When I asked them whether new graduate nurses should do Flex, the overwhelming response was "No!" "I think it would be real hard for a new grad. There is so much to get down. They're worried about learning new skills—not learning differences between units. It helps to stay in one place for a while to build skills. And the staff don't feel safe with people who are so new and uncertain of what to do. You need so much emotional and technical support when you're new" (Nurse 2). "I don't think this is a good job for people who won't speak up, or new grads. Even for an experienced nurse, you have to figure out who to trust. I think it would be very intimidating for someone so new" (Nurse 4).

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Other relationships were less relevant to Flex nurses with regards to their impact on professional performance. I asked about support relationships with managers. Flex nurses based the quality of their relationships with unit managers on the managers' willingness to help or to provide resources for support. "I don't interact much with the unit managers, but they're usually helpful. Sometimes I don't see much of them, but they'll assign me a resource—that's helpful. If I don't get one, I'll usually ask for one—depending on the unit. It's easier than grabbing anybody walking by! (Nurse 3). "Some of the managers will check on you and make sure you're OK. They want to know what is happening on their unit" (Nurse 4).

When discussing Flex management support, there were mixed responses due to the redesign. Depending on the redesign's impact on their Flex routine, responses towards Flex management varied from very negative to very positive. "I don't trust them. They act sympathetic, but they won't do anything to help you" (Nurse 5). "They are not helpful to me. I don't talk to them. I don't see them. I don't count on them, and they won't advocate for you" (Nurse 4). "I think ( ), Flex manager, is wonderful. She'll take the time to talk to you and find out how you're doing" (Nurse 6). I think ( ) and ( ) on Flex are great. They'll come talk to you and ask how you're doing. They'll even act interested. For Flex or Regular management, it helps when they make you feel needed. It's great to have a manager come up to you and say, 'It's great you're working today. We're glad to have you here.' (Nurse 7).

Flex nurses did not have many comments about relationships at work with other professionals, such as physicians, aides or secretaries. In general, they expected a professional level of behavior from their work colleagues. Flex nurses denied any

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preferential treatment (negative or positive) accorded them because of their Flex status. "I get along fine with the CCPs (aides) and the clerks. I don't notice that they treat Flex differently. I can delegate to them and they'll respond" (Nurse 1). "I get along well with the doctors. I haven't noticed a difference being Flex. They treat us with respect and include us in whatever they're doing for the patients. I treat everybody with respect, and I expect reciprocal treatment. I won't delegate to a CCP unless I know I can trust them—what they can do" (Nurse 5).

I also asked Flex nurses whether the nature of their role affected their relationships with patients and families. Flex nurses did not consider their flexing to be a detriment to patient care. They did not believe that families were aware of their Flex status the majority of the time, and some nurses actually felt that their flexing allowed them to provide better care through a broader knowledge base. "Flex does not make a difference for families. I think the lack of continuity is a problem for some kids with chronic problems, but I don't think Flex makes a difference. There are continuity problems with Regular staff. I think the units try their best to provide continuity for the long-term kids, but there are so many of them, and not enough Regular staff to go around (Nurse 1). "Parents don't know. When I first started here, I would tell them I was a new nurse-not to nursing, but to the hospital. I'd ask them to be patient with me if I didn't know where everything was. They see me as a staff person (Nurse 3). "Sometimes a family will say, 'Oh, you're a float nurse.' Mostly I think it is an asset for families. I know so much more from going to different units. I can do more for them" (Nurse 4).

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I observed a Flex nurse caring for an oncology patient who had been assigned a temporary room on the medical unit while waiting for a bed space on the oncology unit. This child was very sick and upset: The mother was upset. A Flex nurse was assigned to care for this child. The Flex nurse had worked on oncology and actually knew the family. The mother and child were both relieved to see her, and the mother said, "Oh, it is so wonderful to have you here. I didn't know if anyone here knew how to properly access ( )'s mediport." The Flex nurse proceeded to joke with the mother and settle in the child.

Emotional support and support relationships were predominantly defined as helping relationships. Flex nurses also acknowledged the importance of work connections for de-stressing on the job and making casual conversation with each other. "There is a special kind of connection there that makes work fun, even when you're busy or stressed. I feel that way at work, but I don't necessarily confide in people at work—nothing that deep" (Nurse 4). "I need emotional support when I'm upset or panicky. People will get up to help. Someone is caring for you. They could let you hang, but they don't. I think good listening is part of emotional support, too. Some people need to complain, and then they're OK. They'll say, 'I'm sorry I went on and on like that.' And you say, 'That's OK. I do that, too.' Emotional support is never having to say you're sorry. Corny, but true" (Nurse 7).

Summary. Flex nurses had professional expectations of their peers. These expectations were based on their concerns with providing safe and effective care. Flex nurses often functioned in situations where they were not experts, and they needed help in order to do their jobs well. Emotional support was that "connection" between

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nurses, whereby Regular nurses accepted the presence of Flex nurses and were willing to offer help—"just because we're Flex and we don't know the unit as well." Flex nurses quickly differentiated between helper and non-helper nurses and units. They rated the units according to their "helpfulness." To these nurses, therefore, support was providing help to be safe. Emotional support was unsolicited, and instrumental support was a task-specific routine, or "something you're expected to do." Work connections also provided opportunities for venting about the day's activities and sharing light conversations and jokes—ways to make work more pleasurable.

Adjustment depended on acclimating to the physical surrounds and routines, and determining who was helpful or not helpful. The nurses also used the word, "trust." "Trust" was used two different ways. It meant "trusting that someone will help you when you need help," and "trusting that someone will do their job when you delegate to them." In both instances, Flex nurses expected a certain level of professionalism from those around them. On new units, Flex nurses employed a type of help seismograph to determine how much effort they needed to expend to get their work done in a safe and professional manner. They used the words "help" and "trust" to indicate their comfort level with other staffs' level of professionalism. Flex nurses expected their peers to provide emotional support as a natural concomitant of guaranteeing safe and appropriate care for the children on the units. They also expected this professional consideration from unit managers. "They'll check us out to see if we're OK," and "They'll get us resources as needed." "Respect" was another word used to express professional regard and reciprocal treatment among work colleagues. "I'll respect them as professionals, and I expect the same treatment from them."

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Overall, Flex nurses required little time to get their bearings and to determine professionalism among peers and other health care professionals.

Flex nurses had a business-like approach to their work. I liken it to a Gestalt figure-ground approach. They entered a unit and focused on the tasks at hand. They solicited support from others, but it was professional support. Flex nurses denied the need or expectation for more intimate or familiar forms of emotional support, such as confiding, or sharing personal life concerns. Flex nurses in the workplace, therefore, used emotional support to get them through their tasks in a safe and effective manner. Social connections were established through increased contacts from "going back to the same units again and again," and these contacts enhanced the work situation through seeing familiar faces to "shoot the breeze with." But Flex nurses did not necessarily increase their expectations or raise the emotional ante among Regular staff with whom they had more contact: They denied forming more in-depth connections with staff at work. Returning to the figure-ground analogy, Flex nurses moved in and move out quickly. "I do my work, I leave my work, and I go on with my life" (Nurse 7). In a like fashion, support needs moved in and out with the situational demands.

Commitment

Commitment was a layered word, depending on its reference to the profession, to the hospital, and to peers. I addressed these different cultural commitments with the Flex nurse interviewees. Since I believe the Flex nurses had the ability to move in and out of work situations, I was interested in knowing whether Flex nurses sensed a commitment to their roles as nurses, as employees to Children's, and as members of a Flex group.

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The Flex nurse interviewees felt a strong sense of "loyalty" to the nursing profession. "Being a nurse is a large part of who I am, and I will always give my best to provide good care out of loyalty to my profession" (Nurse 1). "I love nursing, and I'm very loyal to my profession" (Nurse 3). "I'm proud of being a nurse. I love my work and I feel good about it" (Nurse 7). Of note is that some Flex nurses felt loyal to the profession, but were not sure if they would remain as nurses. "I feel loyal to nursing, but I don't know what I'll be doing in the future. I don't know about future goals—if something better came along. But for here and now, I feel very committed to my work—I am a professional" (Nurse 3).

Although the redesign was in progress during the interviews, most Flex nurses felt loyal to Children's Hospital. They defined loyalty in terms of loyalty to the people and the patients. "I think being loyal to a place and its people is important. It is important for people to trust you and what you can do. Upholding your professional commitments is important" (Nurse 2). "You need to be loyal to where you are. I was at ( ), and I was not part of a team. I like it here, and I like the units I work on because of the staff. That's why I like to go to certain units where I feel part of the staff. I feel welcome, and I want to work here. I like the quality of this hospital, and most people who work here are happy and care about their work. I think you need to be true to a place—it can affect everybody" (Nurse 6). "I'm pretty new here, but I'm working hard to fit in and get a sense of the place. I think it is important to have a sense of loyalty to where you're at—to the organization and the people. It is important to be loyal to your job and to be a professional—you need to hold up your part for others...Loyalty to me is developing a sense of connection to the place and the people"

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(Nurse 3). "Loyalty is caring about what you do—the ultimate goal of giving good care to your patients. This has been a good place to work, because people here care about the kids" (Nurse 5).

Although the majority of nurses expressed a sense of commitment or loyalty to the hospital through its staff and the patients, some nurses also expressed discouragement towards the hospital management and the profession. "Where I was before, they ran us to the ground. It was awful. There was terrible staffing, and it was not safe for the kids. I finally quit, but I stayed as long as I did because of the wonderful staff. Unfortunately, it is the organizations who treat the nursing profession unfairly and unjustly—they will never get my loyalty. As a result, this profession is very discouraging" (Nurse 1). "Loyalty is a two-way street. I thought it was a good idea when we got bonuses last year. We had all worked very hard. I was not happy when we did not get one this year—we probably worked even harder. I don't think much about loyalty to an institution except when bonus time rolls around" (Nurse 7).

Summary. Flex nurses believed it was important to uphold professional standards of care. They took pride in their place of work, the overall quality of service provided to the patients, and the sense of professional connection among fellow staff. Commitment to nursing, to the institution, and to peers was an intertwining of cultural layers. As professional nurses, there was an obligation to provide safe and effective care. There was also an obligation to peers to be a "team player," because "they trust you to do your part." The Flex nurses expressed their pride in working at an institution with an emphasis on quality care for children and their families. There was an undercurrent of dissatisfaction, however, perhaps a reflection of core culture change—

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attitudes of these nurses went beyond the traditional bounds of nursing and the way society has always defined nursing as a service profession. These nurses' comments reflected their awareness that they had an obligation in the here and now, but if something better came along, or if treatment was unfair or unwarranted, it would be time to quit or to look for prospects elsewhere. Some of the nurses expressed sadness and anger towards unfair treatment, and these "grief" reactions will be described in more detail in the redesign theme.

These Flex nurses generated descriptions of commitment or loyalty as maintaining their part of the bargain: As a nurse, being accountable to professional standards; As a hospital employee, providing safe and effective care; As a peer, being trustworthy and respectful. They were willing to question the reciprocal nature of their commitments or loyalties to nursing, to the institution, and to peers. This may represent a new way of nurse thinking inspired by core culture changes: Flex nurses seemed willing to question the integrity of others' commitments to them.

The following theme of "redesign" will frame the four major Flex culture themes of flexibility, safety, support, and commitment within the context of an event that forced many Flex nurses to examine the importance and the meaning of these themes.

The Redesign

The redesign was a critical incident during data collection that spurred a great deal of discussion Flex nurses, and gave me a better view of their culture. What I saw among the Flex nurses and heard from them reinforced the cultural themes of my initial interviews and observations.

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Flexibility. Flex nurses saw the redesign as a damper on their flexibility, and the redesign prompted a type of grief reaction from many Flex staff. There was anger, denial, sorrow, and guilt. The Flex clinical directors also recognized grief responses from the staff. "They have lost control—the way things used to be." For Flex nurses, their emotional responses were in reaction to a loss of flexibility. "Flex was supposed to be for flexibility. Now it is gone. I am very angry" (Nurse 1). "Lots of Flex have their families to consider. They can see no way out with this redesign. The most upset people are those people losing their flexibility" (Nurse 7).

Safety. Flex nurses acknowledged the stressors operating on Regular staff, and pondered whether the redesign would address the biggest stressor of all—lack of safety. Most Flex nurses came to the conclusion that much more was needed than shifting Flex staff around. "They need more bodies—more nurses" (Nurse 7). "There are a lot of stressors for Regular staff- safety is one of them. Sometimes it is hard to give good care when you are pulled so thin" (Nurse 4). "Regular staff are burned out, and rearranging Flex is not going to change that. They've had other redesigns that have not gotten them very far. They should consider the stress for all of us—Regular staff, Flex, and parents. I wouldn't want someone taking care of my child who was so stressed or overwhelmed. It is not safe. We need more nurses" (Nurse 5).

Support. Flex nurses felt that Regular staff and Flex should have been included on the redesign. There was a sense of injustice that the people most affected by the redesign were not allowed to participate directly in the planning process. "They made up their minds without including Regular staff or Flex. We should have brainstormed together. Nursing should have a say in our own futures—it was all managers. I bet

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Regular staff would have had some good ideas. I've got some ideas, but nobody asked us until they had already made up their minds" (Nurse 4).

Flex nurses expressed concern for the well-being of the hospital's nurse population, and during group discussions and conversations with me, several individuals talked about ways to support staff (Flex and Regular) and raise morale. "They need more incentives to hire Regular staff. For a new grad, the starting salary is slave labor. Regular staff are asked to do more and more with less and less. And all the meetings and committee work. For what? Warm fuzzies?" (Nurse 6). "I think they should let Flex who want flexibility keep their schedule options and work for less money. And they should pay Flex and Regular staff differentials for working the off-shifts, weekends and holidays. And I think they should give us more perks for the hard work we all do" (Nurse 7).

Commitment. Redesign stirred a sense of betrayal in Flex nurses. They felt as if they had been loyal and committed to the hospital, but the redesign shook their belief in the hospital's good faith towards them as professionals. "We are just numbers to fill in the gaps. No one cares how many hours you've done, or how many times you've come in. You make an investment of yourself, you do your share, and you don't really count. There is no appreciation for us—Flex or Regular"(Nurse 1). "I have been very flexible, and I have been willing to go to all the units to get in my hours. Now I feel they're really giving it to me. This is a hard thing. This is a loyalty issue. Now it's 'Sign up for this plan—tough it out.' Not much loyalty to us. We have been here for them, but now there is not a whole lot of choice or say. 'If you don't like it, get a new job.'"(Nurse 2).

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Summary.

The redesign themes reflect the Flex cultural themes. The illustrative quotations also indicate that Flex nurses viewed themselves as part of the institution and part of the nursing staff. I was struck by their emotional commitment to finding solutions for the staffing problems. Many of them were affected by the redesign, but many of them actually benefited from the changes, especially those Flex nurses working nights. Regardless of degree of impact, the redesign drew Flex nurses together to understand why it was happening. The redesign, therefore, was not just another plan to meet staffing needs, and it was not just an issue of lost flexibility to Flex nurses . The redesign was an impetus for Flex nurses to examine their culture's norms and values and decide where they stood on issues of commitment, safety, and support.

The Storyline

Flex nurses were willing to get cancelled, they forfeited benefits, and they worked on different units with different people and lots of unknowns. They did this for flexibility. Although there were other benefits from Flex, the Flex nurses I interviewed said that they would give up extra pay for flexibility. Flexibility had multiple meanings. It stood for being with family, doing things spontaneously, seeking challenges at work, and saving one's sanity.

Although flexibility seemed alluring, it also had risks. It was hard to go to different units with different people. There were different routines to figure out, "nothing is where you think it should be," and there were lots of unfamiliar faces. Flex nurses were concerned about the safety issues of being in a strange environment where things could go wrong. The stakes were high with very sick children. Flex nurses

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adapted by learning how to ask questions, and how to identify peers willing to help. It also meant saying "no" to unsafe situations. Flex experienced psychological distress when they were forced to compromise the safe care of their patients.

Being safe is a nursing essential. Flex nurses wanted to provide safe care, and the Regular staff nurses wanted Flex staff who were competent. Through repeat exposures, Flex and Regular staff learned about each other—who to trust. Trust was an exchange process. It was important to trust the professional integrity of your peers and to be trusted. Violations of this credo were hard to overcome and haunted people whose safety or trustworthiness had been questioned.

To be safe on a unit, Flex nurses needed the support of their peers. Flex nurses were not unit-based experts; They were Jack-of-all-Trades. They defined emotional support as other nurses' willingness to acknowledge their presence on the unit, to include them as part of the team, and to offer unconditional assistance. The Flex nurses distinguished between help with strings attached ("They always let you know when they've done something for you") and unsolicited attention. "They see when you're in trouble, and they'll help you out."

