CAREER CONSTRUCTION AND NARRATIVES IN THE NURSING PROFESSION: NURSE MANAGERS AND REGISTERED NURSES ON ALTERNATIVE WORK ARRANGEMENTS

A Dissertation

by

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ABSTRACT

Alternative work arrangements present novel ways of organizing that continuously change the nature of work and careers. This dissertation adds to the growing literature on the changing nature of careers and workplace relationships, specifically on the lived experiences of nurse managers and their supervision of permanent and travel nurses as well as the lived experiences of travel nurses in the United States. I collected data using one-on-one semi-structured interviews and I analyzed the data using thematic analysis.

The first study investigated nurse managers' perceptions of their nurses who worked in alternative work arrangements (RQ1: *How do nurse managers categorize and perceive alternative work arrangements?* RQ2: *How do nurse managers communicate with nurses in alternative work arrangements and nurses not in alternative work arrangements?*). The second study explored how travel nurses perceived their relational experiences with other nurses (RQ: *How do travel nurses manage nurse-to-nurse relationships with permanent nurses?*). The third study considered travel nurses' career construction narratives and how they made sense of their career choice and path (RQ: *How do travel nurses make sense of their careers?*).

My dissertation investigated the relational effects of alternative work arrangements in the management of nurses and the delivery of nursing tasks. I learned that nurse managers and travel nurses view patient care as a team-based enterprise but they differed in how they enact that vision. Nurse managers worked hard at building core

teams of permanent nurses supplemented by travel nurses (and other forms of temporary nurses), while travel nurses viewed their contribution as part of their personal curiosity in learning how other nurses perform tasks. Travel nurses and nurse managers also perceived travel assignments quite differently in terms of professional development where nurse managers viewed travel nurses as interim help while travel nurses viewed travel assignments as learning opportunities to gain exposure and to improve their competencies. These different expectations can create tensions as nurse managers may consider travel nurses as products of the nursing socialization process while travel nurses view themselves as "work-in-progress" protagonists in their constructed career narratives who create their unique socialization experience through travel assignments.

DEDICATION

To my wife, ma, pa, and sister

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Contributors

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The interviews were transcribed by professional transcriptionists. All other work conducted for the dissertation was completed by the student, under the advisement of Dr. Barge of the Department of Communication.

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CHAPTER I

INTRODUCTION

The complexity of today's global economy requires flexible labor that can meet organizations' needs (Spreitzer, Cameron, & Garrett, 2017). To meet the demands of the global economy, the labor market has seen the emergence of alternative work arrangements (AWAs) to supplement standard work arrangements. AWAs "depart from standard work arrangements in which it was generally expected that work was done full-time, would continue indefinitely, and was performed at the employer's place of business under the employer's direction" (Kalleberg, 2000, p. 341). By definition, AWAs refer to the varied types of nonstandard employment relations comprising "temporary help agency workers, on-call workers, contract workers, and independent contractors or freelancers" (Katz & Krueger, 2016, p. 2). AWAs embody a range of flexible and temporary work arrangements that supplement the traditional 9-to-5, 40-hour workweek.

The number of people recruited for and participating in AWAs has increased in recent decades. Katz and Krueger (2016) noted a marked increase in AWAs from 10.7% in early 2005 to 15.8% in late 2015. Furthermore, they observed that approximately half of the overall rise in the last decade came from employees hired from temporary help agencies or contract firms. The rise of AWAs does not come without potential costs. The Pew Research Center (2016) highlighted that 63% of Americans reported that jobs have become less secure than two to three decades ago. Indeed, many jobseekers still prefer

the traditional workweek (Mas & Pallais, 2016), as 57% of Americans viewed contract and temporary work as harmful to American jobs (Pew Research Center, 2016). These two trends allude to AWAs' potential in altering work and employment relations and suggest that workers may become less secure about their employment due to changes in the labor market and emerging work arrangements.

The emergence and rise of AWAs is due to several reasons. First, AWAs give organizations staffing flexibility that can increase their efficiency and decrease labor costs. For example, staffing flexibility in the healthcare sector has given struggling healthcare organizations a boost in surviving financially (Hemann & Davidson, 2012). Organizations can maximize business growth, especially in response to seasonal demands, by capitalizing on the flexibility afforded by AWAs (Katz & Krueger, 2016). Second, organizations may utilize AWAs as a strategy to boost employee recruitment and retention by providing them increased work flexibility (Mas & Pallais, 2016). Third, the changing landscape of today's economy has made jobseekers with inadequate education or skills turn to AWAs for employment (Pew Research Center, 2016). Fourth, at an individual level, AWAs give employees flexibility in how they construct their careers. AWAs facilitate work-life balance for workers with marketable skills needed in today's knowledge-based economy (Faller, Gates, Georges, & Connelly, 2011). Hence, both organizations and employees have their own reasons for choosing AWAs.

The nursing profession in the United States is not immune from the introduction of AWAs as the country faces a persistent shortage of nurses (Long, Goldfarb, & Goldfarb, 2008; Seo & Spetz, 2013). The rising healthcare needs of an aging population

and high nurse attrition perpetuate the problem of nursing shortage (Carnevale, Smith, & Gulish, 2015). The replacement of nurses has not kept pace with nurses who have left the profession (Morrison, 2008) and the retirement of Baby Boomer nurses contributes to the strain on the current nursing shortage (Auerbach, Buerhaus, & Staiger, 2017; Carnevale et al., 2015). Interpersonal and workplace stressors aggravate burnout and worsen the profession's high turnover and attrition rates. Nurses experience stress from sources such as challenging and sicker patients, the toil of working shift work and transporting patients, and constant changes in medical technologies (Carnevale et al., 2015). Nurses do not necessarily make it easier for one another, either; for instance, the colloquial expression *nurses eat their young* epitomizes the high occurrence of systemic nurse bullying (see Castronovo, Pullizzi, & Evans, 2016; Johnson, 2015; Purpora & Blegen, 2015), which can lead to turnover and nurses exiting the profession.

The structure of nursing work can also lead to nurse burnout, turnover, and attrition. Nurses work long hours and erratic schedules that involve any combination of shifts ranging from four to 12 hours. Although nurses, especially full-time permanent nurses, have some control over their schedules, they routinely make noticeable schedule changes during holiday seasons. Furthermore, permanent full-time nurses may *take one for the team* and pick up extra shifts whenever their units do not meet nurse-to-patient ratios. Erratic schedules become most stressful when they affect nurses' personal lives (Havlovic, Lau, & Pinfield, 2002). In such instances, nurses must plan their leisure and family activities around their days off, which may not align with their family members' work and/or school schedules.

As a result, the nursing profession has seen an increase in AWAs in order to address the challenges that healthcare organizations face due to shortages in the labor market. The range of AWAs provides nurses with flexible options as they can now choose work schedules that dovetail with their personal needs and professional aspirations. For example, nurses may choose a compressed week of three 12-hour shifts so that they can pursue an advanced degree and travel during their days off; similarly, other nurses may prefer night shifts because they have caregiving duties during the day. Moreover, healthcare organizations alleviate some of those stressors mentioned earlier by employing temporary nurses who prefer AWAs to standard full-time work arrangements (Faller et al., 2011). Faller and colleagues (2011) observed that baccalaureate-prepared nurses will likely have higher expectations of their jobs and that may either cause job dissatisfaction among such nurses in permanent positions or make them consider AWAs such as travel nursing.

The rise in AWAs calls for a focused investigation into how temporary work, in its various forms, affects workplace relations in general and nurse communication in particular. A number of scholars have studied how communication functions within the nursing profession and they have investigated salient interpersonal communication behaviors such as conflict (e.g., Nicotera, Mahon, & Wright, 2014) and team communication (e.g., Apker, Propp, & Zabava Ford, 2005). Other scholars have also investigated nurse communication that transpires between nurses and physicians (e.g., Bezemer, Korkiakangas, Weldon, Kress, & Kneebone, 2015) and between nurses and patients (e.g., Chan, Jones, Fung, & Wu, 2011). However, those studies tend to either

use samples composed mostly of full-time nurses (e.g., Tourish & Mulholland, 1997; Van Bogaert et al., 2014; Wright, Mohr, & Sinclair, 2014) or do not specify the employment status of their samples (e.g., Mahon & Nicotera, 2011; Moreland & Apker, 2015; Streeter, Harrington, & Lane, 2015). The lack of systematic focus on AWAs'effect on nurse communication is surprising given its emergence within the healthcare industry. As a result, it is important for researchers to understand *why* nurses choose AWAs (or not) and *how* AWAs affect nurse-nurse communication and supervisor-nurse communication.

The sparse knowledge on how the shifting labor market shapes relations among nurse managers (NMs) and nurses is problematic given the proliferation of AWAs in healthcare organizations. Researchers have noted the relative paucity of scholarship on the experience of temporary nurses (Burke, Dolan, & Fiksenbaum, 2014; Faller et al., 2011; Jamieson, Williams, Lauder, & Dwyer, 2008) and an even smaller body of scholarly work on the effects of managers' communication with their nurses (Kunie, Kawakami, Shimazu, Yonekura, & Miyamoto, 2017). Therefore, the focus of this dissertation is to investigate how AWAs affect nurses' communication, work relations, and careers.