Adjusting to different units was dependent upon the amount of support provided by the units' staff. Flex nurses knew which units were helpful and which nurses were helpful. Safety, support, and trust were closely related to each other and to adjustment. Emotional support yielded safe care, and nurses' tendency to proffer support strengthened through contact. Nurses learned through their time with each other who was professional and who was not—who was trustworthy and who was not. These

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factors interacted together to affect the length of adjustment to units. For Flex nurses, adjustment took a few days to a few months.

During the process of getting to know and to trust each other, connections got established, but Flex nurses did not encourage more intimate emotional supports among peers. They were very focused on their work, and support was kept within the confines of work-related needs. "Shooting the breeze," or venting in a stressful situation were added supports that arose through increased contact and connections, but Flex nurses rarely expected more of their work peers.

Peers were the Flex nurses' main supporters. Managers were judged by their willingness to help out as needed, and to provide resources for support. Other professionals were expected to do their job (be trustworthy) and to be respectful. Flex nurses did not feel that their nursing status affected their work relationships with other health care professionals. They also denied any effect of their status on the care to patients and families. The interactions I observed with staff, patients, and families affirmed the Flex nurses' professional behavior. Units tried to provide continuity for their long-term patients, but sometimes, "there are not enough Regular staff to go around." In some instances, Flex nurses were assets to families, because exposure to multiple units, procedures and policies, broadened Flex nurses' knowledge base and skills, and allowed them to offer more to families.

Questions about commitment elicited statements about loyalty. Flex nurses felt loyalty to their profession and to the staff and patients of the hospital. Loyalty was a trust issue for them. They upheld their professional obligations by providing safe care

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within their scope of practice and being trustworthy and supportive colleagues to their peers.

They expected reciprocity. Unfortunately, some of the nurses felt discouraged by the lack of reciprocal commitment from the nursing profession and the hospital. To some of the nurses, the profession had allowed organizations to take advantage of its members, and as a collective group, nurses had passively allowed organizations to treat them unfairly.

Commitment represented the interplay of cultures to which Flex nurses belonged. Nurse culture dictated professional standards of care. Hospital culture had a mission of service and quality care to children. Flex culture expected accountable behavior as a nurse professional, a hospital employee, and a team player.

The Flex nurses felt that commitment or loyalty to them was violated by management when the Flex redesign was introduced. This redesign threatened the Flex nurses' flexibility—the primary reason for their being Flex nurses. The Flex nurses argued against the logic of the redesign and emphasized stressors, such as pushing safe limits among Regular staff, that needed to be corrected. They felt disengaged from the decision-making process and wanted an opportunity to brainstorm with Regular staff peers. They wanted an opportunity to participate in discovering and developing more efficacious support mechanisms for themselves and their peers. They viewed the redesign as a breech of loyalty or commitment from the hospital. They doubted that shuffling around Flex nurses would make a difference to the hospital nurse staffing shortage.

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Flex nurses and management had disparate views of commitment. To Flex nurses, commitment was providing the best possible care. As stated by management interviewees, commitment meant filling staffing needs. This conflict created grief reactions among Flex nurses of anger, sadness, disbelief, and denial. Flex nurses and management were struggling with some resolution of this dilemma. Flex nurses wanted their flexibility, and the redesign infringed on this flexibility and forced them to reconsider the premises of their work life at Children's –safety, support, and commitment.

Summary

The original research questions had to do with Flex work-related social relationships. How were they established? What was helpful or not helpful about Flex nurses' social networks at work? Although these questions were addressed in the qualitative portion of this study, the importance of culture became evident as the study progressed. The research question shifted to an exploration and description of Flex nurse culture within one hospital system. Several themes emerged, highlighted in the previous storyline. This summary will assimilate what has been learned about the role of culture in understanding the Flex nurses at Children's Hospital.

Flex nursing culture was manifested outwardly by the behaviors I observed. From a professional standpoint, I could not distinguish between Flex nurses and Regular nurses. I spent time observing on two of the units most heavily staffed by Flex nurses, and I could not perceive different quality interactions between nursing staff, patients, or other health care professionals. On one occasion, Flex nurses completely

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staffed a unit so that Regular staff could attend a mandatory education day. Several Regular nurses thanked Flex staff for "covering for us for the day."

The middle layer of norms and values was reflected through the Flex nurses' statements about professionalism, and their professional behavior. Flex nurses had a strong sense of nursing professionalism (the norms), and they indicated their desire to work at Children's as a way to fulfill their ideals of what quality care for children should be (the values). In their interviews, Flex nurses described the "should-bes" as support: Professional nurses should provide emotional support for each other. They should be willing to help each other out to guarantee safe and effective care for the patients and their families. "Should-bes" also included reciprocal respect, and trust in one another to behave professionally.

Flex nurses described their work relations positively. There was a good match between the way things should be, and the way things were. Professional norms and values meshed in the Children's Hospital environment. Until the redesign.... The redesign destroyed a perfect job for many Flex nurses, and it created a sense of loss and disloyalty. Flex nurses spent countless conversations with each other trying to figure out why it had to happen. I experienced disbelief, anxiety, anger, sorrow, and other grief emotions from Flex nurses.

Many Flex nurses were trying to decide what to do. They were trying to reconcile what was just or not just about the new demands placed upon them. No one knew by the end of this study what the final outcome would be: who would stay and who would leave. No one knew if this redesign would help relieve the staffing needs for the hospital.

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The eventual redesign outcome will be a reflection of the deepest culture core. Our society has changed the way it does business, and people are modifying the way they get their needs met. The traditional model of nursing always disavowed individualistic behavior. Nurses are a collectivist lot, programmed throughout school and practice to act for the common good—not the self good. This may be changing, and from the comments of Children's Hospital management, Flex self-interest was not well-accepted. Flex nurses did not see it that way. There was a clash of outlooks on what commitment meant. To Flex nurses, commitment meant coming to work and doing the best job possible with the help of peers. To management, commitment meant taking care of staffing needs any way possible.

Our core culture has given us permission to think of ourselves. Flex nurses, perhaps, were rebelling against old stereotypes of what nurses should be and what nurses should do. They had had a glimpse of their ideals, "the perfect job," and they were struggling with its loss.

If we think of biology and natural selection, characteristics get selected that are more vigorous. Flex nurses may be a breed that should survive and multiply within Regular staff ranks, because they were not as threatened by changes and the unknowns. They went to multiple units, they learned quickly how to attain the support they need to provide safe care, and they were very task-focused. At work, their world was focused on work. They were willing to do without benefits and get cancelled, but they wanted their flexibility.

I talked with the managers about the importance of flexibility. Flexibility saved the hospital in 1993. The business world projects that flex models will become

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increasingly popular: They are cost-effective devices for organizations, and they address lifestyle changes in professional populations. The health care profession is struggling with new models like Flex. I believe the struggles result from culture clashes between core culture changes and established norms and values. At Children's, Flex nurses had high standards of commitment to their profession, to the hospital, and to their peers. Their definition of commitment, however, was a new nursing version not found in the dictionaries of many managers. For Flex nurses, it was an exchange process. Flex nurses provided professional care and the hospital provided flexibility. Management was exerting pressure on Flex nurses to change by enforcing plans that "make us more like Regular staff than Regular," and a month past the agreement due date, half the Flex nursing population were "still making up our minds what to do."

Overview of Qualitative and Quantitative Data Findings

A brief review is provided of significant findings from this mixed method study. Triangulation of results will occur in Chapter 5, with discussion of how these analytic findings support each other and are supported by the research literature.

Quantitative Overview

Quantitative analyses were based on a questionnaire survey (N=166). There were 46 Flex nurse responses and 120 Regular nurse responses. The Social Network Questionnaire (SNQ) demonstrated that Flex and Regular nurses had greater proportions of peers than managers in their overall network and in each of the three closeness rings. As network size increased, there was a trend for greater proportions of peers to be added to the first two closeness rings. Paired samples t-tests also showed that proportions of

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peers tended to be concentrated in the first two rings, while there was no specific distribution of proportions of managers among the three closeness rings.

In the 1st ring, as the proportions of peers increased, they were utilized more for all types of emotional support: The same was true for the managers. As proportions of peers increased, utilization of managers decreased for confiding, offering reassurance, and helping with emotional upsets. When the proportions increased of managers offering help with emotional upsets and confiding, the proportions decreased of peers offering these types of emotional support.

In the 2nd ring, as the proportions of peers increased, the proportions increased of peers utilized for reassurance and respect, and the same was true for managers. There were trends that suggested inverse associations similar to what was found in the 1st ring between managers and peers providing certain kinds of emotional support. For instance, one trend showed that as the proportion of peers providing respect increased, the proportion of managers providing respect decreased. Another trend showed that as the proportion of managers providing respect increased, the proportion of peers providing respect decreased. By the 3rd ring, there were no significant associations between types of emotional support and social network composition.

There were no significant differences between Flex and Regular nurse group means for social network composition variables or satisfaction variables. The only significant difference on demographic variables was that Flex nurses worked more units than Regular nurses. For the emotional support variables, Regular nurses used significantly higher proportions of peers for reassurance and dealing with emotional upsets, and there was a trend for confiding.

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Comparisons between the levels of the satisfaction variables (Yes/No), showed that months worked at the hospital was the only variable differentiating between the two levels for "wanting more people in network" and "wanting more people for emotional support." Observed cell counts suggested that nurses who had worked less than 4 years wanted more overall network support and more emotional support than nurses who had worked at the hospital for over 4 years.

Between the demographic variables and the social network composition and emotional support variables, one weakly significant association appeared. As the number of people in the network increased, the proportions increased of peers providing respect. Overall, number of units worked, hours worked per pay period, and months worked at the hospital did not significantly correlate with network variables or emotional support variables.

Other supplemental findings demonstrated that there were significantly greater proportions of 1st ring peers providing all types of emotional supports versus proportions of 1st ring managers. This was also true at the 2nd and 3rd ring levels.

At the 1st ring level, compared to Flex nurses, Regular nurses utilized significantly greater proportions of peers for confiding, reassuring, and helping with emotional upsets. There were no significant differences between the two nursing groups for utilization of proportions of peers for emotional support at the 2nd or 3rd ring levels, and there were no significant differences in nursing group means for utilization of proportions of 1st, 2nd, or 3rd ring managers for emotional support.

Qualitative Overview

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Seven Flex II nurses were interviewed, and four major themes emerged: Flexibility, safety, support, and commitment.

Flexibility represented Flex nurses' primary reason for doing Flex, and their approach to work. Managers described scheduling flexibility as a control issue, but Flex nurses viewed it as an exchange process with the hospital: They were willing to flex to different units on an as needed basis in exchange for flexibility over their schedules. Extra money was of secondary importance to them. Flex nurses also said that being flexible was the most important Flex nursing trait. They had to be able to move in and out of different places with different staff and patients where there were few formal controls on them. They had to be comfortable with flexibility, because professional parameters that existed for Regular staff were usually decreased or absent for Flex staff, such as formal communications lines, supervisor feedback and competency evaluations.

Safety was of paramount importance to the Flex nurses. Since they went to different units under different conditions, they had to be able to say when they needed help or when their assignments were not safe or appropriate. They acknowledged their lack of expertise; they were "Jack-of-all-Trades." Safety was an unwritten, professional understanding among nurses. Flex nurses wanted to be safe, and Regular staff wanted Flex nurses to be safe. The work environment became a dangerous place for everybody when any unsafe conditions existed. Flex nurses developed ways to scan the environment for potential or actual unsafe conditions. The Flex nursing director indicated that she received a very small number of incident reports or error reports.

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To be safe, nurses need to support each other. Flex nurses especially depended on the help of others because of their frequent movement among different units: Territory was not as familiar to them. Flex nurses described emotional support as peers' recognition of their need for help. Helping connections among peers were strengthened through repeated contacts, but there was a professional understanding that help would be provided as needed for safety's sake. There was also professional trust: That peers would behave in a professional manner and provide necessary supports. Safety, support, and trust were intermingled: The best working conditions existed when peers could be trusted to provide emotional support so that care would be safe and effective. Flex nurses gauged nursing units and their staff by this mixture of safety, trust, and support. Adjusting to units or sizing up the safety situation did not take Flex nurses long to do: They reported adjustment times of a few days to a few months. Flex nurses also indicated that they did not need peers at work for other types of emotional support: In fact, they preferred to deal with emotional upsets and personal, emotional needs outside of work. When there were connections with peers through increased contact, free time was spent "shooting the breeze" or "venting" about work-related issues.

Commitment had to do with commitment to the nursing profession, to the hospital, and to peers. Flex nurses were professional care providers who believed that it was important to uphold professional standards of care. Flex nurses also believed in commitment to place and to people. To have a safe and effective working environment, people have to pull together, and that demands commitment or "loyalty." Flex saw this as a two-way process, where they expected equal and fair consideration from nursing,

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from the hospital, and from their peers. They perceived a disruption or breech of commitment with the redesign, and this generated a grief process for many of the Flex nurses. Although they were being asked to give up their flexibility, the grief reaction seemed more directed to loss of belief in others' integrity, rather than loss of flexibility. Flex nurses, by and large, chose to work at Children's because of its professional environment: Disruption of their belief in professional consideration from the hospital triggered anger, sorrow, denial, and many other grief emotions. Of note is that Flex nurses viewed commitment as a here-and-now situation. They were committed to what they were doing and where they were in the here-and-now, but they did not view commitment or loyalty as a long-term proposition: "We'll see if something better comes along."

These themes represent Flex nursing culture at Children's Hospital during a redesign phase. The study revealed "nested" cultures with Flex culture residing within Children's Hospital culture, and the hospital culture nesting within a broader, professional culture. These cultures were intertwined—mutually influencing each other. The findings of this study, therefore, must be viewed from the perspectives of these interwoven cultures. A different group of Flex nurses within a different hospital environment might have generated different cultural themes. Even though the culture of nursing is fairly standard, how this acculturation interacts with people and place makes each situation unique. Chapter 5 will provide insights to the conceptual integration of the quantitative and qualitative analyses.

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CHAPTER 5

DISCUSSION

The first section of Chapter 5 will link inferences from the quantitative data to the themes and assertions from the qualitative data. Another section will revisit the literature review of Chapter 2 with its major concepts of reengineering with Flex nursing as a product of reengineering, socialization, social support, and the nature of work. Culture was another key concept unveiled through the qualitative analysis. The qualitative and quantitative findings will be discussed within the context of these literature topics.

Inferences

Demographics

The quantitative data show that there were no significant differences between Flex and Regular nurses with regard to months worked at the hospital. There was a weak negative correlation between hours worked per pay period and the number of units worked; this pertained to Flex nurses who worked multiple units. This finding may indicate that Flex nurses exercised "flexibility" with regard to numbers of units worked and numbers of hours worked. In their interviews, the Flex nurses said that they enjoyed the freedom to flex their schedules and to flex for variety at work. Many of the Flex nurses talked about their outside interests, such as family and extracurricular sports activities, as reasons for wanting flexible schedules. They figured out how to meet their hours at work and also fulfill their personal lifestyle needs. Several of the nurses

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indicated that by going to different units, there was always some unit "that will want you to work." Going to multiple units, therefore, increased the probability of meeting a desired number of work hours without pre-planning or pre-scheduling. The data may indicate the practical side to Flex nursing—working more units to flexibly schedule requisite work hours, or the personality side to Flex—working more units for variety. For some of the Flex nurses, both sides no doubt applied.

The demographic variables of hours per pay period, months at the hospital, and number of units worked were not significantly related to nurses' network composition. These findings suggest that regardless of time spent at work or the number of work environments negotiated at work, both types of nurses constructed similar types of social networks.

The Network and Emotional Supports

The quantitative data show that Flex and Regular nurses constructed peer-based networks. Although there were managers distributed among all three closeness rings, there were significantly greater proportions of peers in the rings. More importantly, within each of the rings, there were significantly greater proportions of peers utilized for all types of emotional support versus managers. When discussing their work-related social networks, Flex nurses focused on their peer relationships with regard to social support and safety. They acknowledged that managers were also available for emotional support, but during discussions of emotional support and safety issues, peer connections on different units were most important for providing safe and effective care.

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The quantitative, associational data suggest that as network size increased, the proportions of peers in the first two rings also increased. These associations did not exist for peers within the third ring, or for managers within the three closeness rings. Paired samples t-tests showed that there were significant differences between proportions of peers in the first two closeness rings versus the third ring. There were no significant differences in proportions of managers distributed among the three rings.

Paired samples t-tests also showed a difference among the three rings with regard to utilization of peers for emotional support. Proportions of 1st ring peers were utilized significantly more for most types of emotional support than were peers in the 2nd and 3rd rings. Second ring peers were utilized significantly more for reassurance and respect than 3rd ring peers. For managers, there were no significant differences in utilization for emotional support between the three rings.

For both types of nurses, a picture emerges of their work-related social support networks. Peer-based supports were emphasized, and as peer members became more distanced from the center of the network, they were less likely to be utilized for emotional support. The 1st ring peers, in particular, were the preferred source for most types of emotional support. It was also notable that these peer distribution patterns did not hold for managers. Distance from the network center did not influence the proportions of managers found among the rings, nor did it influence the proportions of managers utilized for emotional support. The closeness rings of the SNQ, therefore, carried more significance with regard to peer location and utilization within the network than for manager location.

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The associational data provide other information about the nature of network membership. Significant positive correlations showed that peers in the 1st ring were utilized for all types of emotional support. For instance, as the proportions of 1st ring peers increased, the proportions of peers utilized for all types of emotional supports increased. These significant positive associations were also true for 1st ring managers: As proportions of 1st ring managers increased, the proportions of managers utilized for all types of emotional support increased. There were significant inverse associations between peers and managers, indicating a preference by nurses for either one or the other type of member for emotional support at the 1st ring level. At the 2nd ring level, significant positive associations only existed for two types of emotional support—respect and reassurance. As proportions of 2nd ring peers increased, proportions of peers utilized for respect and reassurance increased. The same positive associations were significant for 2nd ring managers. Unlike the 1st ring, inverse associations between peers and managers for these types of emotional supports were either trends or not significant. By the 3rd ring, there were no significant associations.

These associational data further suggest the importance of the first two closeness rings, particularly the 1st ring, as a source of emotional support. As members became more distanced in the rings, they were less likely to be utilized for emotional support. These data also indicate another pattern within the rings: If 1st ring peers were being utilized for support, managers were not being used—and vice versa. At the 2nd ring level, these inverse associations were weakly present or absent, and they did not exist at all by the 3rd level.

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There were no significant differences between group means for Flex and Regular nurses on network variables. Both types of nurses had similar numbers and proportions of peers and managers belonging to their work-related social support networks. Ring distribution of peers and managers also were not significantly different for Flex and Regular nurses. The Flex and Regular nurses did not differ with regard to satisfaction with network size or satisfaction with emotional and instrumental supports. There were some significant differences between group means of Flex and Regular nurses for emotional support variables. Regular nurses used significantly more proportions of peers for reassuring and managing emotional upsets. There was a trend for Regular nurses to utilize greater proportions of peers for confiding. There were no significant differences between group means for respect or for help with major life decisions. There were no differences between group means for utilization of managers for emotional support.

These findings suggest that Flex nurses required less emotional support from peers at work for reassurance and dealing with emotional upsets. It might be inferred that since Flex nurses worked multiple units, there were more unknowns in the environment, and for safety's sake, they had to stay focused on the tasks. Using the Gestalt analogy of figure-ground, utilizing peers for reassurance and emotional upsets may have been less important to multiple-unit nurses than recruiting people for help as needed.

From the qualitative data, Flex nurses defined emotional support as the help received from peers to ensure a safe and effective work environment. They also defined emotional support as joking around, making casual conversation, and de-stressing about

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work. They denied the desire or need for other types of emotional support, especially related to personal issues or "anything intense." For Flex nurses, therefore, emotional support was very task-oriented in the here-and-now. Other emotional support issues, such as seeking reassurance or help with emotional upsets, may have been relegated to the background (using the Gestalt analogy). Regular nurses who were unit-based and more familiar with their peers, may have had different perspectives of closeness among network members and different definitions of emotional support. Investigating conceptual differences between Flex and Regular staff was not within the scope of this study, but the quantitative and qualitative data indicated a likelihood that Flex and Regular nurses had different types of work-related support needs.

One emotional support type, respect, deserves more exploration because of its primary place in the interviews with Flex nurses. In the interviews, Flex nurses described respect as reciprocal. They indicated that it might take a while for Regular staff to "get to know you and trust what you can do," but Flex nurses also stated that respect is a professional behavior that should be granted to co-workers unconditionally. Flex, therefore, associated professionalism with types of emotional support, such as respect and offering help. In many respects, Flex nurses expected a ready-made social support network based on the professional roles and responsibilities of other nurses. In their interviews, they indicated that on most units, there were supportive staff who served as prefabricated social supports through their willingness to help and to collaboratively provide a safe and effective work environment.

The quantitative data support the importance of respect to both groups of nurses. For Flex and Regular nurses there were significant associations between

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proportions of peers in the first two rings with proportions of peers utilized for respect. This was also true for manager members in the first two rings. For 3rd ring peers and managers, there was a trend towards a positive association between proportions of peers and managers and the proportions of peers and managers providing respect. There were significant differences and trends between Flex and Regular nurses for reassurance, dealing with emotional upsets, and confiding, but there were no differences between groups for respect: For both types of nurses, respect may have been an expected professional behavior from peers and managers.

The quantitative data also show that another emotional support type, receiving help with major life decisions, did not significantly differentiate between nursing group means. The descriptive data from Table 3 show that for both peers and managers, this support type garnered the lowest proportions of support from network members. These findings for major life decisions suggests that it was unlikely for either types of nurses to seek help with major life decisions at work.

Satisfaction

As indicated, there were no differences between group means of Flex and Regular nurses for wanting more network members, wanting more people for emotional support, or wanting more people for instrumental support. The descriptive data, however, show that for both groups there were frequencies of 40-50% for wanting more people overall, and for wanting more people for both types of support. Although there were no differences between groups, there was an indication of desire for more support.

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Months worked at the hospital did not significantly correlate with other demographic variables, with network variables, or with emotional support variables. It was, however, the one significant finding in the comparative analyses with the satisfaction variables as the independent variable. Comparisons between satisfaction variable levels (Yes/No) and the demographic variables showed that nurses who had worked fewer months at the hospital wanted more network members and more people for emotional support. Observed cell counts of a chi square analysis indicated that tenure of 4 years might be a demarcator. These findings suggest that forming social support networks was a priority for these nurses. Social support networks were constructed despite number of units worked, hours worked per pay period, or months worked at the hospital. For the sake of safety and support, nurses wanted to "fit in." This was mentioned by the Flex nurse interviewees who had been at the hospital for a short time; They indicated that they already had a sense of the place and its people. There was a strong drive, therefore, for Flex and Regular nurses to form work-related social support networks. The fewer months worked at the hospital, the more vulnerable both types of nurses may have felt with regards to finding a niche among their co-workers.

Conceptual Discussion

Reengineering

Reengineering became popularized in the early 1990s. Organizations radically overhauled their operational systems to better meet customer needs, and to stay in business. Despite all the "how-to" books on reeingeering, most organizations were not successful with reengineering. Reengineering is an ongoing process, and its success

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depends on buy-in from all of its organizational members. Reengineering also requires the willingness and the ability to adhere to the important precepts of reengineering: Focus on processes versus tasks; Focus on the customer's satisfaction versus outputs; Focus on the people directly involved with the clients versus organizational layers; Focus on cooperation versus competition; Focus on Theory Y (belief in people) versus Theory X (no belief in people).

Despite the initial intentions of most "reengineered" organizations, implementation of reengineering concepts has been difficult. In many instances, schizophrenic work environments have evolved with employees exposed to mixes of old and new. According to Kofman and Senge (1995), our American culture impedes reengineering progress because our culture is based on competition versus cooperation. In addition, our management programs tend to have a harder time teaching Theory Y versus Theory X: It is easier to talk about inputs and outputs.

Reengineering happened in health care systems throughout the country, but the realities of escalating health care costs and managed care drove organizations back to the safety of inputs and outputs: Inputs and outputs are easier to measure and to control. This is important when the public and the government demand accountability for expensive health care service. As Keys (1998) described, it "Neo-Theory X" has crept back into hospital systems. Despite the best intentions of management to provide a reengineered environment, control of work has replaced worker control.

The Flex redesign in Children's Hospital is an example of Neo-Theory X. It also represents two diverse ways of viewing the situation: Management versus Flex.

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When the organization first reengineered, the Flex model was new and it was successful. It allowed the organization to do exactly what it needed to do. The hospital was able to quickly adapt to patient census changes without layoffs. Regular staff were protected, and a new work model for nurses was created—an adaptive response to change.

Along with reengineering, flexibility has been a key concept in the business management literature. Flexibility implies the best of both worlds—organizational ability to adapt to change, and worker ability to better manage their lifestyles.

When the Flex model was first created at Children's Hospital, the nurses who went to Flex chose the plan because of flexibility. They wanted flexibility in their lives, and here was their opportunity. In 1993, the health care market was in bad shape, and Flex nurses had to work many different units and all shifts to get even 50% of the hours they wanted or needed. Times were rough for the Flex nurses. Nevertheless, the majority of these nurses stayed with Flex because of their desire for flexibility.

As the market improved, the patient census went up, and the need for nurses increased. This happened around 1996, and it is still true in 1999. At the time of this study, Children's Hospital was at full census with a significant shortage of Regular staff. Flex nurses were able to work any time and all the time: Some Flex nurses were working full-time with Flex pay, or more dollars per hour. In 1996, the management appointed a task force of nursing clinical directors to assess the situation. Based on what other, similar hospitals were doing, the hospital imposed some restrictions on the Flex model. Flex nurses were asked to work 10% off-shifts. In 1997, without a change in the census situation, another task force was convened, and Flex nurses were asked to

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work 25% off-shifts. In 1998, another task force decided to increase off-shifts to 50%, and to require certain numbers of weekends and holidays. Management stated that this change would better meet staffing needs throughout the hospital and ease the stress of Regular staff. Management had believed that previous Flex redesigns would do the same thing, but Regular staff circumstances did not improve, and staffing shortages remained significant. At present, the new, 1998 Flex plan is being trialed for three months and management will re-evaluate whether it is working or not. Before instituting the latest Flex redesign, management felt that it was important to discuss their plan proposals with Flex staff. Focus groups were designed to solicit input from Flex staff on the redesign proposal before implementation. Management, therefore, tried to adjust the model to meet hospital needs, and task force members tried to communicate their concerns with Flex staff.

Flex nurses, however, viewed the redesign as a breech of loyalty, or a broken commitment from the hospital. They expressed grief-like emotions from a loss of faith in the organization's commitment to them, and a loss of flexibility. Some of the Flex nurses were relatively unaffected by the redesign, especially Flex who worked night shifts. These nurses, however, also expressed dismay at the "rigidity" of the plans and voiced concern for the redesign's effects on Flex and Regular staff. Flex nurses shared a negative perception of the redesign.

There were obvious differences between Flex and management in their interview statements. Flex described themselves as flexible workers who will flex to different units and be responsible for their professional behavior. They used "flexibility" to describe who they are as nurses, and why they do Flex. In response to

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the redesign, they were upset about their loss of "flexibility." Management, however, stated that Flex nurses do Flex because they want "control" of their lives. They identified Flex reactions to the redesign as "loss of control." Flexibility, therefore, is a critical component of the Flex culture, and the management's decision to remove flexibility seriously disrupted Flex nurses' view of themselves within the hospital environment. The Flex nurses questioned a loss of place.

Schabracq and Cooper's (1998) workplace model helps portray what happened with the redesign. According to their phenomenological model, workers adapt to the workplace by learning the rules and the ways to behave. The environment becomes a familiar, safe place for them, and they can focus on tasks and not worry about the environment. Schabracq and Cooper call this "integrity of individual functioning."

A disruption in the "integrity" of the workplace environment can have serious cognitive and emotional consequences for workers. Attention to the task is negatively affected, and there can be considerable stress. "The habitual ways of functioning are no longer viable...This implies a restriction of what that person may do to perform tasks, a restriction of his or her freedom of acting. Indirectly, this may also affect what he or she is able and willing to do" (p. 20).

In this study, the redesign disrupted Flex nurses' "integrity of individual functioning" by reordering their Flex nurse roles. This resulted in cognitive and emotional distress, and many Flex nurses indicated that they were trying to decide what to do.

Work control is prevalent in the management and organizational literature (Schbracq & Cooper, 1996). Most organizational literature uses the word "control" to

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signify different types of work-related autonomy. Karasek's (1979) demand/control model has demonstrated the power of decisional control over health outcomes, psychological and physical (Karasek & Theorell, 1990). Karasek and others have been trying to study the facets of autonomy that make a difference, but as yet, no research studies have differentiated between such things as work method autonomy (control over skills/methods), work scheduling autonomy (control over schedule), and work criteria autonomy (criteria for evaluating performance). There are few studies that examine whether reengineering in organizations and ongoing changes result in increased or decreased job control. Karasek and his colleagues (1987) found some evidence in Sweden that reengineering may actually diminish job control for certain worker groups, such as older individuals and women. The reasons for this are not known, although economic constraints are often associated with increased work controls (Jones & Fletcher, 1996).

In the nursing literature, "control" has been used interchangeably with autonomy, and it usually signifies control over practice decisions. Blegen's (1993) meta-analysis of 48 nursing job satisfaction studies found that job satisfaction correlated most significantly with stress ($r = -.609$), and organizational commitment ($r = .526$). Autonomy was correlated at ($r = .419$). In this meta-analysis, the alternate labels for autonomy were: centralization and powerlessness (negatively correlated), and participation, discretion, and personal control (positively correlated). Hinshaw et al's (1987) earlier research on nursing retention found that autonomy, defined as "control over personal resources for practice," was correlated ($\beta = .17$) with job satisfaction.

"Control" has also been studied in nursing research as a component of

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"hardiness," a personality trait comprised of commitment (dedication to a task that is reevaluated as circumstances change); challenge (the ability to see events as personal challenges rather than threats); and control (the amount of power one possesses) (Kobasa, Maddi, & Kahn, 1982). Hardiness has protected nurses from burnout in stressful situations, such as oncology settings (Vachon, 1998). Boyle, Grap, Younger, and Thornby (1991) and Fusco (1994) found that hardiness is negatively associated to coping styles which attempt to minimize stressful situations without problem resolution. Fusco (1994) theorized that hardy nurses possess a realistic sense of dedication, expect or even desire the challenge of a changing environment, and manifest control as a sense of professional competence. These kinds of nurses are less likely to become emotionally exhausted or cynical about their work.

Vachon (1998) analyzed research articles on nursing stressors in oncology settings, and she also found that "sense of control" over things that happen in life or at work protected nurses from depersonalization and emotional exhaustion. "Nurses who experienced higher degrees of burnout reported a lack of a sense of control over external events" (p. 153). She discussed two types of control: a sense of control over care (skills competence), and a sense of control over practice (setting limits on one's practice, such as amount of time devoted to work). Both control strategies were major problem-focused coping strategies for oncology nurses. Her review also revealed that social support was an important buffer against work-related stressors. Interaction with others provided different kinds of support to carry out work more effectively. Other burnout researchers, such as Pines et al., (1981), have noted that personal support

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systems are insufficient supports for nurses, especially nurses in high stress jobs. Work support networks are necessary to share an appreciation of what work is like.

Laschinger, Sabiston, and Kutscher, (1997) investigated "control over the content of nursing practice" (autonomy) and "control over the context of nursing practice" (participative management) in relation to nurses' perceived empowerment (access to job opportunities, information, support, and resources). This study was designed to test whether reengineering (passing control to nurses in the workplace) had really occurred, and whether it had affected nurses' sense of empowerment. The researchers devised a special questionnaire to measure empowerment based on Kanter's organizational power theory. Other questionnaires assessed nurses' access to informal power (alliances with peers, subordinates), and formal power (jobs associated with organizational power).

The results showed that informal power mediates access to formal power sources. Formal power influences work empowerment directly and indirectly through informal power, and work empowerment has a strong causal direct effect on both types of practice controls. Both types of power, informal and formal, are necessary therefore, to have a sense of control over practice. The researchers concluded that in redesigned organizations, such as organizations with fewer management layers, "effective working relationships within a wide network of alliances are critical to organizational communication and success" (p. 349).

This mixed method study provides support for the research literature on control. As indicated through the research literature, "control" is a label applied to many nursing concepts, such as control over practice, or autonomy. In previous

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research studies, nurses did not generate the label of "control," but responded to its many operational definitions on surveys. In this study, the Flex nurses did not use the word, "control," but there are pertinent quantitative and qualitative findings that can be linked to the control literature.

The Social Network Questionnaire results demonstrate that both Regular and Flex staff had networks comprised of peers (informal power) and management (formal power). This mix existed within all three closeness rings. Since the SNQ results indicate that both types of nurses preferred peer-based networks, the presence of management within nurse networks may signify a necessary combination of formal and informal power sources for empowerment within the hospital system. In the Flex interviews, the nurses indicated that in addition to peers, management served as resources on units and their acknowledgements and praise were appreciated forms of emotional support. Management connections, though less frequent than peer connections, may be essential for a sense of control in the workplace.