AWAs in the Nursing Profession

The United States experiences nursing shortage due to, in part, the increasing demands from its aging population and high nurse attrition (Carnevale et al., 2015), as well as the fact that the replacement rate of nurses has not kept pace with the retirement of older nurses. Varying replacement rates in different geographical locations perpetuate

the nursing shortage problem and have shaped regional patterns of chronic shortages across the country (Buerhaus, Auerbach, Staiger, & Muench, 2013). Although several studies predicted that increased enrolments in United States nursing programs may eventually meet overall demands for registered nurses (RNs) as early as 2025 (Auerbach et al., 2017; U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis, 2014), those projections also warn that nursing shortage may still persist in some states. One such projection reports that Western and Northeastern United States will have a larger per capita of older and retiring RNs (Buerhaus et al., 2013; Auerbach et al., 2017), which means that they will have a harder time attracting and retaining younger nurses to those regions than Southern and Midwestern United States. As a result, healthcare organizations have turned to AWAs to address potential staffing shortfalls in nursing. In this section, I review: (1) types of AWAs, (2) the drivers motivating increased use of AWAs, and (3) the consequences of using AWAs for nurse staffing.

Types of AWAs

Many definitions of AWAs exist that reflect the complexity of studying nursing, nursing labor, and nurses' work arrangements. For purposes of this dissertation, I define AWAs as *all work arrangements that supplement unit-specific and predominantly weekday day-shift permanent staff positions.* This definition encompasses all work arrangements other than the traditional notion of full-time work – that is, a 9-to-5, 40-hour workweek – as AWAs, to the extent that they satisfy one of the following conditions: (1) any temporary position that does not extend indefinitely (such as travel

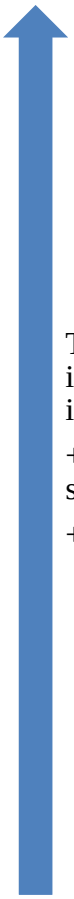
nursing); (2) any permanent position that clocks less than full-time hours at a specific employer's place/s of employment (such as part-time nursing); or (3) any permanent position that does not stipulate work at specific units (such as float pool nursing).

This definition facilitates a more nuanced approach to AWAs because scholars have tended to gloss over many substantive distinctions by typically defining AWAs in reference to job title, conventionally classifying nurses who work in positions other than unit-specific staff positions as supplemental or temporary nurses (see Aiken et al., 2007; Xue, Chappel, Freund, Aiken, & Noyes, 2015). Instead of presuming that job titles mean the same thing across the industry, focusing on substantive job distinctions casts a broader net that captures the wide variety of AWAs.

The proposed definition allows us to recognize that there is temporary-permanent tension that informs AWAs, as some elements of the job may be temporary while others may be more permanent. For example, healthcare organizations have historically employed temporary nurses, also known as supplemental nurses (Aiken, Xue, Clarke, & Sloane, 2007), as a stopgap when they confront nursing shortages (Norrish & Rundall, 2001). Temporary nurses not only supplement nursing labor by working shifts unfilled by permanent nurses, but they may also work permanent AWAs that overlap with permanent nurses' shifts. The broad category of temporary nurses refers to nurses who hold only a finite tenure or number of work hours during any given week; organizations may classify part-time nurses as permanent nurses (if employed indefinitely on a part-time basis) or temporary nurses (if employed for a definitive duration). Part-time nurses represent an important contingent of the nursing workforce (Grinspun, 2003). Thus, part-

time nursing can be both *permanent* – infinite until either party decides to part ways – from the employer's perspective and *temporary* from full-time permanent nurses' perspective.

Table 1 Employment Status and AWAs Chart.

Employment Status	Work Arrangement		
Temporary Nurses (locum tenens/ supplemental/ contingent/casual)	PRN/Per Diem	 This arrow indicates increase in: +Job security (guaranteed shifts) +Tenure +Employee benefits	 This arrow indicates increase in: +Hourly salary rate +Flexibility
	Travel/ Contract		
Permanent Nurses	Part-time Staff and Float pool/ Resource team		
	Full-time Staff and Float pool/ Resource team		

Float pool nurses also reflect the temporary-permanent tension that permanent part-time nurses may experience. For example, an understaffed unit may receive float pool nurses *temporarily* for a particular shift but the hospital may employ the same float pool nurses *permanently* for an indefinite tenure. The temporariness in temporary nurses' employment status holds true to the extent that they work a finite tenure at any given organization or unit. That means that work arrangements such as part-time and float pool nursing bear little indication of nurses' tenure or permanence with their respective organizations.

AWAs in the nursing profession typically fall into two categories: (1) externally-sourced nurses, and (2) internally-managed nurses. Externally-sourced nurses composed of PRN (the Latin abbreviation for *pro re nata* or loosely translated as "as needed") nurses, per diem nurses, travel nurses, and contract nurses. Internally-managed nurses may also include PRN/per diem nurses but they typically refer to float pool and resource team nurses.

Externally-sourced nurses. The nursing profession broadly considers externally-sourced nurses as temporary or supplemental nurses (Aiken et al., 2007) and uses job titles such as agency nurses, casual nurses, contingent nurses, contract nurses, locum tenens nurses, PRN/per diem nurses, registry nurses, and travel nurses. On the one hand, these AWAs are similar as they function to provide temporary help that supplements understaffed units. On the other hand, from a human resource perspective, these AWAs do differ administratively in how and the duration hospitals hire them.

Externally-sourced nurses normally come from temporary help agencies (also known as registries), fill short-term staffing needs, and work at healthcare organizations that purchase their services (Strzalka & Havens, 1996). Hospitals purchase the services of agency- or registry-based nurses by paying the agencies/registries that provide these short-term temporary nurses, who often serve as last-minute replacements (Grinspun, 2003). Agency-based externally-sourced agency nurses work as outsourced employees for a predetermined short-term duration (Strzalka & Havens, 1996; Cicellin, Pezzillo Iacono, Berni, & Esposito, 2015). In turn, agency-based externally-sourced nurses ordinarily receive salaries and employee benefits from their agencies (Manias, Aitken, Peerson, Parker, & Wong, 2003), although some of these nurses may not receive employee benefits depending upon individual arrangements. Regardless of job titles, agencies/registries continuously maintain an employer-employee relationship with their nurses even during the periods when their nurses perform their services at the respective hiring hospitals.

NMs whose units need externally-sourced nurses will normally recruit such short-term nurses by coordinating with agency representatives. The coordination conveys the required nursing expertise and other nurse-related characteristics that NMs' units need. Agency representatives then provide NMs with a shortlist of qualified nurses for their consideration. Before NMs make employment offers, they ascertain candidates' "fit" with required skills and abilities of those nursing positions through one-on-one or even group interviews.

Externally-sourced nurses may also work for themselves. These enterprising nurses seek out self-employment opportunities independently as contract nurses or independent contractors (Wall, 2015); such individual or private practice further diversifies the types of AWAs available to RNs (Wall, 2014).

Internally-managed nurses. Internally-managed nurses on AWAs receive payments for their services directly from their hospitals, not through agencies or registries. The same human resource management system or a separate but internal human resource office within the same system manages unit-specific nurses and internally-managed AWAs nurses. Hospitals may employ these nurses permanently (in the case of float pool or resource team nurses) or hire them temporarily (in the case of PRN/per diem nurses). Thus, float pool nurses appear as temporary nurses from a unit perspective but they usually work as permanent nurses from their organizations' perspective.

PRN/per diem nurses. Healthcare organizations may either develop and maintain their own internal systems of on-call PRN/per diem nurses or rely on agency-based PRN/per diem nurses whom they can utilize as a rapid response to fluctuating patient census. These part-time nurses generally reside in the neighboring communities and can usually respond promptly to increased temporary need for nurses. The unpredictable nature of PRN/per diem work means that nurses may register themselves with several local agencies/registries and/or hospitals. Alternatively, nurses of all work arrangements may also avail themselves to PRN/per diem assignments shifts at their hospitals and/or other hospitals so that they can earn extra money and gain access to

another healthcare network (Grinspun, 2003). Former permanent nurses who prefer fewer hours may also opt for the PRN/per diem route (May, Bazzoli, & Gerland, 2006). Thus, PRN/per diem nursing offers the highest degree of flexibility – as such, sits at the top of the chart (see Table 1) – and nurses in both permanent full-time positions as well as in AWAs may take advantage of it as an additional source of work and income.

PRN and per diem nurses share some similarities. They usually work a few shifts each month so that they stay on their (multiple) organizations' on-call lists; their organizations may also solicit interest from these nurses first in times of unexpected short-term need for additional nurses. Although healthcare organizations may manage PRN/per diem nurses internally, these nurses may receive different compensation packages than nurses of other AWAs hired by the same organizations. These types of temporary nurses normally do not receive employee benefits such as insurance and paid time off (Adams, Kaplow, Dominy, & Stroud, 2015), but they may instead receive higher hourly salaries than permanent full-time nurses (see Table 1). Their flexible work arrangement with their employers creates a lax employment relationship whereby the shifts these temporary nurses work depend upon a mutual overlap between their and their employers' interests.