The Flex interviews show that as Flex nurses moved among different units, they scanned the environment for nurses, in particular, who were willing to help them out. They constructed their networks of individuals who supported them in times of need, and who helped to ensure a safe working environment. For Flex nurses, therefore, the data indicates that network construction was designed to provide a sense of control over the work environment, and the same may have been true for Regular nurses who displayed similar network compositions.

In the control research, control of practice content (autonomy/competence) and control of practice context (participative decision-making) significantly affect job

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satisfaction and a sense of empowerment (having sufficient support, resources, and information). Flex nurses in this study used the word "flexibility" to denote these types of control over work. Flexibility, therefore, was what Flex nurses needed to feel empowered. Within their culture, they established effective networks of informal and formal power to maintain a sense of empowerment over their environment. The redesign disrupted the integrity of their situation.

From the interview data on the redesign, the nurses identified loss of flexibility as loss of scheduling autonomy, or the freedom to call in and work as desired, and a loss of control over context (participative decision-making). They felt excluded from the redesign task force, and they labeled this as a type of betrayal. They did not, however, mention in their interviews that they had ever felt a lack of control over practice (autonomy/competence). The Flex nurses indicated that they had considerable control over practice (communications, evaluations, skills), and they derived many personal and professional rewards from working with the children and their families. With the redesign, they specifically targeted loss of flexibility as a break in their understanding or alliance with their formal power sources. The redesign, therefore, threatened the formal power ties that Laschinger et al's (1997) work suggested can affect a sense of empowerment within the workplace. Empowerment includes access to instrumental and emotional support, material resources, and information. The grief-like emotions expressed by Flex nurses over the redesign signaled a greater loss than loss of control over scheduling autonomy: Rather, Flex nurses were experiencing loss of faith and trust in an important source of power and empowerment within their social network. This loss of connections with management was especially apparent in the Flex

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nurse interviews where nurses felt betrayed, punished, and abandoned by their management.

The interview data also show that when the redesign was first announced, the majority of Flex nurses chose their informal power alliances (peers) to discuss the proposed changes. There were Flex nurses, however, who were very upset and went to the Director of Nursing and the Flex directors for advice. Data from the SNQ indicate that the nurses relied more on the peers within their first two rings for emotional support needs. It may be hypothesized from the qualitative and quantitative data that when there is a severe disruption of integrity, nurses will enlist informal and formal power sources in an effort to make sense of a stressful event. Perhaps it is possible to gauge the intensity of an environmental disruption by the sources of workplace power mobilized against the disruption. In this instance, the Flex nurses who were most distraught not only turned to peers, but also went to management.

This section on reengineering and its aftermath has shown that there are many types of control in force during times of organizational stress. Core culture, a competitive American society, has placed conscious and unconscious restrictions on how we do business. The effects of core culture restrictions have filtered through to challenge a cultural premise of the Flex nursing model—flexibility. Since so many definitions and applications of flexibility exist (as for control), the redesign provided an opportunity to discover the Flex nurses' definition of loss of flexibility, the different "control" perceptions of Flex versus management, and the Flex reactions to a loss of flexibility.

Culture

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The redesign exposed the different layers of culture as defined by Trompenaars (1994). His definition, "culture is the way in which a group of people solves problems," suits the core culture problems associated with reengineering, and the Flex culture's struggle with loss of flexibility. This following section will explore Flex culture in relation to nursing culture.

A culture's middle layer consists of values and norms that are reflected through the artifacts or outward products of the culture. Nurses demonstrate their values and norms through their professional behaviors. Nurses create work climates that reflect their professional norms and values. Joseph and Deshpande (1997) examined the impact of work climate on nursing job satisfaction. They surveyed the nursing staff of an acute care hospital, and the nurses rated their work environment on six climate scales (professionalism, caring, rules, instrumental, efficiency, and independence). Ninety-nine percent of the nurses described their work environment as professional. The majority of nurses also rated their hospital high on caring (where people look out for each other) and rules (providing regulations, such as policies and procedures). The caring and rules climates were the only two climates associated significantly and positively with job satisfaction and satisfaction with supervisors. Although it was surprising that professionalism did not correlate with job satisfaction, professionalism may be a "given" for nurses. Wanting rules and regulations may indicate nurses' desire to feel protected and safe by their scope of practice and the institution's provision of formalized policies and procedures. Caring is an important concept to nursing: Although it is considered a professional nursing right and duty to provide care to others (peers and patients), the presence of caring environments may not be a nursing

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"given." In the Joseph and Deshpande study, therefore, nurses rated their satisfaction with workplace according to people's caring qualities and the provision of formal boundaries for practice.

In the Flex nurse interviews, the nurses used words to describe their work climate similar to the favored climates in the Joseph and Desphande study (1997). The themes of safety and support emerged from the qualitative portion of this study. To the Flex nurses, it was important to be with peers who were willing to help out and ensure safe and effective care. The Flex nurses indicated that their comfort with units was determined by others' willingness to provide emotional support, thus creating a safe space for the patients and the staff. Safety was of paramount importance to them, and they acknowledged its reciprocal nature. They monitored unit staff's willingness to help ensure a safe environment, and Regular staff monitored them for their competence and willingness to ask for help as needed. Puetz (1983) showed that personal credibility is important for network-building. Some Flex nurses expressed their discomfort with being in units where they had not had an opportunity to learn the skills and to be competent and safe. They were concerned about the Regular staff's perceptions of them—"doubting you."

Flex staff, therefore, expected the hospital staff to be professional and provide support services, but they acknowledged that some units and staff were better about helping than other units. In agreement with the findings of the Joseph and Desphande (1997) study, the Flex nurses expected professionalism (a given), but they determined their satisfaction with workplace according to safety and support.

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Nursing culture is frequently described as a "caring culture" (Watson, 1988). Research on nurse caring has shown that connections between peers precede caring (Sherwood, 1997). The development of caring connections requires openness to others and a willingness to take the initiative to make contact. Individuals need to empathize with each other—to understand the other's condition. "People tend to feel safe when they sense the other is trying to understand their feelings as well as their words" (p. 34). The Flex nurses interviewed described helping and the establishment of a safe working environment with the same terminology as described in Sherwood's research. Caring connections in the literature, therefore, are related to the Flex nurses' themes of safety and support.

Caring research has demonstrated that caring connections are developed and maintained by people's willingness to trust in each other. "Relationships work best when there is faith in people. By exercising faith and trust in the other person, the focus shifts from controlling the negative aspects of the relationship to emphasizing the positive" (Sherwood, 1997, p. 35). The research has also shown that caring connections are present-focused, or focused on helping others get through demanding situations, no matter how difficult or how demanding the situation.

The Flex interview data support Sherwood's (1997) findings. The Flex nurses described the importance of trusting others to help, and they also indicated how helping situations were present-focused. Flex nurses viewed themselves as flexible-able to move in and out of situations. They were able to quickly dissociate task from ground (Schabracq & Cooper, 1998) to concentrate on what needed to be done. In their culture, therefore, they prided themselves on their ability to be flexible, and to stay

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focused on tasks. They trusted their peers, as professionals, to make caring connections of help or emotional support so that safe and effective care could be provided. If these care connections did not occur, Flex considered these units unsafe, unsupportive, and untrustworthy.

When nurses feel oppressed by their work conditions, they express their feelings of anger and frustration as lack of helping and being unsupported. Oliver (1987) conducted a grounded theory study of nurses' "unacceptable" behaviors and found that unsafe nursing practices and unwillingness to help negatively affected co-nurses more than any other factors with respect to perceptions of the workplace. In the Flex interviews, the nurses identified particular units where the staff were less helpful and unsupportive. These were units where staff were described as very stressed and less cohesive. Flex also said that these staff were more apt to "dump on you." Observational data confirmed unsupportive behavior between Regular staff and towards Flex. On one occasion, a Flex person confronted a manager about the lack of support and unsafe work conditions. Later, she commented that the interaction was hard on her, and that it was better to "avoid that unit as much as possible."

The Flex interviews and the SNQ data help delineate the nature of networks. Nurses' work networks are support channels or caring connections (Gruber-May, 1993; Kavanagh, 1989). The study data indicate that nursing networks were readily established because of their importance for safety and support. Flex nurses said that it took them a matter of days to months to figure out a safe network, and the SNQ data also indicate that nurses were concerned about network size and adequacy of emotional support based on months worked at the hospital. An inference is that nurses begin

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building their networks early as a safeguard against environmental unknowns, and they are concerned about workplace vulnerability until they have had sufficient time to establish caring connections or an adequate network.

Some nurse researchers have looked at the ethical dimensions of nurses' caring culture (DeMarco, 1998). Nurses make choices of how to respond to each other. "The responsibilities to be honest, to create trust, and to be responsive, which are readily acknowledged as ethical approaches to and for clients, can be redirected as nurse-centered needs and rights"(p. 130). As noted by the Flex nurses in their interviews, professional nurses should know what is right to do. Levine (1977), another nurse ethicist, noted that ethical behavior between professionals should exist on a day-to-day basis in mundane work situations as well as times of crisis. It is an expression of "commitment to other persons" and ways in which nurses are expected to relate to each other within their culture.

Commitment was an artificially generated term in the Flex study. Nurses were asked to discuss their commitment to the profession, to the hospital, and to peers as a way to identify differences between the cultural layers. The Flex nurses used the word "loyalty" to describe their commitment to the nursing profession. Of note is that although they felt loyal to nursing in the here-and-now, they were open to other opportunities—personal and professional. The Flex nurses also used "loyalty" to describe their commitment to the hospital and to their peers. Despite their feelings about the redesign, Flex felt an ethical and professional responsibility to provide quality care to the patients and families, and to do their fair share for the sake of their peers. They viewed themselves as members of the organization, and they felt bound to

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uphold their professional commitments to nursing, to the hospital, to the patients, and to their co-workers. Some Flex also voiced their discouragement with post-reeningeering trends that treated them as numbers filling staffing gaps, rather than as contributors to the team.

Gilligan (1982) and Surrey (1991) described women's moral development as different from men's. Surrey theorized that women develop a sense of self and right and wrong through their connections with others, termed, "self in relation." Women, therefore, have an orientation to form connections or relationships, and to view caring towards others ethically and morally. Some ethicists, such as Demarco (1998), have questioned whether the development of caring connections and networks among nurses, who are predominantly female, is driven by an inherent, moral developmental process that brings women in relation to one another. Nurses may convey a sense of professional duty and commitment when they talk about loyalty to the profession, to peers, and to the organization, but there may be a developmental process in place as well. Surrey's (1991) work with women's relationships has indicated that for women, socialization is a developmental process whereby individuals move from relationships with primary caregivers (childhood) to a "more comprehensive and flexible adult form of relationship" (p. 63).

For this study, therefore, the nursing research literature on nurses' social support networks, nursing as a caring culture, and the women's literature on women's connections were supported by the SNQ data and the data from Flex nurse interviews. The four major Flex culture themes, particularly the themes of safety, support, and commitment, were closely interwoven. The SNQ data also suggest how important it

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was to form networks at work. For instance, regardless of demographics, such as hours worked per pay period, months worked at the hospital, or number of units worked, both Regular and Flex nurses constructed similar social support networks.

Socialization

The previous sections have touched upon socialization, or the process by which nurses acquire the values, norms, and behaviors of their social group. In other words, how did Flex nurses evolve into a Flex culture with their own group/culture identity within the hospital? The last section identified the themes that define the Flex culture, and the cultural contributions from the nursing profession and the work environment were also discussed. This section will deal more with process.

In the literature review, many theories were outlined that might explain the socialization process for Flex nurses. It is necessary to sift through those theories to find support through the qualitative and quantitative findings from the Flex nurse study.

Socio-cognitive theorists postulate that the social environment and the interactions within it result in cognitive constructions of what to do and not to do—social sanctions and social taboos. The workplace environment and work-related social interactions can strongly influence whether an individual settles for routinization or seeks out innovation and initiative (Billett, 1998; Vann, 1996). Bandura (1997) stated that a person's sense of self-efficacy, or belief that she can do a task, is socially shaped through feedback received from others. People interacting as teams or groups can develop a sense of "collective efficacy." Efficacy beliefs moderate workplace adjustment and socialization (Jones, 1986; Saks, 1995).

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The Flex nurse interviewees stated that they loved their work. They were stimulated by the challenge and variety of going to different units, and they had a great deal of freedom or professional autonomy within Children's Hospital. They were not threatened by the unknowns that create dismay for many Regular staff when they "float" outside their home base. The Flex nurse comments indicated that they developed a sense of security from knowing that the majority of their co-workers were very supportive or willing to provide support as needed. They also learned that it was all right for them to ask questions--lots of questions. They shaped an identity of themselves as nurses who were willing to go to different units, who did not know everything, and who needed the help of their peers. All the Flex nurse interviewees described the same process of going to unfamiliar places and connecting quickly with helpers on the staff.

The Flex nurses also described the importance of competence and confidence in their skills. Comfort was diminished in situations where they did not have the skills necessary to be safe. One nurse indicated concerns about her skills competencies for one unit, and she stated that the only way to overcome doubts was to return again and again and to learn through the help of the other nurses. The Flex nurses also stated that Flex nursing is not for inexperienced nurses or new graduates. To be a Flex nurse requires the acquisition of the competencies and the emotional maturity to handle the flexing to different places with different people. The Flex nurses, therefore, described a process whereby they brought high self-efficacy to the situation, and they received necessary social reinforcement from their peers, Flex and Regular. Bandura (1997) stated that modeling, guided practice, and corrective feedback help individuals achieve

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a higher sense of work efficacy. Flex nurses were willing to seek out feedback and support, and helpful staff were willing to provide it to them.

Bandura (1997) explained how social support networks raise adoptive behavior through multiple modeling. The Flex nurses stated that they had many links between each other and especially enjoyed the opportunity to work together and with Floats, because "they understand what it's like." Flex, therefore, used their network of peers, particularly Float and Flex staff, to increase their group cohesion and reinforce their culture. The redesign prompted increased interactions among the Flex nurses as they tried to figure out what to do about the proposed changes. At the first focus group on redesign, there were few Flex members present, and there were comments raised about the plans. By the last focus group, a very vocal group of Flex nurses were present who had prepared statements reflecting the consensus of many Flex nurses who had been communicating through their grapevine.

The Flex nurse socialization process at Children's, therefore, was a success, and a culture evolved through the interactions of Flex personal characteristics, peer support, and hospital support. Children's Hospital contributed to Flex socialization. According to the nurses, they were granted considerable freedoms, and they were held accountable for maintaining professional standards of practice; these were part of their flexibility. One of the reasons the redesign was so difficult for Flex to appreciate was that their relationship with the hospital and its management had been very positive. Flex were willing to absorb previous task force redesigns, but the most recent redesign was such a radical departure from the freedoms they had enjoyed professionally and personally, that Flex nurses did not accept it. Most Flex nurses expressed incredulity at

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the management and the redesign, because they saw themselves as a successful, helpful group of nurses within the Children's Hospital system.

The affective aspects of socialization have been investigated by Vachon (1998), Nelson et al. (1991), and the self-in-relation theorists (Jordan, 1991; Surrey, 1991). Vachon studied personal and environmental coping strategies for managing work-related stressors. She found that personal qualities, such as self-efficacy, facilitate coping, but they are not sufficient to handle stressors found in acute care settings. Supportive work relationships are necessary to buffer stressors at work. The Flex nurse interviews and the SNQ data indicate that Flex nurses were aware of the importance of maintaining their social networks. Even though they covered more units than Regular staff and spent less time in any one place, the SNQ data show that their networks were as well-developed and maintained as Regular staff.

Nelson et al. (1991) proposed an attachment theory foundation for socialization based on psychological contracting, or an implicit agreement based on an individual's perceptions of reciprocity in the relationship. Socialization is an uncertainty reduction process. In a new relationship or a new situation, the worker tries to establish a secure base by establishing supportive relationships with others. The newcomer sizes up the potential for support, and the insider sizes up the overall merits and potential of the newcomer. "As the interaction process begins, establishing reliability may be a key factor in reducing uncertainty and distress for both parties. Secure relationships which evolve among individuals are the basis for positive psychological contracts with the organization" (p. 58).

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There are strategies for developing secure attachments. Individuals can approach others with positive strategies, such as self-reliance, or with insecure strategies, such as being overly dependent, or dismissing or preempting help from others. Positive strategies result in a support network of secure attachments that are characterized by reciprocity and satisfaction. Secure attachments also indicate successful socialization where there is a level of mutual acceptance and understanding.

Although this process provides a secure base for individuals, the implicit psychological contracts (give and take agreements) with the organization and with network members can change and initiate a new socialization process. At the beginning of the socialization process, "multiple psychological contracts form and reliability is actively being tested" (Nelson et al., 1991, p. 63). If there is considerable disparity between expectations and reality, psychological distress can occur and the socialization process is aborted.

Seeking attachments may be an intrinsic part of human nature: seeking protection and security from unknowns. Psychobiological research (Eibl-Eibesfeldt, 1975) suggested that attachments provide a state of steady functioning or "biological homeostasis" that is a characteristic of close relationships. Nelson and colleagues proposed that this intrinsic drive continues into adulthood and is manifested as situational contracting—trying out the territory until safety and support are obtained.

Nelson et al.'s (1991) overview of organizational attachment was similar to the Flex nurses' descriptions of making connections. Instead of reliability, the Flex nurses referred to trust: Trust had to be established between co-workers before a work environment was considered safe and supportive. Nelson et al.'s theory also suggests

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that in the work environment, there is always the possibility that the attachment process will be affected by change and that new psychological contracts will arise. In the Flex situation, the nurses indicated a new round of contracting post-redesign. Although they had felt secure in their work relationships, the redesign necessitated a new approach to the workplace, especially with regards to management.

The issue of attachment as a psychobiological phenomenon, and Surrey (1991) and Gilligan's (1982) work with self-in-relation theory and women's moral development, raise the question as to whether women in the work environment will automatically seek out each other to form secure attachments or relationships. There was agreement among the Flex nurses about how connections were established and maintained in the work environment, and the SNQ data suggest the possibility of patterns for network development, but considerably more documentation, perhaps universal documentation, is needed to determine the intrinsic or developmental nature of women's workplace socialization. This study's data indicate that the desire for more network size and emotional support corresponded to months at work. There may be a "critical period," therefore, when nurses are more intent on establishing connections in line with Nelson et al's (1991) description of how the socialization process unfolds. It would be interesting to study differences in workplace socialization processes between Flex and Regular staff to determine what happens when one group of nurses are expected to be flexible, and another group of nurses are expected to develop more comprehensive relationships among their home base peers. How do the nature of these connections influence the socialization process, and vice versa?

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A series of ethnographic studies describing women's workplace socialization supported the empowerment research of Laschinger et al. (1997). Women working with institutionalized mentally retarded adults created a supportive work environment by enlisting informal power from peers and delegated power from authorities to practice with relative autonomy. Lamphere (1985) described the women health care employees in her ethnography as "enabled." Another ethnography by Diamond (1988) found that nursing homes that had converted to "business models" removed formal power from their employees, and these women had a difficult time creating satisfaction through their work, despite their informal power sources. These ethnographic situations are similar to what happened to Flex nurses at Children's Hospital. Initially, Flex nurses had a great deal of freedom, and their culture flourished through a combination of peer social supports and relative autonomy ceded them through management. When management installed a rigid work plan for the Flex nurses, these nurses began struggling to redefine themselves within their workplace.

Mezirow's transformative learning theory (1991) combined motivational, cognitive, and affective components to explain how people learn to deal with new situations. Mezirow claimed that when there is cognitive dissonance, people's anxiety levels are raised and they will seek solutions. Sometimes the disruptions occur from without, but Mezirow and several psychotherapists, such as Rogers (1980), believed that people are intrinsically motivated to push the envelope. Whether they continue to pursue unknowns and to expand their frame of reference depends on a sense of support and safety in the social environment. For Flex nurses, safety and support were two of the main themes of their culture. To be a successful Flex nurse, these two conditions

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had to exist. The Flex nurses, however, also seemed to possess an intrinsic motivation to view unknowns positively, rather than negatively.

From the perpsective of Mezirow's theory, therefore, Flex nurses were successful at workplace socialization because within their culture, they defined and constructed a safe workplace environment with a supportive network of peers, and they seemed to have the intrinsic motivation to manage challenge. The interview data and the SNQ data demonstrate that Flex nurses successfully constructed social networks that offered them safety and support in their workplace. More needs to be done, however, to determine differences, intrinsic or extrinsic, that motivate flexible nursing staff to undertake the challenge of flexing among different units. An inference can be drawn from the interview data that these Flex nurses desired the flexibility. Although there were extrinsic rewards to flexing, such as more money per hour and flexibility in scheduling, the Flex interviewees indicated that they would not do Flex (with its imminent stressors of unknowns, no benefits, cancellations) if they did not enjoy the diversity and challenge.

There are different aspects of the span of socialization theories that fit this study's construction of Flex nurse socialization. In sum, the Flex culture themes of flexibility, safety, support, and commitment describe the products and processes of Flex nurse socialization. To become socialized as a Flex nurse, certain conditions had to exist. Flex nurses had to have the personal characteristics of high self-efficacy and intrinsic motivation to be flexible and meet unknowns as challenges. They had to have the safety and support of a social network of co-workers, and they had to have considerable professional autonomy or few controls from management. As the socio-

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cognitive theorists pointed out, the people and the place can either invite initiative or stifle it. A specific combination of cognitive, affective, and motivational components had to exist within Flex nurses and in their work environment to generate flexibility—their hallmark. Whether attachments to people and place are intrinsic or not, or ethically and morally expected, this study's data indicate that there was a strong tendency for Flex nurses to connect with people in the workplace, and to establish social support networks.

Social Support and Social Networks

Hupcey and Morse (1997) tried to distinguish between social support and professional support. They defined professional support as delimited by policy and scope of practice versus "open" social support, which includes anything to aid the recipient. Professional support relationships are situational, and social support relationships are expected to endure over time. Professional relationships are unilateral trust relationships where the recipient is trusting but not necessarily trustworthy, and social supports are based on mutual trust. Professional relationships are based on an obligation to provide service, and in social relationships, there is social obligation: Reciprocity arises through kinship or friendship bonds. Recipients can expect support via these social connections. Hupcey and Morse (1997) and Pearlin (1985) suggested that social support is a complex process that involves knowledge of network members with historical ties that enhance a sense of who will provide support without directly requesting it, and who will not. Professional support, on the other hand, does not require special knowledge of the providers, because it is situational with formal constraints on the services rendered.

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In this study, Flex nurses revealed an interesting mix of both types of support towards peers. They had a strong sense of professional obligation towards their co-workers with regard to providing support and respect, but they also acknowledged a social component to their interactions—how they differentiated between emotional support and instrumental support. "Emotional support is something emotional—you give it without being asked, because the need is there and you know it. With instrumental support, you do it because you have to." The Flex nurses, therefore, described their provision of social support towards co-workers as a combination of professional obligation with a socially defined component—arising from repeated contact and ongoing connections that resulted in reciprocal trust: A sense of social obligation as well as professional obligation.

Heller, Price, and Hogg (1990) examined social supports as business-like exchange processes where equity between people is important. People need opportunities to give and to receive support to maintain balanced social relationships. Atonucci (1986) also addressed the "bank-like" quality to social support. Their research is supported by this study's data. The Flex nurses discussed the importance of reciprocity. They identified reciprocal exchanges of trust and respect as necessary to maintain social supports in the workplace. The SNQ data demonstrate that Flex and Regular nurses' networks were peer-based. An inference is that peer-based networks may be preferred by nurses, because it may be harder to maintain a balanced exchange with management; power relations may preclude the opportunity for gleaning too much social support from managers.

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The social network research has shown that networks are concentrated within the first two rings. The types of social support provided is strongly influenced by ring closeness (Cochran, 1990; Laireiter & Baumann, 1995). More emotionally distant members are not expected to provide the same types of support as closer, core members. The SNQ data showed that the majority of emotional supports were provided through members of the first two rings, and as distance from the center increased, less types of emotional supports were utilized from both peers and managers.

Dunkel-Schetter and Skokan (1990) reviewed the literature on unsolicited support. They determined that people in acute distress received more support, especially if the distress levels were low to moderate. Individuals trying to manage their distress were also more likely to receive assistance. And people manifesting high self-esteem and self-control also elicited more support.

In the Flex nurse interviews, the nurses described emotional support as unsolicited help. "People know when you need help, when you're in trouble. They'll get up and help you out." Flex nurses indicated that the majority of the time, they received all the help they needed from peers. This social support process was probably based on the factors studied by Dunkel-Schetter and Skokan. As previously mentioned, Flex nurses no doubt possessed a high self-efficacy. They oriented to their work environment in a task-oriented or problem-focused fashion, and their needs for support were situational, or based in the here-and-now. They were, therefore, more apt to receive adequate supports because they possessed the types of recipient factors that influence support assistance.

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In addition, the controllability of the situation can affect support provision: Uncontrollable situations elicit more support than situations where the recipient contributed to the problem. Empathy with the recipient also spurs an "altruistic motivation" to assist. Provider personal experiences somehow contribute to decisions to help, but this research is less clear (Dunkel-Schetter & Skokan, 1997).

During participant observations, several nursing care situations were observed where Flex nurses either asked for help or received help without asking. In these instances, their needs were acute, and it was apparent that the situation was beyond their control and patient safety was potentially compromised. The exchanges were professional; the Flex nurses were behaving professionally, and their peers immediately responded with professional support. It is not known whether an empathic reaction triggered the staff responses, but the Flex nurses said that they enjoyed working with other Floats and Flex, because "they know what it's like for you."

The qualitative data, therefore, provide support for the social support and social network research. Social support is a complex phenomenon that has different dimensions, as suggested by Hupcey and Morse (1997). To the Flex nurses, there was a professional and a social aspect to work-related social exchanges. There was also evidence to support Dunkel-Schetter and Skokan's research (1990), that Flex nursing characteristics no doubt influenced the receipt of unsolicited support from co-workers. It matters whether Flex nurses were perceived as active problem-solvers, hard workers, and team players. Flex nurses indicated in their interviews that a "sizing up" process was always going on: "If they can trust you to be safe, and if you can trust them to help when you need it."

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The Workplace

Karasek's work model of demand/control was tested on nurses in an acute care setting by Seago and Faucett (1997). They found that these nurses were in "active" jobs with high psychological demands and high job control. As previously mentioned, the "control" construct has many implications for nurses. In their interviews, the Flex nurses described their work as challenging and rewarding. In their situation, flexibility provided them with plenty of psychological demands and their Flex positions also awarded them considerable control over practice. This model, therefore, is helpful for understanding the workplace components at Children's Hospital that influenced Flex nurse satisfaction and commitment. It also helps explain the reactions of Flex nurses to the redesign.

Schabracq and Cooper's (1998) phenomenological framework based on Gestalt figure-ground psychology is helpful for understanding the task-oriented Flex nurses who could move in and out of situations. They appeared to concentrate on task-specific situations, and other environmental events receded into the background. These researchers' concept of "integrity" also suits the redesign situation as Flex nurses underwent a disruption in their workplace environment, or sense of integrity.

Another, important workplace model that helps explain Flex nurse work relationships is the "swift trust" model originally discussed by Kanter (1989) and Peters (1992). This model has become increasingly important for temporary work groups and virtual organizations that quickly band and disband people for the sake of a finite goal. The Flex nurses met the specifications of a temporary system. A temporary

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system arises when the existing organization and its people are unable to meet demands. The Flex model originated to meet staffing needs of Children's Hospital.

The swift trust model suggests that the usual, slow development of trust between people is pre-empted by a swifter version when the environment necessitates it. "There is a premium with making do with whatever information is available so that work can be initiated quickly. Swift judgments about trustworthiness can't be avoided, because they enable people to act quickly in the face of uncertainty" (Meyerson, Weick, & Kramer, 1996, p. 170). The phenomenon of "swift trust" has been studied in organizations and groups where successful outcomes depend on a diverse body of collective knowledge and skills where individuals have little time to sort through who knows what. There usually are high-stakes outcomes, yet there are typically few formal controls to minimize the chances of something going wrong. There is little time for traditional modes of confidence-building and trust formation (Meyerson, et al., 1996).

In temporary systems, there are many unknowns. Workers try to reduce these unknowns by adopting an attitude of "I can do it" (Bandura's self-efficacy), by distancing themselves from the emotional context and focusing on the task, and by presuming that other people will be trustworthy (Meyerson et al., 1996). The Flex nurses appeared to manifest these temporary worker qualities. They became members of "temporary" teams as they worked interdependently with co-workers to provide safe and effective care. Flex nurses seemed to have high self-efficacy, and they admittedly distanced themselves from specific unit activities and focused on situational tasks. As stated in their interviews, trust was important between co-workers, and it developed quickly as Flex nurses sized up their work environment and their peers sized them up.

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The elements of swift trust formation within a temporary system existed for the Flex nurses.

In temporary systems, workers typically offer unconditional trust when individual actions impact others (mutual fate control), and there are the prospects of increased interaction. Both of these situations existed for the Flex nurses. Their activities affected smooth functioning of the unit, patient outcomes, and the workloads of others: There was always the probability of flexing to the same units. In their interviews, the Flex nurses repeatedly discussed the importance of reciprocal trust and unconditional support or help.

Dawes (1994) discussed how roles affect swift trust formation. Especially in initial interactions, people deal with each other as roles, rather than as individuals. Expectations are standardized, and roles provide more control over unknowns than dealing with personalities. To reduce uncertainty, people fall back on categorical assumptions. Of note is that individuals in the roles begin to identify themselves according to role expectations and practices, especially when they are in settings where they are recognized by others according to their roles versus individual selves.

> Expectations defined in terms of categories are especially likely because people have little time to size up one another. Categories invoked to speed up perception reflect roles, industry recipes, cultural cues, and occupational and identity-based stereotypes... Categorization effects appear to be quite robust, emerging even when the basis of social unit formation is arbitrary, transient, and objectively meaningless (Meyerson et al., 1996, p. 174).

In the Flex nurse interviews, the ways they defined themselves and their Flex roles were highly consistent. Their descriptions were also drawn significantly from nursing culture or professional expectations. In an environment where there was little

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structure imposed on who they were and what they were supposed to do, the Flex nurses took cues from the environment (the hospital culture) and their professional standards (nursing culture) to create their own Flex culture with role descriptions that decreased uncertainties and enhanced connections and communications with fellow co-workers.

Researchers who have studied swift trust formation have found that it is most successful when the level of interdependence or emotional support issues are kept "modest through a combination of distancing, adaptability, resilience, and interacting with roles rather than personalities. Swift trust is less about relating than doing" (Meyerson et al., 1996, p. 191). A hypothesis is that for flexible nurses, there may be a continuum of flexibility that characterizes their degree of interdependence or work connections with others. The sign of successful flexibility may be a nurse's ability to remain task-focused while relating to others through roles. This may indicate why the SNQ data show differences in group means for proportions of peers utilized for reassurance and dealing with emotional upsets: Flex nurses demonstrated significantly reduced proportions of peer utilization for these types of peer support. In their interviews, the Flex nurses also indicated that they preferred not to get involved with the units' issues or hospital socialization. "I do my job and then I go home."

The swift trust model, therefore, mirrors many of the comments made by the Flex nurses, and it helps explain how Flex nurses managed to move in and out of different situations while eliciting and reciprocating trust among co-workers. More research is needed to determine how situational explanations or models of Flex behavior, such as the "swift trust" model, coincide with broader theories such as "self

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in relation" theories. Is it possible that Flex nurses experience an intrinsic desire to belong or to connect with others, but they suppress these needs to be successful in their Flex roles? What is the price of this adaptability? Is this where we're heading with the future of organizations and work-related social relationships?

Conclusions

This mixed method study with its literature review provide important insights about Flex nursing culture within one, bounded system. The qualitative data delineated the culture themes that characterized these Flex nurses. In their world, flexibility personified who they were and why they did Flex. Because of their unique circumstances—many unknowns with little controls—they adopted mechanisms for quickly constructing situational support systems to ensure their safety and others' safety. Many of their interactions with co-workers were dependent on a sense of professionalism to provide support and respect: This was a reciprocal process, and it developed quickly. The swift trust model (Meyerson et al., 1996) provides potential explanations for how Flex nurses were able to adapt readily to different environments, particularly when trust was required among co-workers.

Although, Flex nurses were able to engage and disengage from work with little difficulty, they retained a sense of commitment to their peers, to the patients, and to the hospital: They saw it as a professional duty and a moral obligation. Because of the reciprocal nature of their interactions with people and place, disruption of their sense of "integrity" created distress. This was apparent with the Flex redesign.

The quantitative portion of the study indicates that Flex and Regular nurses constructed similar support networks. Although Flex nurses worked under different

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circumstances, creating and maintaining networks were important features of the workplace for both types of nurses. Some theorists suggest that this may be an intrinsic, self-preserving process of connecting with others.