Travel and contract nurses. When healthcare organizations' locales and surrounding areas cannot provide adequate immediate temporary nursing support, those in desperate need of nurses and that have the necessary financial resources may resort to recruiting nurses farther away (Burke et al., 2014). These nurses commonly come from agencies (known as agency or registry nurses). They may commit anywhere from a few

shifts to multiple 13-week stints. These nurses normally do not have many local connections and they come from other locations (travel nurses) and may negotiate work independently (contract nurses).

PRN/per diem, travel, and contract nurses share a similarity in that they typically fill urgent gaps in nursing staff. The urgency and cost of hiring these short-term (usually) externally-sourced nurses mean that hospitals expect that these nurses can and will contribute as soon as they arrive. As a result, temporary nurses such as per diem and agency nurses do not always receive thorough orientations (Adams et al., 2015; Manias et al., 2003). In fact, they usually receive an abbreviated version of the orientation that healthcare organizations provide to new permanent nurses.

Float pool and resource team nurses. Float pool nurses emerged in scholarly literature in the 1960s (Dziuba-Ellis, 2006). Healthcare organizations today manage internal float pool nursing programs so that they can ensure the quality of their nurses (Dziuba-Ellis, 2006; Institute of Medicine, 2004; Linzer, Tilley, & Williamson, 2011; May et al., 2006; Strzalka & Havens, 1996). However, float pool nurses by design typically possess broad generalist nursing skills so that they can fill unanticipated but urgent needs in a broad range of specialty units (Hemann & Davidson, 2012). That means that nurses employed specifically as float pool nurses serve a wider patient population than unit-based nurses who specialize in serving niche patient populations (Linzer et al., 2011). Float pool nurses may appear as temporary to the units to which they float, but their permanent nurse status means that they typically receive a similar or the same orientation to organizational policies and procedures as other permanent unit-

specific nurses (Adams et al., 2015; Strzalka & Havens, 1996). Float pool nurses have an interesting work arrangement that makes them both *permanent* nurses to their organizations and *temporary* nurses to which the units they will float.

The more thorough orientation that float pool nurses receive makes them more cost efficient than agency nurses (Linzer et al., 2011), whom facilities start paying from the day they report for work and not when they start providing direct patient care. Float pool nurses, also known as resource team nurses (Dziuba-Ellis, 2006), often receive little to no notice on which understaffed units they will report for work (Linzer et al., 2011; Rudy & Sions, 2003). For example, a float pool nurse may work in the intensive care unit today and the recovery room tomorrow. Some float pool nurses may even move between different specialty units within a given shift (Hemann & Davidson, 2012). Drastic changes in work environments and team compositions may burden nurses with unanticipated stress and conflict but drastic changes can also create the adrenaline rush and broad professional exposures welcomed by other nurses.

Healthcare management and scholarship have historically used float pool nursing and resource team nursing as interchangeable labels. Even contemporary structuring and organization of nurses labelled as either of these two terms vary widely across the industry. The labelling of these two terms matters less than whether healthcare organizations make nurses float against the latter's will (Dziuba-Ellis, 2006). Nurses who performed involuntary reassignments felt less productive because they spent time learning their new units' routines and that caused job dissatisfaction and occupational stress (Rudy & Sions, 2003). The distinction between these two labels therefore should

preoccupy with how management deploys either type of nurses, the quality of support that they receive, and whether their existing nursing competencies can ensure quality patient care.

The Drivers for AWAs

The utilization of AWAs diversifies the range of short- and long-term strategies that hospitals can implement in response to the nursing shortage (May et al., 2006). Research regarding the phenomenon of flexible nursing workforce has mainly concentrated on cost-related factors (Grinspun, 2003), focusing attention on the importance of healthcare economics. While the literature tends to focus on AWAs in regard to the organizational restructuring of nursing staff and the associated cost savings, AWAs also offer new opportunities for nurses regarding their evaluation of the profession and its viability as a career option. The drivers for AWAs can be viewed as both organizational (e.g. efficiency and cost saving) and individual (e.g., increased professional opportunities and flexibility).

Organizational drivers. North American hospitals have undergone elaborate and drastic organizational change over the past few decades. Organizational restructuring has redefined many processes including adjustments to hospitals' nursing staff in light of hospitals' evolving operational objectives and the wider workforce composition (Norrish & Rundall, 2001; Grinspun, 2003). Such restructuring affects the roles and workload of RNs, as hospitals consider how they can maximize cost efficiency with the competencies of their RNs as hospitals deemphasize nurse-patient relations in favor of team nursing (Norrish & Rundall, 2001). For example, in Canada,

organizational restructuring forced thousands of nurses into AWAs (Grinspun, 2003). AWAs allow hospitals to create cost-driven staffing structures so that they can meet anticipated patient census and maintain a lean yet reliable pool of permanent nurses. Increases in patient census baseline will require additional nurses, typically nurses who are in AWAs.

Units that supplement their unit-based permanent nurses by utilizing AWAs may find this approach less expensive than paying overtime allowances to permanent full-time nurses (Strzalka & Havens, 1996). However, it is also the case that after factoring in permanent nurses' employee benefits, temporary nurses generally receive a higher – albeit statistically insignificant – hourly pay than permanent nurses (Xue et al., 2015; see also Norrish & Rundall, 2001). Hospitals that frequently need temporary nurses may find that the overtime allowances for staff nurses cost less than the salaries they pay to internally-managed temporary nurses and that the salaries paid to internally-managed temporary nurses cost less than the salaries paid to externally-sourced temporary nurses (May et al., 2006). Facilities will reap the cost-efficiency benefit only if they modulate the appropriate employment tenure and type/s of temporary nurses so that they prevent overstaffing (Strzalka & Havens, 1996; Xue et al., 2015). Cost efficiency tapers off when units spend more than 50% of their budgets on part-time nurses (Maenhout & Vanhoucke, 2013). Accordingly, healthcare organizations reduce cost by utilizing temporary nurses to the extent that facilities maintain a minimum number of permanent nurses proportionate to anticipated patient census and that they only use temporary nurses in response to increases in patient census.

Both unanticipated and anticipated staff absences confound the nursing shortage problem. Permanent nurses receive employee benefits that include time off for a variety of personal reasons. Such staff absences happen when permanent nurses take vacation time, maternity leave, or sick leave (Hemann & Davidson, 2012). These requests for time off notify healthcare organizations about when and for how long imminent reductions in nursing labor will take place. Healthcare organizations can then respond by looking at internal options such as temporarily reassigning or "floating" nurses from low-census units to high-census units as well as mandating overtime shifts from existing part-time and/or full-time staff (Norrish & Rundall, 2001). Alternatively, they may find replacements in the form of external temporary nurses (see May et al., 2006). However, the *timing* of staff absences among permanent nurses complicates staffing plans. Therefore, AWAs provide healthcare organizations with flexible options as they respond to the imminence and duration of staff absences created by their permanent nurses.

In sum, hospitals restructure patient care delivery in tandem with forecasts of their financial survivability and staffing capacities as affected by anticipated and unanticipated staff absences. The use of AWAs allows hospitals to retain long-term nursing staff and supplement it with short-term help. This approach of tapping into AWAs works best if hospitals can predict accurately their anticipated patient census, which helps them maximize their nursing labor and minimize cost.

However, the fluctuating nursing labor needed based on forecasted patient census does not always match up with actual nursing care demand and that mismatch affects permanent nurses to a lesser degree than do to temporary nurses. Other than mandating

overtime work from permanent nurses when patient volume rises and/or when staff absences decrease nursing staff capacities (Grinspun, 2003), hospitals may also demand that permanent nurses take time off when patient census falls below budgeted levels (Norrish & Rundall, 2001). Either of these two requests serves organizational needs more than nurses' needs because the former request disrupts nurses' non-work life while the latter request means that permanent nurses must involuntarily use their earned time off while temporary nurses must endure the prospect of loss of pay. These uncertainties contribute to turnover and attrition among nurses who prefer predictable work conditions (Norrish & Rundall, 2001). Consequently, the notion of hospitals as business entities drive hospitals toward organizational restructuring policies that favor lean and cost-effective staffing.

Organizational restructuring can create constraints that inevitably cause unpredictable work conditions and even inflexible schedules; nurses who dislike unpredictable schedules may turn to AWAs so that they regain control over their income and work. On the one hand, organizational restructuring can cause nursing shortages and force nurses into nonstandard arrangements (Grinspun, 2003). On the other hand, organizational restructuring can also change nurses' perception of nonstandard arrangements and make them view AWAs as attractive options (Jamieson et al., 2008; Manias et al., 2003). Both paths lead to AWAs, regardless of how nurses perceive organizational restructuring or how organizational restructuring affects them. Organizations that desire flexibility and that keep a close watch on their expenses must therefore manage the use and effects of AWAs. Indeed, organizations have and must

come to the realization that they will lose good employees if they do not offer their employees the option of flexible arrangements (Mas & Pallais, 2016; see May et al., 2006). Organizational drivers such as restructuring inevitably perpetuate nursing shortages and attrition in some instances; yet, they can also facilitate retention by offering nurses employment flexibility.