The SNQ data show that although Flex and Regular nurses displayed similar network compositions, the utilization of network members for emotional support was different. According to Hupcey and Morse (1997), supports can be classified as social or professional supports, based on certain characteristics of the circumstances, the recipients, and the providers. On an imaginary support continuum, Regular nurses may have an inclination towards "social support" connections and Flex nurses may have an inclination towards "professional support" connections. The SNQ data also indicate that although there were no differences in group means for Flex and Regular nurses on the satisfaction variables, both groups indicated a moderate desire for more support. In any situation, particularly an acute care situation, whether the drive is intrinsic or not, individuals may desire more help.

Only one demographic variable, months worked at the hospital, significantly differentiated between group means for wanting more network members and wanting more network members for emotional support. Network variables and emotional support variables did not significantly affect satisfaction with network size or emotional and instrumental supports. Nevertheless, 40 to 50% of the Flex and Regular nurses indicated that they wanted larger networks as well as more people for emotional and instrumental support. More research needs to be done, therefore, to discover what social and physical, environmental factors affect the development and maintenance of effective work-related social relationships.

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Study Limitations

The study limitations were the length of time associated with the qualitative portion of the study, and external validity issues for the quantitative portion of the study. Richer description of the Flex culture could have been obtained from more time spent in their work environment over a longer period of time. Observations were typically snippets, rather than true participant observation. In addition, interviews with Regular nurses would have helped clarify different work perceptions for the two groups, and Regular nurse interviews would have helped triangulate the data from the SNQ.

Although questionnaires were distributed to all accessible inpatient nursing mailboxes, there must have been other nurses without mailbox access who did not receive a questionnaire with cover letter. Two managers indicated that there were 600 inpatient nurses, but only 300 questionnaires were distributed to mailboxes and 100 questionnaires delivered by mail. Effectiveness of the sampling method from the accessible population was questionable, and the return rate was only 42%.

The Social Network Questionnaire is a complex instrument, and although I have used it before, there were validity and reliability concerns that could not be addressed through this study. For instance, at a later time, it might be beneficial to create a composite score for the types of emotional support that were highly intercorrelated in order to simplify the analytic results. For this study, however, it was useful to examine emotional supports as separate entities. Since the questionnaire was adapted to this specific nursing situation, however, more needs to be done to ensure the instrument's research validity. Instead, the success of the tool in past settings, with previous validity

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and reliability reports, were accepted as the reliability and validity measures of the SNQ.

The SNQ works with raw numbers and proportions. The proportions were very difficult to interpret, and the analytic findings were difficult to report in a clear and succinct fashion. This instrument, therefore, provides a rich amount of data, but it is not easy to interpret or explain.

The mixed method approach was challenging. It was particularly tempting to over-interpret the findings of the SNQ after observing and interviewing the Flex nurses. There was the tendency to find more in the numbers than they were intended to provide, even though they are called "inferential" statistics.

Although this was a case study, between-case (between-hospital) comparisons would have enriched the findings of this study. Going to other institutions would have broadened the conceptualization of flexible nursing.

Recommendations

According to the socialization literature, how people are socialized affects their work direction—whether they value self-direction or routinization. A Flex culture evolved at Children's where nurses defined themselves in self-directed and professional terms. They coped with different people and different work environments; they devised mechanisms for providing safe and effective care, and they had high self-efficacy and were proud of their work. As evidenced by the redesign, however, the hospital was not able to effectively communicate its needs and concerns to Flex, and vice versa. Reactions of anger, denial, and sorrow resulted from miscommunication.

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Flexibility is important and it will be more important as work place changes continue to accelerate. In this study, Flex nurses possessed many work qualities suited to successful change, such as a capacity to adapt to different environmental demands. Flex is not just a staffing model of peripheral workers to meet organizational needs. Flex nurses are a diverse and talented resource that can help socially model flexible work qualities that will be needed in the future. These nurses, working with Regular staff, have the potential to create a collective efficacy mentioned by Bandura, but Flex nursing will not survive if flexibility continues to be reduced.

To harness flexibility potential within the hospital, the management tenets of Theory Y should be employed; this will require cooperation from management, Flex nurses, and Regular staff. Effective communication and cooperation will also require the mediation of neutral facilitators, such as Human Resources professionals. There were efforts from management and Flex nurses to communicate during focus group sessions before the redesign. Despite conscientious attempts to share thoughts and feelings on the redesign proposal, parallel communications and misconceptions arose which might have been avoided with assistance from the Human Resources Department. There were also benefits concerns raised during focus group discussions that could have been better addressed by Human Resources personnel in an objective fashion.

Research on restructuring and downsizing efforts has shown that certain strategies are able to minimize the negative effects of change. In a survey of 48 chief nurse executives (CNEs) across the southeast United States, "The most useful strategies identified in minimizing the effects of downsizing were clear and continuous

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communication, advance planning, staff input, and manager availability" (Young & Brown, 1998, p. 260). When Flex redesign was imminent, therefore, nursing management, Regular and Flex nurses should have planned the change together with the assistance of Human Resources professionals to facilitate open communication channels.

This research has just scratched the surface. So much still needs to be known about the socialization process within the workplace. What is known is that Flex nurses at The Children's Hospital found a way to create social networks for safety and support, and they thrived under their own professional guidance. Although there were problems with the Flex model, as revealed in discussions with management, there was much good to be gleaned from Flex nurses' active, problem-solving strategies, and their task-focused approaches to work.

Nurse managers and educators need to find ways to tap the positive and creative energies of employees who have developed support mechanisms for functioning in changeable work environments. Theory Y tenets and managerial support of employee workplace networks will no doubt be significant keys to maximizing employee workplace potential, and enhancing employee retention, workplace satisfaction, and organizational commitment.

The May 1999 American Psychological Association (APA) Monitor was devoted to concerns about worker stress and worker health—physical and mental. Russ Newman, the APA Executive Director for Practice, contributed an article on "networks for health care reform" (p. 24). According to Newman, typical organizational bureaucracies are incapable of meeting the complex needs of organizations. Networks

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of people working together and supporting each other are requisite structures of organizations poised for change and for success. Future research, therefore, should be devoted more to understanding the processes by which members of organizations create constructive, work-related social support networks.

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REFERENCES

Antonucci, T. (1985). Social support: theoretical advances, recent findings, and pressing issues. In I. Sarason & B. Sarason (Eds.), Social support: Theory, research, and applications. The Hague: Martinus Nijhoff.

Antonucci, T. (1986). Social support networks: A hierarchical mapping technique. Generations, 10, 10-12.

Antonucci, T., & Akiyama, H. (1985). Social networks in adult life and preliminary examination of the convoy model. Paper presented at the annual meeting of the Gerontological Society of America: New Orleans.

Argyris, C. (1964). Integrating the individual and the organization. New York: John Wiley & Sons.

Atkinson, J. (1984). Manpower strategies for flexible organizations. Personnel Management, 16, 64-74.

Bandura, A. (1997). Self-efficacy: The exercise of control. New York: W.H. Freeman & Company.

Benton, D. (1995). Applied human relations: An organizational approach. Englewood Cliffs, NJ: Prentice Hall.

Billett, S. (1998). Ontogeny and participations in communities of practice: A socio-cognitive view of adult development. Studies in the Education of Adults, 30, 21-34.

Blancett, S., & Flarey, D. (1995). Reengineering nursing and health care: The handbook of organizational transformation. Gaithersburg, MD: Aspen.

Blegen, M. (1993). Nurses' job satisfaction: A meta-analysis of related variables. Nursing Research, 42, 36-41.

Bowlby, J. (1982). Attachment and loss. New York: Basic Books.

Boyle, A., Grap, M., Younger, J., & Thornby, D. (1991). Personality hardiness, ways of coping, social support, and burnout in critical care nurses. Journal of Advanced Nursing, 16, 850-857.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Brannon, R. (1996). Restructuring hospital nursing: Reversing the trend toward a professional work force. International Journal of Health Services, 26, 643-654.

Brodell, E. (1996). Nursing career satisfaction: The effects of autonomy, social integration, and flexible scheduling. Prairie Rose, September-November, 4-6.

Buckley, M., Fedor, D., & Kicza, D. (1988). Work patterns altered by new lifestyles. Personnel Administrator, 33, 40-43.

Campbell, R. (1985). Cross-cultural issues in the concept of social support. Discussion session at the annual meeting of the Gerontological Society of America: New Orleans.

Cochran, M. (1990). Personal networks in the ecology of human development. In M. Cochran, M. Larner, D. Riley, L. Gunnarsson, & C. Henderson (Eds.), Extending families: The social networks of parents and their children. Cambridge: University Press.

Cohen, S., & Wills, T. (1985). Stress, social support, and the buffering hypothesis.Psychological Bulletin, 98, 310-357.

Cooperrider, F. (1980). Staff input in scheduling boosts morale. Hospitals, 54, 59-61.

Corey, G. (1996). Theory and practice of counseling and psychotherapy. Pacific Grove, CA: Brooks/Cole Publishing Company.

Coyne, J., & DeLongis, A. (1986). Going beyond social support: the role of social relationships in adaptation. Journal of Consulting and Clinical Psychology, 54, 454-460.

Cramer, L., Riley, P., & Kiger, G. (1991). Support and antagonism in social networks: Effects of community and gender. Journal of Social Behavior and Personality, 6, 991-1005.

Creswell, J. (1994). Research design: Qualitative and quantitative approaches. Thousand Oaks, CA: Sage.

Creswell, J. (1997). Composing a mixed method study. A contributed paper presentation for the American Educational Research Association Annual meeting, March 26, 1997: Chicago.

Creswell, J. (1998). Qualitative inquiry and research design: Choosing among the five traditions. Thousand Oaks, CA: Sage.

Curtain, L. (1995). Contingency plans: Employment relationships in the late '90s. Nursing Management, 26, 51-53.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Davis-Blake, A., & Uzzi, B. (1993). A study of temporary workers and independent contractors. Administrative Science Quarterly, 38, 195-223.

Dawes, R. (1994). House of cards. Psychology and psychotherapy built on myth. New York: Free Press.

DeLaune, S., & Ladner, P. (1998). Fundamentals of nursing: Standards and practice. Albany, NY: Delmar Publishers.

DeMarco, R. (1998). Caring to confront in the workplace: An ethical perspective for nurses. Nursing Outlook, 46, 130-135.

DePaulo, B. (1982). Social-pyschological processes in informal help seeking. In T. Willis (Ed.), Basic processes in helping relationships (pp. 255-279). New York: Academic Press.

Diamond, T. (1988). Social policy and everyday life in nursing homes: A critical ethnography. In A. Stratham, E. Miller, & H. Mauksch (Eds.), The worth of women's work: A qualitative synthesis (pp. 39-56). Albany, NY: State University of New York Press.

Dunkel-Schetter, C., & Skokan, L. (1990). Determinants of social support provision in personal relationships. Journal of Social and Personal Relationships, 7, 437-450.

Eibl-Eibesfeldt, I. (1975). Ethology: The biology of behavior. New York: Holt, Rinehart, & Winston, Inc.

Feldman, D., Doerpinghaus, H., & Turnley, W. (1994). Managing temporary workers: A permanent HRM challenge. Organizational Dynamics,23, 49-63.

Fischer, C. (1982). To dwell among friends: Personal networks in town and city. Chicago: University of Chicago Press.

Fisher, C. (1985). Social support and adjustment to work: A longitudinal study. Journal of Management, 11, 39-53.

Flarey, D. (1995). Quality improvement through data analysis: Concepts and applications. In S. Blancett & D. Flarey (Eds.), Reengineering nursing and health care (pp. 180-195). Gaithersburg, MD: Aspen.

Flynn, J. (1997). The role of the preceptor: A guide for nurse educators and clinicians. New York: Springer Publishing Company.

Forte, P., & Forstrom, S. (1998). Work complexity assessment: Decision support data to address cost and culture issues. Journal of Nursing Administration, 28, 46-53.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Foster, R. (1997). Addressing epistemologic and practical issues in multimethod research: A procedure for conceptual triangulation. Advances in Nursing Science, 20, 1-12.

Fusco, P. (1994). Hardiness, coping style, and burnout: Relationships in female hospital nurses. (Doctoral dissertation, University of North Texas, 1994).

Gilligan, C. (1982). In a different voice: Psychological theory and women's development. Cambridge: Harvard University Press.

Gruber-May, J. (1993). Networking: A strategy for professional success. Medical-Surgical Nursing, 2,136-137.

Guba, E. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. Educational Research Information Center Annual Review,29, 75-91.

Hammer, M. (1996). Beyond Reengineering: How the process-centered organization is changing our work and our lives. New York: Harper Business.

Hammer, M., & Champy, J. (1993). Reengineering the corporation: A manifesto for business revolution. New York: Harper Business.

Hansen, H. (1995). A model of collegiality among staff nurses in acute care. Journal of Nursing Administration, 25, 11-20.

Hastings, C., & Waltz, C. (1995). Assessing the outcomes of professional practice redesign: Impact on staff nurse perceptions. Journal of Nursing Administration, 25, 34-42.

Heller, K., & Mansbach, W. (1984). The multifaceted nature of social support in a community sample of elderly women. Journal of Social Issues, 40, 99-112.

Heller, K., Price, R., & Hogg, J. (1990). The role of social support in community and clinical interventions. In B. Sarason, I. Sarason, & G. Pierce (Eds.), Social support: An interactional view (pp. 482-509). New York: John Wiley & Sons.

Herriot, P. (1995). The changing context of assessment and its implications. International Journal of Selection and Assessment, 3, 197-201.

Herzberg, F. (1968). "One more time: How do you motivate employees?" Harvard Business Review, 46, 56.

Hinshaw, A., Smeltzer, C., & Atwood, J. (1987). Innovative retention strategies for nurses. Journal of Nursing Administration, 17, 8-16.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Hollabaugh, S., & Kendrick, S. (1998). Staffing: The five-level system. Nursing Management, 29, 34-36.

Hughes, L. (1993). Peer group interactions and the student-perceived climate for caring. Journal of Nursing Education, 32, 78-83.

Hupcey, J. (1998). Clarifying the social support theory-research linkage. Journal of Advanced Nursing, 27, 1231-1241.

Hupcey, J., & Morse, J. (1997). Can a professional relationship be considered social support? Nursing Outlook, 45, 270-276.

Johnson, J. (1986). The impact of the workplace social support, job demands, and work control on cardiovascular disease in Sweden. (Doctoral dissertation, Johns Hopkins University, 1986).

Jones, F., & Fletcher, B. (1996). Job control and health. In M. Schabracq, J. Winnubst, & C. Cooper (Eds.), Handbook of work and health psychology (pp. 33-51). Chichester, UK: John Wiley & Sons.

Jones, G. (1986). Socialization tactics, sefl-efficacy, and newcomers' adjustments to organizations. Academy of Management Journal, 29, 262-279.

Jordan, J. (1991). Empathy, mutuality, and therapeutic change: Clinical implications of a relational model. In J. Jordan, A. Kaplan, Baker Miller, J., Stiver, I., & Surrey, J.(Eds.), Women's growth in connection: Writings from the Stone Center (pp. 283-291). New York: Guilford Press.

Joseph, J., & Deshpande, S. (1997). The impact of ethical climate on job satisfaction in nurses. Health Care Management Review, 22, 76-81.

Kanter, R. (1989). When giants learn to dance. New York: Simon & Schuster.

Kanter, R. (1997). On the frontiers of management. Harvard: Harvard Business Review.

Karasek, R. (1979). Job demands, job decision latitude, and mental strain: Implications for job redesign. Administrative Science Quarterly, 24, 285-307.

Karasek, R. (1981). Job socialization and job strain: The implications of two related psychosocial mechanisms for job design. In B. Gardell & G. Johansson (Eds.), Man and working life: Social science contributions to work reform (pp.208-244). Chichester, UK: Wiley & Sons.

Karasek, R., Gardell, B., & Lindell, J. (1987). Work and non-work correlates of illness and behaviour in male and female Swedish white-collar workers. Journal of Occupational Behavior, 8, 187-207.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Karasek, R., & Theorell, T. (1990). Healthy work, stress, and productivity:The reconstruction of working life. New York: Basic Books.

Kavanagh, K. (1989). Nurses' networks: Obstacles and challenge. Archives of Psychiatric Nursing, 4, 226-233.

Kaye, B., & Jacobson, B. (1996). Reframing mentoring. Training and Development, August, 44-47.

Keddy, B. (1993). Dis-ease between nursing and feminism: Nursing caring for one another within a feminist framework. Issues in Mental Health Nursing, 14, 287-292.

Keys, P. (1998). The betrayal of the Total Quality Movement in western management: Managed care and provider stress. Family and Community Health, 21, 1-19.

Kieltyka, C., Robertson, S., & Behner, K. (1997). A flexible staffing model for patient service associates. Journal of Nursing Administration, 27, 48-54.