Individual drivers. AWAs afford nurses with the option of not only striking their desired work-life balance in the sense of meaningful work and the social engagements that they partake outside of work, but also in the sense that they choose work shifts that accommodate their physical and emotional needs. Many nurses choose AWAs for the better monetary compensation and greater control over their schedules (Faller et al., 2011; Hurst & Smith, 2011; Jamieson et al., 2007), while others may choose AWAs for better work environments (May et al., 2006).

Temporary nurses value their personal lives as highly, if not higher, than their professional lives. They purposefully pursue meaningful commitments such as volunteer work and social relationships (Manias et al., 2003). Such commitments frame their lives' purpose and they intentionally construct work as peripheral but necessary pursuit. The career flexibility afforded by AWAs makes it possible for nurses to simultaneously honor their personal commitments and manage their professional obligations, thus allowing them to achieve work-life balance.

AWAs also help reduce burnout and the physical toils of nursing work. The labor-intensive nature of nursing makes nurses value personal health preservation (Jamieson et al., 2007). For example, New Zealand nurses aged over 50 found flexible

arrangements more sustainable than full-time positions because they could meet their individual needs without leaving the workforce (Clendon & Walker, 2016). Hospitals may also retain their overall nursing staff by employing older nurses for administrative tasks (see May et al., 2006), which gives mature nurses an alternative to leaving the professional altogether. Nurses who view nursing as a long-term career are likely to consider AWAs seriously at various stages of their lives so that they can remain in the profession without compromising their emotional, mental, and physical health.

Nurses may also desire AWAs in order to avoid the politics associated with nursing units. An atmosphere that promotes communication and support among coworkers makes work environments more pleasant and improves nurses' work experience. Positive work environments can help retain nurses, as opposed to negative work environments that are characterized by bullying (or horizontal violence). However, nurses have cited bullying as a persistent problem (Castronovo et al., 2016; Johnson, 2015; Purpora & Blegen, 2015). Some may identify bullying as a manifestation of office politics, especially among permanent nurses. AWAs' short-term and temporal nature let nurses focus on the clinical side of nursing. As such, AWAs appeal to nurses who want to dedicate as much energy as they can to direct patient care. Such nurses will likely view AWAs, such as working only the quieter night- or weekend- shift, as desirable options that distance them as far away as possible from day-to-day office politics.

Consequences of AWAs

AWAs alter nurses' work environments, reshape workplace relations, and raise legitimate concerns about the quality of patient care. The use of AWAs carries both advantages as well as disadvantages.

Advantages. The primary benefit for healthcare organizations that utilize AWAs is their ability to more efficiently and economically manage changes in patient census (Seo & Spetz, 2013). Instead of investing substantial resources into training and maintaining a high payroll, hospitals find that minimal use of temporary nurses yields cost-efficient outcomes (Xue et al., 2015). Cost-efficient outcomes refer to healthcare organizations' financial survivability and patients' quality of care expectations (Hemann & Davidson, 2012). Healthcare organizations recognize that float pool nursing lets them maintain their quality of patient care while at the same time control salaries as an accounting expense item because float pool nurses cost less than externally-sourced nurses such as agency nurses (Dziuba-Ellis, 2006). While some hospitals have the option of determining the employment mix of their nurses, other hospitals that have difficulty recruiting and/or retaining nurses must meet their nursing needs through AWAs (Seo & Spetz, 2013). Therefore, hospitals with or without staffing difficulties have an immediate and viable labor option in AWAs.

AWAs may also enhance nurses' job satisfaction. Maenhout & Vanhoucke (2013) observed that units that utilize part-time nurses reported increased job satisfaction. Three possible explanations exist regarding why AWAs may be associated with increased job satisfaction. First, nurses may choose AWAs based on their

personalities. Float nurses reported higher levels of independence and openness to change than unit-based nurses did, whereas unit-based nurses conformed better to conventional standards (Linzer et al., 2011). These reported personality traits fit well with the respective natures of float nursing and unit-based nursing. Second, permanent nurses may appreciate the additional help whereas temporary nurses may find the new environment refreshing. Some agency nurses switched from permanent to temporary work arrangements because they felt that their former employers disrespected them by paying them inadequately and for providing inappropriate work conditions (Manias et al., 2003; see also Grinspun, 2003). Other agency nurses may also have switched work arrangements so that they can seek work environments that value them more, such as units plagued with chronic nursing shortage. Third, nurses with an entrepreneurial flair have pursued independent or private practice in the form of self-employment contracts (Wall, 2014). Self-employed nurses have reported increased job satisfaction as they gained independence and greater flexibility in how they provide their nursing services (Wall, 2015), whether in clinical settings or at patients' homes. Their newfound autonomy liberated them from the complicated bureaucracy of healthcare organizations.

Another benefit to nurses who work AWAs is lessened health and safety risks. Part-time workloads may help nurses better manage sleep deprivation caused by working different shifts (Jamieson et al., 2007). Permanent part-time work differs from other AWAs whereby nurses in temporary arrangements such as PRN/per diem cannot reasonably anticipate future shifts at those same units. While part-timers have more time off between shifts, full-timers who have back-to-back night and day shifts must stay

awake for long hours. Time off lets nurses reconnect with meaningful activities and relationships outside of work. Whereas a regular schedule of consecutive night shifts can hamper some nurses' emotional health and personal relationships (Jamieson et al., 2007), other nurses may prefer permanent night shifts as this arrangement works best with their individual circumstances (Clendon & Walker, 2016). Consequently, AWAs avail options for work-life balance.

Finally, AWAs open up a variety of professional development opportunities to nurses. Industrious temporary nurses may attend nursing conferences on some of their days off for professional development purposes (Manias et al., 2003). Agency nurses found that working at different clinical sites exposed them to why hospital administrations operate differently (Manias et al., 2003). Every new clinical site also makes them learn about themselves as individuals and nurses. Similarly, the generalist role that float nurses perform gives them a wide breadth of opportunities in different specialty units (Linzer et al., 2011). Float nurses not only thrive in the diverse range of settings where they can hone and acquire skills but they also enjoy the variation (Hemann & Davidson, 2012). Both agency nursing and float pool nursing represent two AWAs that expand nurses' professional network and skill sets where agency nurses choose assignments within geographic boundaries of their choosing while float pool nurses receive assignments within the facilities of their healthcare organizations. Nurses experience variety in clinical settings, nursing specialties, and geographical locations through AWAs.

Disadvantages. First, contingent scheduling practices can create financial insecurity and stress for some AWA nurses as their work schedules may depend upon healthcare organizations' late cancellations and requests. Fluctuations in patient census translate into late notifications on whether on-call nurses such as per diem and registry nurses will get any shift on any given day. On the one hand, hospitals that experience erratic spikes in patient census must rapidly seek additional nurses so that they can meet the unexpected nursing care demands (Norrish & Rundall, 2001). On the other hand, healthcare organizations may also make late cancellations on agency nurses' shifts when patient census plummets (Manias et al., 2003). Hospitals constantly calculate the amount of nursing care they need in light of patient acuity or the severity of patients' conditions. Not only do hospitals need additional nurses when patient census increases, they also need additional nurses that can care for sicker patients. Per diem and registry nurses have the flexibility of accepting impromptu shifts when their daily routines permit but it also means that they may not receive shifts when healthcare organizations do not need them.

Second, the irregular utilization of temporary nurses such as float pool and per diem nurses means that temporary nurses have a harder time developing enduring workplace relationships with their unit-based coworkers. The lack of guaranteed work for certain types of temporary nurses resembles the situation of permanent part-time nurses who can anticipate regular part-time shifts but do not participate routinely in unit-level decision-making and interactions. The lower participation in such discourse by temporary nurses as compared to their permanent full-time colleagues makes miscommunication more likely and that may lead to negative experiences and negative

job satisfaction (Burke et al., 2014). These expectations placed on temporary nurses can cause anxiety and organizational identification issues especially among agency nurses because they labor under the supervision of their hiring units while receiving their salaries and high-level instructions from their agencies (Cicellin et al., 2015; Manias et al., 2003). Furthermore, internally-managed temporary nurses have reported that their part-time presence creates glass ceilings that limit access to professional development and career advancement that may ultimately limit the fulfilment of their full productive potential (Jamieson et al., 2008). In turn, unfulfilled productive potential reduces overall organizational productivity.

Healthcare organizations recognize that flexible staffing practices may also prevent the formation of stable full-time nursing teams (Baumann, Hunsberger, & Crea-Arsenio, 2013). Whereas temporary nurses fill the nursing shortage gap, the perpetual utilization of temporary nurses as substitutes for permanent full-time nurses affects nurse communication. The contingent nature of temporary employment means that high staff rotation or turnover hinders nurses from building relationships with other nurses (Jamieson et al., 2008). Inefficiencies increase as staff nurses who work in units of high staff rotation or turnover must constantly adjust to new or temporary nurses' competencies (Norrish & Rundall, 2001).

Third, the use of AWAs may lessen organizational commitment and identification. Apart from disrupting the formation of stable nursing teams, long-term reliance on temporary nurses may cause other problems. Some may argue that organizational restructuring strategies that develop cost-saving staff levels demotivate

both temporary and permanent nurses, weaken nurses' commitment, and induce job insecurity (Grinspun, 2003). Weakened commitment becomes problematic when nurses do not feel emotionally connected with their organizations and novice nurses who desire full-time permanent positions cannot secure them (Grinspun, 2003). Organizational policies that favor lean nursing staff can have huge personnel implications such as lower levels of commitment and organizational identification. Disjointed teams perpetuate the segregation of permanent nurses and nurses of AWAs, as nurses may seek social support from those in the same work arrangements as them and group themselves by AWAs (Cicellin et al., 2015). Selective social support presents a significant managerial concern because the lack of mutual support compromises the quality of nursing teams (Bae et al., 2017). The overreliance on temporary nurses disrupts the formation of core nursing teams and negatively affects quality of care (Institute of Medicine, 2004; Maenhout & Vanhoucke, 2013), resulting in invisible costs bore by nurses and patients.

Frustrations and conflicts among nurses arise when agency nurses' expertise does not meet healthcare organizations' needs. Agency nurses may arrive at their temporary sites and realize that their original unit allocations have changed (Manias et al., 2003). Healthcare organizations sometimes do not clearly state the types of nursing expertise they need; they may also misrepresent job scope so that they fill gaps in their nursing teams. These practices can cause anxiety to both permanent and temporary nurses.

Fourth, the use of AWAs may decrease the quality of care. The quality of care provided by temporary nurses has been debated (Burke et al., 2014; May et al., 2006; see Xue et al., 2015). AWAs may provide convenience to healthcare organizations and

nurses but such convenience should not detract from the main nursing purpose: patient care (Dziuba-Ellis, 2006). Quality of care may decrease if the utilization of temporary nurses means that patients have poorer access to experienced nurses (May et al., 2006). The operative word *experienced* implies that temporary nurses may possess the requisite qualifications and certifications but they may not have as much experience in their specialty areas and/or the clinical sites at which they will work. Higher patient acuity settings will more likely require nurses that have a greater amount of relevant experience.

Quality of care may decrease if the utilization of AWAs disrupts continuity of caregiver (Grinspun, 2003). Continuity of caregiver refers to the approach of assigning specific patients to specific nurses as often as possible. This approach helps cultivate nurse-patient relationships, thereby enhancing continuity of care. The use of AWAs will more likely affect chronic patient care than acute patient care whereas some AWAs (such as fixed-term, nonrenewable travel nursing) have greater effects on continuity of care than other AWAs (such as permanent part-time nursing).

Experience alone does not dominate the discussion on patient care. Researchers found that the utilization of supplemental nurses – referring to both agency and float pool nurses – did not lower quality of care (Aiken et al., 2007). One study that examined nurses' documentation practices as a measure of quality of care concluded that float pool nurses consistently documented more thoroughly than unit-based nurses and agency nurses (Strzalka & Havens, 1996). The difference may result from the more thorough orientation that the former group receives as compared to agency nurses, more frequent

reminders from their supervisors, and possibly even longer anticipated tenure than agency nurses will have. While the findings suggest that float pool nurses probably took the *if it isn't documented, it didn't happen* adage to heart, neither these findings nor more contemporary studies have offered definitive proof regarding whether AWAs necessarily result in better or poorer quality of care.

Communication and Nursing

Nurses communicate with a variety of people at work, over a variety of topics, and through numerous channels. The ways that nurses communicate have important implications for patient care and workplace relations. Interactions involving nurses and other stakeholders have received extensive attention from scholars across the communication, healthcare management, and nursing disciplines (e.g., Bezemer et al., 2015; Brinkert, 2010; Chan et al., 2011). As the healthcare systems in many countries move toward team-based care (Doherty & Crowley, 2013; Norful, Martsolf, de Jacq, & Poghosyan, 2017), communication becomes even more important for effective coordination and collaboration among healthcare team members. The relational aspect of communication complements the therapeutic effects of nursing science.

Nurses communicate with two broad categories of stakeholders: (1) patients and (2) colleagues. The first category includes patients' families because patients often make medical decisions after consulting with their family members, who in turn may consult nurses. In situations where patients do not or no longer possess medical decision-making capacity, those decisions may fall upon family members (Watson & October, 2016; see also Pecanac, 2017). The second category of stakeholders involves communication with

many healthcare providers including other nurses, physicians, and allied health professionals. Professional communication among nurses plays a crucial role because nurses perform many tasks in teams and in collaboration with other health professionals to ensure continuity of care (Andreatta, 2010). Miscommunication and inadequate communication in nurses' communication with patients or colleagues can diminish the quality of healthcare delivery. Therefore, interpersonal communication with patients and families as well as (inter)professional communication among nurses and between nurses and other health professionals are vital to effective care delivery (Apker, Propp, Zabava Ford, & Hofmeister, 2006).

Communication with Patients

All clinical contexts can benefit from supportive nurse communication, but nurse communication has the greatest effect at alleviating stress experienced in acute care settings such as neonatal intensive care units (NICUs) and pediatric intensive care units (PICUs). Critical care nurses have the most amount of contact with families (Watson & October, 2016), in part because critical care units have some of the lowest nurse-to-patient ratios. Families may also find themselves most involved in the medical care process due to the developmental and dependent nature of young patients and critically-ill patients.

Critical care involves many difficult and delicate conversations on issues such as end-of-life care, where clinicians elicit patients' desires through their surrogates or families (Pecanac, 2017). These conversations are also difficult in NICUs and PICUs as families may not have had talked with their young patients about life-sustaining

treatments. Such conversations may be impossible either because patients do not fathom the situation or patients have no means of expressing their desires. The therapeutic function of nurse communication becomes most salient during times when patients and their families feel anxious and uncertain about prognoses.

The business side of healthcare sometimes interferes with the social side of healthcare. Nursing labor is an expensive commodity (Crawford & Brown, 2011). Moreover, healthcare systems have adopted a managerial framework that views the delivery of evidence-based care as tasks on nurses' to-do lists measured against productivity benchmarks (Feo & Kitson, 2016). Such managerial frameworks make it harder for nurses to build relationships with patients and vice versa. Patient-centered care and communication require a paradigm shift from a time-based shiftwork mentality to one whereby nurses' availability allays patient anxiety (Chan, Jones, Fung, & Wu, 2011). For example, nurses who adopt a time-based shiftwork mentality may perceive *small talk* as a mindless and not very useful activity (Chan et al., 2011). However, *small talk* serves an important caregiving function that can cultivate relationships with patients; the length of the conversation does not matter as much as nurses' intention to reach out to their patients (Chan et al., 2011; Crawford & Brown, 2011). By availing themselves to patients through *small talk*, nurses foster nurse-patient relationships through information exchange that may manage patient uncertainty.

Nurse-patient communication cultivates therapeutic clinician-patient bonds that achieve and improve patient outcomes (Juvé-Udina et al., 2013). The patient-centered communication function of information exchange presents a notably important direct

pathway to improved health outcomes (Street, 2016), particularly in the management of medical conditions in time-critical and severe acute care settings. Patients generally have accompanying family members, who give them social support and to help them understand the purpose and potential implications of the medical treatments and nursing tasks that they will receive. The presence of clinical nurses at family conferences involving intensive care patients lends emotional support to families and gives families added perspective on patient care (Watson & October, 2016). Similarly, emergency care patients and their visitors ranked information exchange with nurses as their top communication need (Pytel, Fielden, Meyer, & Albert, 2009); the nurses surveyed by the same study also perceived information exchange as patients' and visitors' top communication need. Other than information exchange, emergency care patients and visitors reported that emergency nurses met their second most important communication need by answering their questions (Pytel et al., 2009). By doing so, nurses also reduce miscommunication and patient grievances (Crawford & Brown, 2011). Furthermore, effective nurse-patient communication reduces misunderstanding, which in turn reduces complaints (Chan et al., 2011). As patient misunderstanding decreases, patient satisfaction may increase (Crawford & Brown, 2011; Pytel et al., 2009). This proximal outcome extends as an indirect pathway that by itself can lead toward improved health outcome (see Street, Makoul, Arora, & Epstein, 2009). Thus, the physical presence of familiar and trusted nurses who can answer patients' questions communicate assurance to concerned patients and families.

Communication with Colleagues

Nurses communicate with their colleagues, including nurses and other healthcare professionals, to complete tasks and maintain role relationships. When nurses collaborate and coordinate with others on their teams, they exercise communication skill sets essential to professional nursing (Apker et al., 2006). The negotiation of role relationships poses a challenge as responsibilities may overlap and personalities may clash as a result of territorial behaviors (Ellingson, 2003). This section sets out several key functions of nurse (inter)professional communication.