Kinneman, M., Hitchings, K., Bryan, Y., Fox, M., & Young, M. (1997). A pragmatic approach to measuring and evaluating hospital restructuring efforts. Journal of Nursing Administration, 27, 33-41.

Kobasa, S., Maddi, S., & Kahn, S. (1982). Hardiness and health: A prospective study. Journal of Personality and Social Psychology, 42, 168-177.

Kofman, F., & Senge, P. (1995). Communities of commitment: The heart of learning organizations. In S. Chawla & J. Renesch (Eds.), Learning organizations (pp. 15-45). Portland, OR: Productivity Press.

Kohlberg, L. (1981). The philosophy of moral development. New York: Harper & Row.

Kohut, H. (1971). The analysis of the self. New York: International Universities Press.

Kopelman, R. (1985). Job redesign and productivity: A review of the evidence. Natural Products Review, Summer, 237-255.

Kovner, C., Hendrickson, G., Knickman, J., & Finkler, S. (1993). Changing the delivery of nursing care: Implementation issues and qualitative findings. Journal of Nursing Administration, 23, 24-34.

Krefting, L. (1990). Rigor in qualitative research: The assessment of trustworthiness.The American Journal of Occupational Therapy, 45, 214-222.

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Kreitner, R. (1995). Management. Boston: Houghton Mifflin Company.

Kutash, M., & Nelson, D. (1993). Optimizing the use of nursing pool resources. Journal of Nursing Administration, 23, 65-68.

Laireiter, A., & Baumann, U. (1992). Network structure and support functions-theoretical and empirical analyses. In H. Veil & U. Baumann (Eds.), The Meaning and measurement of social support (pp.33-55). New York: Hemisphere.

Lamphere, L. (1985). Bringing the family to work: Women's culture on the shop floor. Feminist Studies, 11, 519-540.

Laschinger, H., Sabiston, J., & Kutszcher, L. (1997). Empowerment and staff nursedecision involvement in nursing work environments: Testing Kanter's theory of structural power in organizations. Research in Nursing and Health, 20, 341-352.

LeGrow, C. (1993). The effects of employment status and job peripherality on the work attitudes of full-time and part-time nursing professionals. Unpublished doctoral dissertation, Ohio University.

Levine, M. (1977). Nursing ethics and the ethical nurse. American Journal of Nursing, 77, 845-849.

Levitt, M. (1985). Cross-cultural issues in the concept of social support. Discussion session at the Gerontological Society of America: New Orleans.

Levitt, M., Gaucci-Franco, N., & Levitt, J. (1993). Convoys of social support in childhood and early adolescence: Structure and function. Developmental Psychology, 29, 811-818.

Likert, R. (1961). New patterns of management. New York: McGraw-Hill.

Lincoln, Y. (1995). Emerging criteria for quality in qualitative and interpretive research. Qualitative Inquiry, 1, 275-289.

Lincoln, Y., & Guba, E. (1985). Naturalistic inquiry. Beverly Hills, CA: Sage.

Lipsey, M., & Wilson, D. (1999). Meta-analysis tool kit. Nashville, TN: Vanderbilt University, The Institute of Public Policy.

Lundgren, R., & Browner, C. (1990). Caring for the institutionalized mentally retarded: work culture and work-based social support. In E. Abel & M. Nelson (Eds.), Circles of Care: Work and identity in women's lives (pp. 150-173). Albany, NY: State University of New York Press.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

MacPhee, D., Fritz, J., & Miller-Heyl, J. (1996). Ethnic variations in personal social networks and parenting. Child Development,67, 3278-3295.

MacPhee, M., Hoffenberg, E., & Feranchak, A. (1998). Quality-of-life factors in adolescent Inflammatory Bowel Disease. Inflammatory Bowel Diseases, 41, 6-11.

Maslach, C., & Jackson, S. (1982). Burnout in health professions: A social psychological analysis. In G. Sanders & J. Suls (Eds.), Social psychology of health and illness (pp. 227-251). Hillsdale, NJ: Erlbaum.

Maslow, A. (1954). Motivation and personality. New York: Harper & Row.

McAteer-Early, T. (1992). The impact of career self-efficacy on the relationship between career development and health-related complaints. Paper presented at the Academy of Management Meeting: Las Vegas, Nevada.

McCloskey, J. (1990). Two requirements for job contentment: Autonomy and social integration. Image, 22, 140-143.

McCloskey, J., Mass, M., Huber, D., Kasparek, A., Specht, J., Ramler, C., Watson, C., Blegen, M., Delaney, C., Ellerbe, S., Etscheidt, C., Gongaware, C., Johnson, M., Kelly, K., Mehmert, P., & Clougherty, J. (1994). Nursing management innovations: A need for systematic evaluation. Nursing Economics, 12, 35-44.

McGuinness, B. (1998). The change in employee loyalty. Nursing Management, 29, 45-46.

McLaughlin, F., Thomas, S., & Barter, M. (1995). Changes related to care delivery patterns. Journal of Nursing Administration, 25, 35-46.

Merriam, S., & Heuer, B. (1996). Meaning-making, adult learning and development: A model with implications for practice. International Journal of Lifelong Education, 15, 243-255.

Meyerson, D., Weick, K., & Kramer, R. (1996). Swift trust and temporary groups. In R. Kramer & T. Tyler (Eds.), Trust in organizations: Frontiers of theory and research (pp. 166-196). Thousand Oaks, CA: Sage.

Mezirow, J. (1991). Transformative dimensions of adult learning. San Francisco, CA: Jossey-Bass.

Miles, M., & Huberman, A. (1994). Qualitative data analysis. Thousand Oaks, CA: Sage.

Miller, M. (1984). Implementing self-scheduling. Journal of Nursing Administration, 14, 33-36.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Moore, S., Kuhrik, M., Kuhrik, N., & Katz, B. (1996). Coping with downsizing: Stress, self-esteem, and social intimacy. Nursing Management, 27, 28-30.

Morgan, G., & Griego, O. (1998). Easy use and interpretation of SPSS for Windows. Mahwah, NJ: Lawrence Erlbaum Associates.

Mowday, R., Steers, R., & Porter, L. (1979). The measurement of organizational commitment. Journal of Vocational Behavior, 14, 224-247.

Nelson, D., Quick, J., & Joplin, J. (1991). Psychological contracting and newcomer socialization. Journal of Social Behavior and Personality, 6, 55-72.

Nollen, S., & Axel, H. (1996). Managing contingent workers: How to reap the benefits and reduce the risks. New York: Amacom Press.

Oliver, N. (1987). Processing unacceptable behaviors of co-workers: A naturalistic study of nurses at work. Unpublished doctoral dissertation, New York University, New York.

Parker, M., & Slaughter, J. (1994). Why participations programs endure. In M. Parker & J. Slaughter (Eds.), Working smart: A union guide to participation programs and reeningeering (pp. 121-124). Detroit, MI: Labor Education and Research Project.

Parsons, T. (1953). The super-ego and the theory of super systems. In T. Parsons, R. Bales, & E. Shils (Eds.), Working papers in the theory of action. Glencoe, IL: Free Press.

Patterson, P., Blehm, R., Foster, J., Fuglee, K., & Moore, J. (1995). Nurse information needs for efficient care continuity across patient units. Journal of Nursing Administration, 25, 28-36.

Patton, M. (1990). Qualitative evaluation and research methods. Newbury Park, CA: Sage.

Pearlin, L. (1985). Social structure and processes of social support. In S. Cohen & S. Syme (Eds.), Social support and health (pp. 43-60). Orlando, FL: Academic Press.

Peters, T. (1992). Liberation management. New York: Knopf.

Pines, A., Aronson, E., & Kafry, D. (1981). Burnout:From tedium to personal growth. New York: Free Press.

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Plante, E., Kiernan, B., & Betts, J. (1994). Method or methodolotry: The qualitative/quantitative debate. Language, Speech, and Hearing Services in Schools, 25, 52-54.

Porter-O'Grady, T. (1987). Shared governance and new organizational models. Nursing Administration Quarterly, 5, 281-286.

Prucho, R., & Faletti, M. (1983). The social world of institutionalized aged: Structure versus function. Paper presented at the annual meeting of The Gerontological Society of America: San Francisco.

Puetz, B. (1983). Networking for nurses. Rockville, MD: Aspen.

Roberts, S. (1983). Oppressed group behavior: Implications for nursing. Advances in Nursing Science, 5, 21-30.

Roedel, R., & Nystrom, P. (1988). Nursing jobs and satisfaction. Nursing Management, 16, 34-38.

Rogers, C. (1980). A way of being. Boston, MA: Houghton Mifflin.

Rothwell, W., Sullivan, R., & McLean, G. (1995). Practicing organization development: A guide for consultants. San Diego, CA: Pfeiffer & Company.

Saks, A. (1995). Longitudinal field investigation of the moderating and mediating effects of self-efficacy on the relationship between training and newcomer adjustment. Journal of Applied Psychology, 80, 211-225.

Sandelowski, M. (1993). Rigor or rigor mortis: The problem of rigor in qualitative research revisited. Advances in Nursing Science, 16, 1-8.

Schabracq, M., & Cooper, C. (1998). Toward a phenomenonological framework for the study of work and organizational stress. Human Relations, 51, 625-645.

Schabracq, M., Cooper, C., & Winnubst, A. (1996). Work and health psychology: Towards a theoretical framework. In M. Schabracq, A. Winnubst, & C. Cooper, (Eds.), Handbook of work and health psychology. New York: John Wiley & Sons.

Schiff, G., & Goldfield, N. (1994). Deming meets Braverman: Toward a progressive analysis of the continuous quality improvement paradigm. International Journal of Health Services, 24, 655-673.

Seago, J. (1996). Work group culture, stress, and hostility: correlations with organizational outcomes. Journal of Nursing Administration, 26, 39-47.

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Seago, J., & Faucett, J. (1997). Job strain among registered nurses and other hospital workers. Journal of Nursing Administration, 27, 19-25.

Senge, P. (1990). The fifth discipline. New York: Currency Doubleday.

Shaffer, F., & Kobs, A. (1997). Measuring competencies of temporary staff. Nursing Management, 28, 41-45.

Sherwood, G. (1997). Patterns of caring: The healing connection of interpersonal harmony. International Journal of Human Caring,1, 30-8.

Smith, A., & Flarey, D. (in press). The process centered health care organization. Gaithersburg, MD: Aspen.

Stake, R. (1995). The art of case study research. Thousand Oaks, CA: Sage.

Stenske, J., Biordi, D., Gilles, D., & Holm, K. (1988). Resource teams: their structure and function. Journal of Nursing Administration, 18, 34-38.

Stiver, I. (1991). The meaning of care: Reframing treatment models. In J. Jordan, A. Kaplan, Baker Miller, J., Stiver, I., & Surrey, J. (Eds.), Women's Growth in connection: Writings from the Stone Center (pp. 250-268). New York: Guilford Press.

Strauss, A., & Corbin, J. (1990). Basics of qualitative research: Grounded theory procedures and techniques. Newbury Park, CA: Sage

Surrey, J. (1991). The self-in-relation: A theory of women's development. In J. Jordan, A. Kaplan, Baker Miller, J., Stiver, I., & Surrey, J. (Eds.), Women's growth in connection: Writings from the Stone Center (pp. 51-67). New York: Guilford Press.

Tett, R., & Meyer, J. (1993). Job satisfaction, organizational commitment, turnover intention, and turnover: Path analyses based on meta-analytic findings. Personnel Psychology, 46, 259-291.

Trompenaars, A. (1994). Riding the waves of culture: Understanding diversity in global business. Burr Ridge, IL: Irwin Professional Publishers.

Vachon, M. (1998). Caring for the caregiver in oncoloy and palliative care. Seminars in Oncology Nursing, 14, 152-157.

Van Maanen, J. (1976). Breaking in: Socialization to work. In R. Dubin (Ed.), Handbook of work, organization, and society (pp. 67-130). Chicago: Rand-McNally.

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Van Maanen, J., & Schein, E. (1979). Towards a theory of organizational socialization. In B. Staw (Ed.), Research in organizational behavior (209-264). Greenwich, CT: JAI Press.

Vann, B. (1996). Learning self-direction in a social and experiential context. Human Resource Development Quarterly, 7, 121-130.

Wachel, W. (1994). Reengineering: Beyond incremental change. Healthcare Executive, 9, 18-21.

Wanous, J., & Colella, A. (1989). Organizational entry research: Current status and future research directions. In K. Rowland & G. Ferris (Eds.), Research in personnel and human resources management (pp. 59-120). Greenwich, CT: JAI Press.

Warren, I., & Rozell, B. (1995). Supplemental staffing: Nurse manager views of costs, benefits, and quality of care. Journal of Nursing Administration, 25, 51-57.

Watson, J. (1988). Human science and human care: A theory of nursing. New York: National League of Nursing.

Werbel, J. (1985). The impact of primary life involvements on turnover: A comparison of part-time and full-time employees. Journal of Occupational Behavior,6, 251-258.

Wetzel, K., Soloshy, D., & Gallagher, D. (1990). The work attitudes of full-time and part-time registered nurses. Health Care Management Review, 15, 79-85.

Wilshire, D. (1994). Myths and mysteries of the triple goddess. Rochester, VT: Inner Traditions.

Wilson, C., Grams, K., & Kosowski, M. (1997). Caring groups in nursing education: Creating caring connections in nursing practice. International Journal for Human Caring, 3, 22-31.

Winnicott, D. (1971). Playing and reality. New York: Basic Books.

Wren, D. (1979). The evolution of management thought. New York: John Wiley & Sons.

Wulff, K. (1994). Flextime and self-scheduling: Benefits and difficulties. In J. McCloskey & H. Grace (Eds.), Current issues in nursing (pp. 261-267). Boston, MA: Mosby.

Young, S., & Brown, H. (1998). Effects of hospital downsizing on surviving staff. Nursing Economics, 16, 258-262.

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Zander, K. (1988). Nursing case management: strategic management of cost and quality outcomes. Journal of Nursing Administration, 18, 23-30.

Zavella, P. (1985). Abnormal intimacy: The varying work networks of Chicana cannery workers. Feminist Studies, 11, 497-518.

Zunz, S. (1998). Resiliency and burnout: Protective factors for human service managers. Administration in Social Work, 22, 39-55.

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APPENDIX A

Social Network Questionnaire and Cover Letter

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Dear Colleague,

The purpose of this questionnaire, The Social Network Questionnaire, is to investigate nurses' social networks at work. Little is known about the types of relationships that nurses develop at work, and whether these relationships are supportive or not, particularly with regards to emotional support needs (someone to confide in, someone for reassurance, et cetera). Most research has focused on nurses' instrumental support needs (information, technical assistance). You are being asked to participate in this study because you are a nurse at Children's Hospital.

You are being asked to anonymously complete this questionnaire about your social network at Children's Hospital. This questionnaire will be distributed to every nurse at Children's. You may take the questionnaire home and complete it at your leisure. The estimated completion time is 30 minutes. The pages may be detached for easier completion. Please return the entire questionnaire in the envelope provided. Place the envelope in a designated box in your nursing lounge. I will be checking the box on a weekly basis, and I also will post periodic reminders to nursing staff. I will be doing this portion of my research study through November.

There are no risks or benefits from participating in this study. This is a self-funded study, although a small nursing research award will help cover the costs of this project. I have been a nursing staff member at Children's for fifteen years, and I am very interested in staff education and development. I want to know about nurses' social networks, because I believe that they are an important consideration when designing staff education and development programs.

The questionnaire is one part of my research project at Children's. I also will be doing in-depth interviews with some nursing staff members, and I will be doing observations of nursing interactions.

If you have any questions, concerns, or comments, I would be glad to address them by phone or in person. Please call me at home (970-224-3928) or leave a message for me at 4 North Nursing (861-6500).

Thank you so much for participating in this research.

Sincerely,

Maura MacPhee

Maura MacPhee, RN, MS.

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Nursing status: Circle Flex or Regular Gender: Circle M or F

Number of units you work:_____

Number of hours you work per pay period:_____

How long have you worked at Children's:_____

THE SOCIAL NETWORK QUESTIONNAIRE

I would like to ask you about the people who are important to you at work right now. The circle diagram on the next page represents a network of people at work who are important to you.