Interpersonal relationships and communication. Quality communication helps to foster relationships (see Lee & Doran, 2017). Nurses today mostly work in teams and have at their disposal a wide range of asynchronous and synchronous communication tools such as emails and text messaging. They use electronic communication tools with one another not only for work-related communication but also for personal purposes (Koivunen, Niemi, & Hupli, 2015). The latter type of nurse communication bonds nurses together as they share, for instance, jokes to which they can relate.

The types of communication that nurses use to coordinate their relationships can be categorized as either professional or personal communication. Professional communication refers to both human and mediated communication mandated by policies or regulations. These forms of communication encompass official interactions pertaining to patient care. Examples of professional communication include documenting patients' charts and verbalizing checklists before a procedure. Nurses may execute these professional, communicative activities individually or in the presence of others. The

absence of important communicative exchanges may snowball into greater stress and bury the root causes of conflicts deeper (see Johansen & Cadmus, 2016). Miscommunication also hinders the formation of meaningful relationships beyond nurses' common identity and the social support that they extend to one another at the workplace.

Interpersonal relationships help nurses in their daily interactions (Morrison, 2008), but the nature of nursing complicates workplace relationships. Just as nursing scholars have concerns about how nurses' perception of communication as part of caregiving shapes nurses' communication behavior with their patients (see Chan et al., 2011), organizational scholars should also have a similar concern about how the formation of nursing teams and the profession's technology usage alter nurses' communication as a function of workplace relationship. Day-shift nurses have different workloads and have more colleagues working on the same shift than their evening- or night-shift colleagues (Bae et al., 2017). Shifts that have greater nursing staff availability open possibilities for more collaborative work and help among nurses. Weekday-shift nurses may also receive more administrative support from clerical staff than weekend-shift nurses. Thus, the limitations of work shifts configure the communication and social support available to nurses.

Social support. Nurses also communicate for social support. This communication skill set centers on the care and concern that team members have for one another (Apker et al., 2006). Health professionals may engage in casual conversations about non-task-related topics such as families and vacations (Ellingson, 2003). Casual

conversations can also include task-related topics, such as offering impressions of their patients with one another (Ellingson, 2003). This communicative behavior lets them express frustration. Upset health professionals may vent as a stress-coping mechanism as they seek social support from their listening colleagues. Similarly, nurses may share with their colleagues their joy of working with appreciative patients and such interactions can boost team and unit morale. Despite the formative potential of social support for relationship building, team members' relationships typically remain professional and collegial with few – if any – developing into close friendships (Ellingson, 2003).

Professional communication among nurses contributes more toward patient care than nurses' work experience while personal communication among nurses contributes more toward their work experience than patient care. Personal communication refers to the communication that nurses engage in while they are away from patients. Examples of personal communication include small talk (what they did yesterday, for instance) and substantive topics (interests and hobbies, for instance). Regardless, personal communication brings nurses closer together and helps them foster relationships. Nurses may also use personal communication to support one another, especially when they talk about work. For instance, nurses may relieve stress by confiding in one another about transgressive patients (Vandecasteele et al., 2017). Nurses may help their aggrieved colleagues by taking over their tasks so that they do not need to care for those offending, transgressive patients (Vandecasteele et al., 2017). Although nurses may establish mutual support only with those who work the same work arrangements as them (Cicellin et al., 2015), they nevertheless will support one another even in the absence of strong

work relationships (Vandecasteele et al., 2017). If the quality of workplace relationships does not hinder nurses from seeking and receiving social support from their peers, it implies that nurses usually form a common group identity that bonds them as *us* and their patients as *them*. Inductively, nurses will unite when resistance from non-nurses challenges their collective authority or identity. That means that nurses will support one another whenever they perceive that patients have mistreated one of them and they will view that as a sharper distinction that they should care about than the differences among AWAs. Nurses who align with the "*us-them*" perspective value the support that they can give to and receive from one another.

The "*us-them*" perspective creates social capital so valuable that nurses may avoid offending one another as much as possible so that they preserve and accumulate goodwill. Two strategies to not *rock the boat* include conforming to informal rules that govern nurses' behaviors and to adopt the avoidance conflict management style (Johansen, 2014; Vandecasteele et al., 2017). Nurses, especially emergency room nurses, frequently use the avoidance style so that they minimize workflow interruptions (Cavanagh, 1991; Johansen, 2014). The fast-changing nature of emergency rooms means that nurses must adapt quickly to rapid changes in patient acuity and census. Social support therefore helps nurses through their shifts.

Nurses who perform challenging work may need greater social support as a stress-relieving outlet. However, researchers conceded that the lack of knowledge on the direct relationship between educational levels and teamwork involvement has shed limited light on nurses' "job dissatisfaction and poor commitment to their current job"

(Bae et al., 2017, p. 362). While nurses may mitigate job dissatisfaction by pursuing challenging work through AWAs, temporary/nonpermanent nurses find themselves spending time learning routine details not directly related to clinical care and that learning curve itself also causes job dissatisfaction and occupational stress (Rudy & Sions, 2003). Temporary/nonpermanent nurses working in a busy department or on a quieter night- or weekend- shift may have little support that they can turn to for help. It appears plausible that educational strata do inevitably erect communication challenges that have direct influence on nurses' job dissatisfaction and stress levels. Moreover, nurses reported communication dissatisfaction when they received poor personal feedback from their NMs (Wagner, Bezuidenhout, & Roos, 2015). Thus, communication challenges arise from the dichotomy between the types of responsibilities that come with better-educated nurses' autonomy (over choice of work and work arrangements) and their innate desire for greater communication and connection with their colleagues.

Collaboration. The nursing shortage phenomenon results in a demand that makes nursing labor a finite commodity (Chan et al., 2011), which alters nursing practice. Nurses working in understaffed units shoulder additional tasks, on top of the expanding burdens imposed by heavy bureaucratic oversight and the utilization of evolving clinical technologies such as EHRs. Nursing has increasingly become a task-oriented profession driven by technology whereby nurses not only engage in human interactions with patients and colleagues but they also interface with nonhuman entities such as EHRs and other electronic medical devices. Technology may mitigate nursing shortage to some degree because electronic medical devices – such as electronic vital

signs monitors – can execute nursing tasks previously operated by humans. Similarly, communication technologies have helped nurses coordinate better and use time more effectively (Koivunen et al., 2015). Such shifts in work processes imply that while nurses can now channel their limited energy and time to tasks that require their expertise, electronic medical devices and communication technologies have also changed how and the extent that nurses interact with others. This salient distinction becomes most pertinent in the nursing hierarchy where RNs possess higher levels of clinical skills and exercise greater involvement in patients' care plans than licensed practical nurses.

Educational levels may make collaboration more challenging. Scholars recognize that the higher job expectations of baccalaureate-prepared nurses can lead to higher job dissatisfaction (Faller et al., 2011). The crux of that insight suggests that baccalaureate-prepared nurses may expect greater on-the-job interactions and/or that they desire challenging work. Challenging work will require greater collaboration with colleagues since challenging work will most likely require broader expertise and participation than what a single nurse can offer. AWAs complicate challenging work further when nurses are unfamiliar with one another's communication styles and preferences, although standardized communication tools and protocols should minimize those differences.

Nurses communicate to make joint evaluations (Martin & Ciurzynski, 2015). This decision-making challenge increases not only when nurses work with other health professionals but also when they work with other nurses in different specialty areas or who have different levels of training. Even nurses who share a common nursing qualification will have different perspectives on what patient care should look like after

they have undergone additional training. Take the nurse practitioner (NP) role in the United States as an example. Baccalaureate-trained NPs and RNs undergo similar nursing training to attain the same RN licensure, but NPs undertake additional graduate-level training and certifications so that they may diagnose illnesses and prescribe medications.

Nurses communicate formally and informally to collaborate nursing care. Collaboration is an information processing function whereby nurses – and others on the team – serve as resources with insights into patients and knowledge (Apker et al., 2006; see also Ellingson, 2003). They communicate with other nurses in their teams about their patients and those data will in turn inform how they communicate with their patients. Such communication typically transpires where nurses congregate, planned or unplanned, at places such as nurses' workstations or along hospital ward corridors (Ellingson, 2003; González-Martínez, Bangerter, Lê Van, & Navarro, 2015). While scholars have observed the communicative behaviors surrounding collaboration among nurses, scholars have done little research that explores collaboration among NMs (Lamont, Brunero, Lyons, Foster, & Perry, 2015). The literature also has a research gap on how acting NMs assume and execute their responsibilities; this gap further limits insights into how temporary supervisory assignments reshape existing and future relationships, especially after acting NMs return to their previous roles.

Collaborations that yield satisfying outcomes will require not only high levels of communication-based social skills but also high levels of analytical skills exhibited in problem-solving personality traits. A recent study found that nurses who scored high on

personality traits such as conscientiousness and openness would typically use the integration strategy of the Rahim Organizational Conflict Inventory-II (Erdenk & Altuntaş, 2017), which characteristically resembles the collaboration conflict management style of Thomas and Kilmann's Dual-Concerns Model. That study described conscientiousness as being performance-oriented and decisive while openness referred to descriptors such as creative and flexible.

A nationwide survey conducted in April 2017 on U.S.-based nurses concluded that 83% of its respondents would help tired nurses out by letting them take a break. At the same time, 75% of those respondents conceded that they would not have "survived" but for the help they received from their teammates (Kronos, 2017). This survey notes that nurses help one another out in scenarios that transpire during shifts and whenever they switch shifts among themselves, but these interactions can only happen if nurses communicate their needs to their coworkers. These responses signify that nurses not only take pride in their work but they also have concerns about whether their fatigued mind and body can provide a high level of patient care, an inference answered in the affirmative by 44% of the sample. Fatigue, work-life balance, and helping one another out underscore the importance of nurse communication and workplace relationships. Of note, the communication relationships and challenges undergird the resulting outcomes.

Communication directly influences patient care. Nurse communication accomplishes a number of objectives, including the conveyance of completed nursing tasks (Manias et al., 2003). While the types of nurse-nurse interactions in the Kronos survey constitute nurse communication, those interactions will likely take place only if

nurses share a positive work relationship and that they feel comfortable confiding in one another. Such interactions transpire at a deeper interpersonal stratum beneath superficial – albeit important – nurse communication that pertains more directly to patient care. A nurse calling in sick, as a surface-level communication example, embodies a simple message that can have a profound performance impact on that nurse's team (see Lee & Doran, 2017). Nurse communication functions as an impetus of patient care that can change dramatically during staff absences and among transient teams.

Conflict management. The ubiquitous nature of conflict as an outcome of miscommunication, communication, or the lack thereof, implies that the management of inherent differences among nurses can improve tangibles such as high patient care and high nurse welfare. Conflict scholarship traditionally views productivity as a byproduct in relation to the amount of conflict: too much conflict causes chaos, too little conflict encourages complacency, while a moderate amount of conflict stimulates "self-criticism, learning, and innovation" (Almost, 2006, p. 447). Thus, a moderate amount of conflict creates the most beneficial environment for desirable outcomes.

Fast-changing and emotionally-charged healthcare contexts make conflict an unpreventable feature and a common stressor among nurses (Johansen, 2014; Johansen & Cadmus, 2016; Morrison, 2008). Conflict's impact on healthcare delivery and its prevalence in work life have resulted in voluminous research conducted on this phenomenon in the nursing work environment (Almost, 2006; Brinkert, 2010). Researchers generally agree that conflict involves interdependent actors entangled in incompatible goals (Hocker & Wilmot, 2013).

Nurses perform many tasks individually but they almost never work alone exclusively. They collectively deliver the bulk of direct patient care and they must coordinate as a team to ensure continuation of care. From a theory standpoint, anticipated dependency makes communication necessary and conflict an unavoidable component (Hocker & Wilmot, 2013); if nurses interact or coordinate how they will perform nursing tasks and how they can support one another as teammates, their negotiations then take place within the context of past, present, or future relationships (Lewicki, Saunders, & Barry, 2015). Their existing relationship or the prospect of future interactions as part of a care team forms the foundation for a functional nursing team. The nature and quality of relationships and how they may evolve during nurses' interactions as teammates shape the level of dependency that they will have with one another.

Personalities create communication challenges. Healthcare contexts replete with fluctuating degrees of patient acuity, census, and staffing availability generate high amounts of uncertainty, stress, and conflict. These competing tensions become profound problems when personalities manifest in different individual conflict communication preferences. These preferences bring out different conflict management styles, with the avoidance style most commonly used by nurses (Cavanagh, 1991; Johansen, 2014; Mahon & Nicotera, 2011; Vandecasteele et al., 2017). However, conflict is not always inherently negative because conflict also presents opportunities for growth and positive outcomes (Almost, 2006; Mahon & Nicotera, 2011).

Although the avoidance style proves effective in some clinical situations (Cavanagh, 1991), nurses will benefit from expanding their conflict management repertoire as the avoidance style may not always work in every emotionally-charged situation. Johansen and Cadmus (2016) recommended that nurses hone their conflict management skills by way of understanding and considering how their social skills might enhance emotional intelligence, as increased emotional intelligence correlated with increased collaboration among nurses as well as better conflict and stress management (Morrison, 2008). Strong social skills in the healthcare context can help nurses better relate to and communicate with others at their workplace. Increasing emotional intelligence may ultimately yield satisfying outcomes that help manage nurses' stress levels and uphold patient care quality.

Poor workplace communication festers not only conflict and stress among nurses, it also perpetuates into an organizational issue that results in patients receiving poor care and NMs providing inadequate support to their nurses (Johansen, 2014). A recent study concluded that nurses who worked in supportive environments experienced lower levels of stress; the same study also found that nurses who avoided conflict also experienced lower levels of stress than nurses who adopted other conflict management styles (Johansen & Cadmus, 2016). However, nurses do not always find themselves in supportive work environments. NMs will only know how they can improve teamwork and interpersonal relationships if they understand the extent of their nurses' social skills (Morrison, 2008).

Busy nurses have high workloads and they must place patients as their top priority. They must work around interpersonal conflicts so that they can focus on patient care. This may explain why time-strapped nurses may use the avoidance style for practical reasons. However, scholars do not know exactly why nurses have certain conflict management preferences other than the possible link between conflict management strategies and nurses' personality traits (see Erdenk & Altuntaş, 2017). Nurses may also opt for the avoidance style because they feel helpless, due to horizontal violence for instance. The lack of insight into this preference therefore invites investigations into how the avoidance style may have eliminated important communicative exchanges pertinent to constructive conflict management and relationship building.

Information sharing. Nurses communicate to clarify roles and duties (Apker et al., 2006). Not having the same understanding of the specifics of their individual and collective responsibilities can complicate the completion of interdependent tasks. Healthcare teams, in particular, have more complicated features than non-healthcare teams (Andreatta, 2010). Moreover, health professionals' training and experience oftentimes overlap, especially those in primary care (Doherty & Crowley, 2013); a conceivable scenario may entail an intensivist overseeing a unit in collaboration with acute care nurse practitioners and critical care physician assistants; in configurations like this, role negotiation may help clarify individual responsibilities. Health professionals from different disciplines may also intentionally blur role boundaries (Ellingson, 2003). For example, a situation may involve a pediatric patient's pediatric nurses, primary care

nurse practitioner, and pharmacist. Finally, interruptions can abruptly disrupt the dynamics of roles and duties (Ellingson, 2003), which require immediate interactions so that nurses and their teams can strategically redistribute the workload. As teams compensate for staffing shortage or inadequacies, they must adapt quickly by ascertaining their present needs and available resources. Thus, scholars and practitioners have raised concerns about effective approaches in which they can promote authentic and efficient teamwork (West & Lyubovnikova, 2012, 2013).

Nurses must communicate salient patient information, such as which nursing tasks they have completed and what incoming nurses must do and/or observe. Two major nurse communication activities, namely documenting/charting and handoffs, require a high degree of accuracy and completion. These communicative activities demand intense concentration on top of the cognitive and physical burdens that busy clinical settings already place on nurses. Documenting/charting and handoffs today take place mostly electronically because of the advent of EHRs (Streeter et al., 2015). While nurses previously trained in paper documenting/charting have largely now become competent in electronic documenting/charting, scheduled and unscheduled technology downtimes mean that nurses must do these communicative activities on paper or alternative non-electronic platforms (and transfer information onto the electronic format when their local EHRs resume normalcy). A lapse of concentration during these two critically important activities can cause miscommunication and conflict. Therefore, the introduction of medical technology increases productivity but it also complicates nursing communication as it can elicit communication challenges pertaining to conflicting

communication styles from individuals of different educational training and personalities.

The advent of information technology has profoundly changed communication. E-mails open up another communication channel while at the same time remove several important aspects of face-to-face human communication that have potentially fragmented how health professionals work and interact (O'Sullivan et al., 2015). The impact most pertinently affects teams.

Team communication and relationships. Organizational restructuring that increases mobility and flexibility of nursing positions creates transient teams. Although transient teams meet specific patient needs through some combination of available healthcare professionals, constantly reconfigured teams affect communication and relationship building because nurses must adapt to new coworkers. Constant changes create unsettling effects that disrupt team stability and the accumulation of shared knowledge (Bezemer et al., 2015). Transient teams happen most often in acute care settings where healthcare professionals may work with teammates whom they may not have worked with before and whom they will likely not work with again as a team (Weaver, Dy, & Rosen, 2014; see also Lee & Doran, 2017). Despite the interdependent nature of teams, transient teams' temporal formation oftentimes results in low group identification (Deneckere et al., 2012), which further hampers communication relationships.

Scholars have noted from various international settings that poor communication and care provided in acute care settings compromise patient safety (Feo & Kitson, 2016).