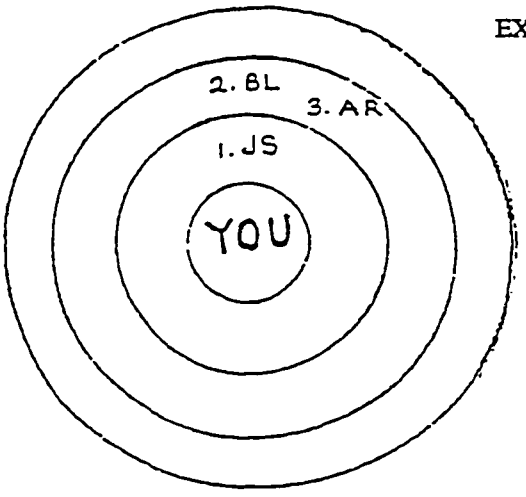
YOU are at the center. The first ring represents people you feel closest to at work. The second ring represents people you feel less close to at work, but they are still important to you. The third ring represents people you feel least close to at work, but they are still important to you.

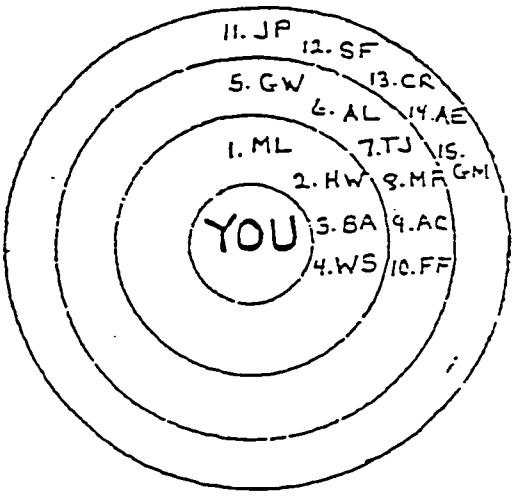
Put people in your network who are important to you –not just people you happen to know.

Please fill in your network by putting in the INITIALS of people who are important to you, beginning with the inner circle and working out towards the third circle. NUMBER EACH PERSON AS YOU PLACE HER OR HIM IN YOUR NETWORK.

Circles may be empty, full, or anywhere in between.

EXAMPLES





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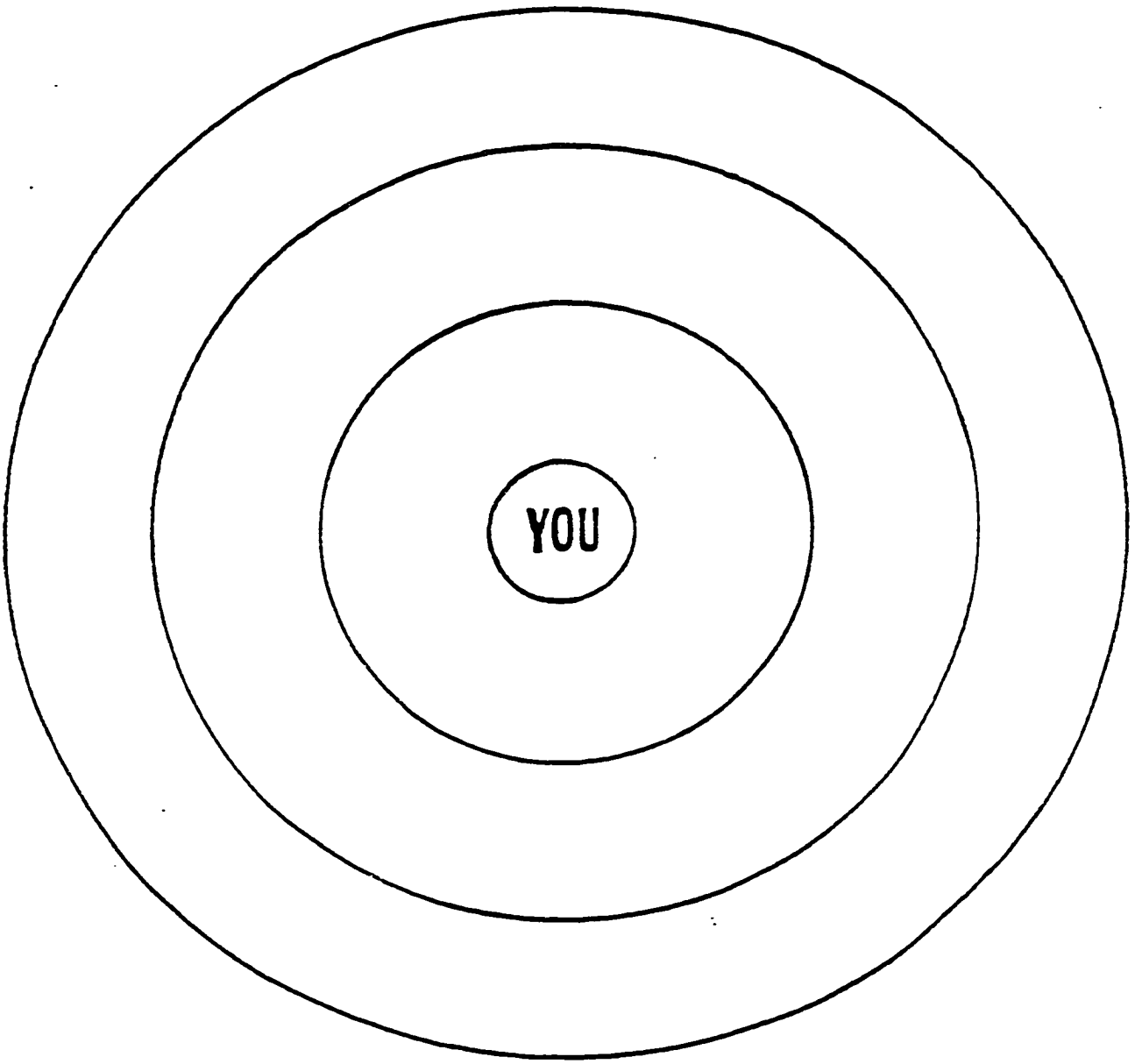
NETWORK DIAGRAM



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PLEASE FILL IN THE FOLLOWING INFORMATION ABOUT THE PEOPLE IN YOUR NETWORK:

(Just do this for the first 15 people you have listed in your network. Remember, any number of people in your network is OK).

PERSON #	RELATIONSHIP OF PERSON TO YOU: (Examples: peer, manager)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	

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Below are some questions about the people in your network. For each of these questions, **CIRCLE THE NUMBER** from your network diagram of each person who fits the question. If no one does, circle 0. For instance, if you confide in Persons 6 and 8, circle them as follows: 0 1 2 3 4 5 (6) 7 (8) 9 10 11 12 13 14 15

1) Are there people at work you **confide** in about things that are important to you?

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15

2) Are there people at work who **reassure** you when you're feeling uncertain about something personal?

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15

3) Are there people at work who make you feel **respected**?

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15

4) Are there people at work who you talk to when you are **upset, depressed, or nervous**?

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15

5) Are there people at work to whom you turn for advice about **major life decisions**?

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15

Please **CIRCLE** the following Yes/No Questions about your social network at Children's.

1) Would you want to have more people in your network? YES NO

2) Would you want to have more people in your network for **emotional** support? YES NO

3) Would you want to have more people in your network for **instrumental** support? YES NO

Instrumental=assistance with nursing tasks, information

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APPENDIX B

Contact Summary Sheet, Interview Questions, Consent Form

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CONTACT SUMMARY SHEET

Date:

Place:

People involved:

Describe what happened:

Special words or gestures?
Anything salient?

What were your impressions?

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INTERVIEW QUESTIONS

1) What is it like being Flex?

2) What are your reasons for doing Flex?

3) What are your work relationships like?

a) Nurses:
Regular

Flex

b) Managers:

Regular

Flex

c) Physicians
d) Other health care workers
e) Families and patients

4) How does Flex affect your relationships with (nurses, managers, etc)?

5) What types of supports would be helpful to you?

6) What does emotional support mean to you? How do you get the support you need?

7) What does instrumental support mean to you? How do you get the support you need?

8) What is different about being Flex? Different from being a Regular nurse?

9) Have you had any problems at work from being Flex?

10) What does commitment mean to you? (To nursing, hospital, peers)?

11) What are your future goals?

12) What do you think of the redesign?

13) How has the redesign affected your work relationships at the hospital?

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Consent Form Approval

Allan Prochazka, MD/Victor Spitzer, Ph.D. Co-Chair, COMIRB

Date 9/29/98

COLORADO MULTIPLE INSTITUTIONAL REVIEW BOARD

"A Mixed Method Study of Flex Nurses' Work-Related Social Relationships"

Principal Investigator: Maura MacPhee

SUBJECT CONSENT
September 19,1998

You are being asked to take part in a study of Flex nurses' work-related social relationships at The Children's Hospital of Denver. Little is known about the types of relationships nurses develop at work, and whether these relationships are supportive or not. In work environments, professionals often develop connections with other individuals to meet emotional needs (reassurance, someone to confide in), as well as instrumental needs (information, technical support). "Flex" staffing is a nursing management model, and health care institutions all over the United States employ Flex nurses. Business management trends indicate that Flex nursing will always be in need, although the models will change as health care institutions change. Flex nurses are an important part of the workforce, but there is little research on their perspectives of the work environment. This study is meant to address a specific aspect of Flex nurses' work environments, the social relationships they form with other people at work. You are being asked to participate in this study because you are a Flex nurse at Children's Hospital.

If you agree to participate in the study, you will be interviewed about your work relationships at Children's Hospital. You will be interviewed at least one time, and the investigator may need to contact you for a follow-up interview. The initial interview will take a maximum of two hours, and it will be tape recorded. You will receive a typed copy of your interview to proof read, and you may also be asked to comment on the investigator's interpretations of your thoughts and feelings in a follow-up interview.

There are no risks from participating in the study, and there is no direct benefit to you for being in the study.

This is a self-funded study, although a small nursing research award will help cover the costs of this project.

 Subject initials_____ Date:_____

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Your participation in this study is voluntary, and you have the right to withdraw at any time. You have the right to refuse to answer any question(s). Your name will not be associated with specific responses to questions. The information from this study will be part of a doctoral dissertation and may be published in the future. Your identity will not be revealed and all data will be treated with professional standards of confidentiality.
All cassette recordings and transcripts will be stored in a locked cabinet file and will be destroyed upon completion of the study.

You are encouraged to ask questions about any aspect of the study, or this consent form, either now or in the future. If you have any questions or concerns, the investigator would be glad to address them by phone or in person. Please call Maura MacPhee at (970) 224-3928, or leave a message at 4 North Nursing, Children's Hospital: (303) 861-6500. If you have any questions regarding your rights as a research subject, please call Vicki Starbuck, Program Assistant of COMIRB, at (303) 315-8081.

AUTHORIZATION

I have read this paper about the study or it was read to me. I understand the purpose of the study and voluntarily consent to participate in this research project. I know that I can withdraw from this study at any time. I will get a copy of this consent form. (Initial all pages (2) of this consent form).

Signature:_____

Print Name:_____ Date:_____

Consent form explained by:_____

Print Name:_____ Date:_____

Investigator:_____ Date:_____

Page 2 of 2 Subject initials_____ Date:_____

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APPENDIX C

1999 Flex Redesign Plans with Cover Letter

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Flex Team

TO: ALL FLEX TEAM MEMBERS

FROM: TRACI LINK, RN, BSN
FLEX TEAM CLINICAL COORDINATOR

DATE: DECEMBER 1, 1998

RE: FLEX TEAM REDESIGN PLAN

Each year there are Flex Team Task Forces to evaluate and modify the Flex Team Program. This year the Task Force members were managers who were given the responsibility to evaluate and make necessary modifications. The members were Susan Koch, Bridget Theunissen, Linda Brazen, Michelle Steinwand, Kris Light, Camille Shea-McAleavey, Sheila Kaseman, Angela Pollack, Traci Link, and Jan Kersey.

The Task Force identified the need to make changes to the current Flex Team policy in order to maintain a balance in staffing trends throughout the hospital. The Task Force did a local and national market analysis of other hospitals. With that information, the Flex Team Task Force created a plan proposal. The Flex Team Task Force then held many focus groups which were posted throughout the hospital inviting both Flex and regular staff. There were also many one on one conversations to obtain input. Our own Finance, Human Resources, and Payroll departments were consulted in this process as well. As a result of the input from all of these sources, many changes were made to the original plan. The changes were the addition of New Years to winter holidays, flexibility of shift hours (originally only 12 hours), off-shift includes evenings (originally only nights), and the addition of the weekend and straight night plans. The plans were then presented to Clinical Directors and Program Directors who gave final approval of the Flex Team Redesign Plan.

The Task Force recognizes that these changes are major changes. There was a great deal of discussion regarding the notion of "grandfathering" current Flex employees. The decision was to not "grandfather" because it would not help to create balanced staffing.

The Task Force will do a program evaluation of the new plan after the first three months of implementation and at periodic intervals. Based on findings, changes may be made.

Enclosed in this packet is a copy of the Flex Redesign Plan and an Agreement Statement for the Flex Team Plans. I want to give you this information as soon as possible so that you may take your time in making your decision. **I need to have all Agreement Statements completed and returned to me by January 25, 1999.** This date was chosen in order to have enough time to process the paperwork necessary to enable us to implement the plan on March 7, 1999. I hope that all of you will be able to choose a plan that will work for you because I want you to stay at Children's!

As of January 1, 1999 Flex Team nurses will be evaluated based on revised Standards of Performance for a Clinical Level III RN. I have enclosed a copy of those standards for Flex Team nurses only.

As of January 1, 1999 Flex Team Mental Health Counselors will be evaluated using the Standards of Performance for Mental Health Counselors. I have enclosed a copy for Mental Health Counselors only.

I want to thank each and every one of you for your input and your patience throughout this entire process. Please contact me with any questions you may have in regards to the new Flex Redesign Plan. I can be reached at (303) 837-2829.

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Common baseline components that apply to all plan options:

- Minimum 2 years Pediatric/Neonatal experience with adult experience considered
- Flex transferring from regular status must have demonstrated Level III competency
- Level of performance is based on LIII Clinical Standards of Performance
- All Plans are either unit/Program based or centralized
- 12 hour shifts preferred
- Pre-scheduling preferred
- May be pre-assigned to units or to centralized group.
- Availability must be to designated needs.
- Each Flex Team member will negotiate their Plan selection with the appropriate Nursing Manager. Commitment to the selected plan is a minimum of six months. Please see Attendance Policy.
- Floating and cancellations determined by unit needs
- Time off can be taken for the equivalent of four weeks per calendar year with no more than two weeks at a time. Time off is to be discussed and arranged in advance with Nursing Managers.
- Not included in Staffing Alert plan
- This document outlines changes to current Flex Team Policy.
- Pension plan if eligible (see Pension plan)

ADDITIONAL MODIFICATIONS:

Elimination of:

- New Grad Flex
- Restricted Flex
- Extended Flex
- Part-time Flex
- Flex Staffing Alert

Maintain the Flex Traveler

DEFINITIONS:

* Weekend shifts:
Any shifts beginning 3p or after Friday and ending 7a Monday

** Off-shifts:
Shifts beginning at or after 3pm or designated as receiving evening or night differential by Human Resources policy (evening and night shifts on weekends will count in both Weekend and Off-shift requirements)

***Holidays:

Summer:
Memorial Day (11p the night before to 7a the day after)
July 4 (11p the night before to 7a the day after)
Labor Day (11p the night before to 7a the day after)

Winter:
Thanksgiving (11p the night before to 7a the day after)
Christmas (3p Christmas eve to 7a the day after)
New Years (3p New Years eve to 7a the day after)

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FLEX REDESIGN PLAN
Implementation date: March 7, 1999

PLAN A:
- Minimum availability of one shift per pay period
- Shifts determined by unit/program
- One Summer and one Winter holiday ***

PLAN B:
- Minimum availability of 24 hours per pay period
- Minimum 24 hours of weekend shifts* per 6 week schedule (16 hours for 4 week schedules and 32 hours for 8 week schedules) – 12 hour shifts preferred
- 50% off shifts**
- One Summer and one Winter holiday ***

PLAN C:
- Minimum availability of 48 hours per pay period
- Minimum 36 hours of weekend shifts* per 6 week schedule (24 hours for 4 week schedules and 72 hours for 8 week schedules) – 12 hour shifts preferred
- 50% off shifts**
- One Summer and one Winter holiday with an additional holiday ***

PLAN D:
- All weekends
- Available for 6 out of 7 weekends
- Minimum 16 hours per weekend
- One Summer and one Winter holiday (regardless of days of week) ***

PLAN E:
- Straight nights
- Minimum availability of 32 hours per pay period
- One Summer and one Winter holiday***

COMPENSATION:

	RNs	MHCs
Plan A	$20	$12
Plan B	$25	$14.50
Plan C	$26	$15
Plan D	$26	$15
Plan E	$26	$15

TCH shift and holiday differentials apply. Overtime will be paid at time and one-half for any hours worked over 40 per week or 12 per shift.

November, 1998

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