Acute care settings in university-affiliated or teaching hospitals experience communication issues more severely because of the high percentage of staff that rotate through departments, creating situations whereby a substantial number of acute care team members having never worked together before (Rabøl, McPhail, Østergaard, Andersen, & Mogensen, 2012; see Andreatta, 2010). Similarly, interdisciplinary teams assembled for a highly novel surgical procedure will probably never work together again (West & Lyubovnikova, 2013). The instructional nature of teaching hospitals makes salient the hierarchical and power distance among experienced preceptors, permanent health professionals, and new colleagues who may only work in those departments for predetermined number of shifts so that they accumulate the clinical experience to meet their individual training requirements. Combinations like these proliferate the formation of pseudo teams—groups of individuals that communicate with one another to perform their respective work but neither toward shared goals nor interdependent tasks (see West & Lyubovnikova, 2012, 2013). Furthermore, health professionals who rotate through departments may not identify with those departments as their home units and they may feel less motivated to participate in performance improvement projects such as those targeted at improving teamwork and communication (Martin & Ciurzynski, 2015). The large number of rotations may explain part of the communication problem that results in poor patient care; however, communication involves not only message senders but also message receivers. To achieve the goal of delivering quality patient care, nurses must coordinate with other nurses and health professionals through communication events such as huddles and handoffs as well as through communication tools such as checklists

and electronic health records (EHRs). These communication activities serve an imperative and central function in patient care (Ellingson, 2003). Hence, nurses must interact effectively in both synchronous and asynchronous communication channels to safeguard patient safety.

Communication supports team processes and collaboration. The prevalence of complex medical conditions in today's aging population underscores a greater emphasis on effective teamwork and team communication among collaborating clinicians from different medical specialties and healthcare disciplines (Chamberlain-Salaun, Mills, & Usher, 2013; Doherty & Crowley, 2013; Leonard, Graham, & Bonacum, 2004). In fact, professional nursing organizations such as the American Nurses Association and the International Council of Nurses identified collaboration as an essential professional competency (see Lamont et al., 2015).

Teamwork undergirds the healthcare system (Ellingson, 2003). Teamwork refers to:

> A dynamic process involving two or more health professionals with complementary backgrounds and skills, sharing common health goals and exercising concerted physical and mental effort in assessing, planning, or evaluating patient care. This is accomplished through interdependent collaboration, open communication and shared decision-making. This in turn generates value-added patient, organizational and staff outcomes. (Xyrichis & Ream, 2008, p. 238)

Highly collaborative teams will more likely yield quality decisions and solve problems effectively (see Lamont et al., 2015). Teams that do not collaborate well will likely exhibit poor coordination, which implies poor teamwork and communication that result in adverse events such as patient morbidity and mortality (O'Sullivan, Moneypenny, & Mckimm, 2015; Rabøl et al., 2012). Teams that collaborate and coordinate well increase the odds of their delivering the intended effects of medical and nursing interventions (see Apker et al., 2006); they will also more likely manage unanticipated turn of events better than dysfunctional or pseudo teams that do not pool their collective expertise and knowledge.

Effective teamwork refers to a process that optimizes patient care, improves patient outcomes, and promotes healthcare safety (Leonard & Frankel, 2011; Xyrichis & Ream, 2008). These patient-centered definitions for "teamwork" and "effective teamwork" place an emphasis on clinician communication and processes, proficiently executed by purposefully-formed teams of health professionals that share common goals for their patients (West & Lyubovnikova, 2012, 2013). In turn, effective teams improve patient safety and quality of care (Leonard & Frankel, 2011; Weaver et al., 2014). However, the different *professional languages* that different health professionals speak become important in interdisciplinary teams (see Rabøl et al., 2012). Team members of interdisciplinary teams may define and perceive care differently, an outcome due to different ways in which the different health disciplines socialize their members. Those expectations result in different communication patterns and protocols (Andreatta, 2010). Hence, nurses who can demonstrate their proficiency amidst interdisciplinary work

relationships discursively display their expertise and adaptive communication skills by avoiding jargons or vague terminologies foreign to those trained in other *professional languages* and by mediating conflicts directly and objectively (Apker et al., 2006).

The high number of clinical communication failures and breakdowns has dramatically increased interest in teamwork training and development (T&D) because scholars not only know that teamwork affects clinical performance and patient outcomes but more importantly they also know that teamwork T&D works (O'Sullivan et al., 2015; Salas & Rosen, 2013). Teamwork T&D entails the breaking of old (and oftentimes poor) communication habits that pervade in time-pressured contexts. Miscommunication abounds in clinical documentation: Some nurses may choose to handwrite notes throughout their shifts so that they only need to document completed tasks at the end of their shifts; while this approach may save time, it also increases the possibility of nurses entering wrong or inaccurate information in patients' records. In some instances, fatigue and the lack of time may result in no documentation altogether. T&D that emphasizes on teamwork as communication and the interdependent nature of teams may help nurses become more meticulous about documenting patients' records in a timely fashion. Similarly, a performance improvement project found that the use of structured communication tools improved interactions among interdisciplinary team members (Martin & Ciurzynski, 2015). To achieve efficient communication, however, will require buy-in from both nurses and their managers. As such, teamwork T&D presents a form of cultural intervention that depends upon leadership support for effective implementation

(O'Sullivan et al., 2015; Salas & Rosen, 2013). The ways in which NMs communicate with their nurses can influence nurses' task-related and workplace communication.

Purpose of Dissertation

Scholars and clinicians concerned about care delivery must understand how AWAs "affect how work is done, how people feel about their work, what their orientation toward work is, and the role of work in their lives" (Spreitzer et al., 2017, p. 486). The nursing profession will continue to experience changes in the utilization and types of AWAs, as work and employment patterns change with updated technologies and novel ways of organizing are introduced into health care settings (Barley, Bechky, & Milliken, 2017). For example, the varied ways in which different healthcare organizations organize their float pool nurses – nurses who work a particular type of AWA – highlight the ongoing role that AWAs play in addressing staffing needs (Dziuba-Ellis, 2006). A focused investigation into the practical implications of AWAs will help us understand and explain how this phenomenon affects different patient populations and organizational settings. Because care delivery and workplace relations depend heavily upon effective collaboration, an exploration into the way that how AWAs impact NMs, permanent nurses on the regular day shift, and nurses in AWAs is warranted.

It is an empirical question as to whether AWAs influence the communication with patients and other members of healthcare teams as well as health outcomes. However, a reasonable argument may be made that the transitory nature of AWAs may influence the communication among nurses in AWAs, patients, and NMs.

First, the transitory nature of contemporary healthcare teams may affect nurses' communication with their patients. Frequent staff changes in transitory teams entail involuntary and voluntary nursing turnover, which may affect the quality of communication between nurses and patients as well as the quality of care (North et al., 2013). For example, nurses who float or get rotated to ICUs have limited opportunities to cultivate relationships with their patients. Although it is an open question regarding whether and how AWAs may affect nurse-patient communication, patients and families will most likely feel less comfortable seeking clarifications from unfamiliar nurses than from familiar nurses. Just as scholars have only recently begun to study the role of clinical nurses in family conferences regarding life-support treatment options (Watson & October, 2016) and how clinicians broach the subject (Pecanac, 2017), a dearth of research on how the transitory nature of teams that include short-term nurses who deliver care raises concerns regarding how patients and their families understand treatment plans as articulated by their nurses. Uncertainty surrounding treatment plans can implicate consent and medical decision-making—two communicative events that will affect care delivery. Given that AWAs are associated with temporary work and transitions in and out of units, the temporariness of the AWA position may influence interactions with patients.

Second, the limited and short amounts of time that NMs have with nurses in AWAs may also affect how NMs support and communicate with their nurses. Staff support serves an instrumental role in achieving good patient outcomes and in ensuring staff well-being (Chisengantambu, Robinson, & Evans, 2017; Gittell, 2016). For

instance, NMs who typically work the traditional 9-to-5 shift have a finite physical presence in 24-hour units and their workday limits the provision of support that they can extend to nurses who do not work the 9-to-5 shift. As a way around this limitation, NMs may come to work early and/or leave late so that they can interact face-to-face with nurses who work outside their regular work hours. Nurses who work the occasional night shift may not see their NMs often, but they nevertheless must still perform at a consistently high standard with little to no supervision. In comparison, nurses permanently scheduled for the night shift may receive more frequent supervision because of the integral role that they perform not only in ensuring continuity of care but also as a way of relaying their NMs' messages to others on shifts that their NMs normally do not work.

AWAs also make mentoring more challenging for NMs. NMs serve a special role of providing feedback to their nurses (Sveinsdóttir, Ragnarsdóttir, & Blöndal, 2016). Positive feedback reinforces best practices and can also constructively correct deficiencies, which new nurses may appreciate as mentorship. Younger nurses who have two or three years of full-time bedside experience may choose AWAs for their next job as a way of expanding their career options; such nurses will probably need continued mentoring so that they hone and diversify their skill sets (Hemann & Davidson, 2012). Older nurses may not necessarily need as much guidance; they may choose AWAs so that they can continue working at a more manageable pace (Clendon & Walker, 2016). One form of positive reinforcement that works with a particular nurse may not make another nurse feel as rewarded. NMs who understand how their nurses perceive – and

why their nurses choose – AWAs will have an additional insight into how they may mentor and supervise their nurses.

Nursing turnover perpetuated by AWAs makes relationship building harder among teams and that can affect work performance and feedback. Recent research found that nurses well-supported and praised by their NMs had stronger organizational commitment and perceived their work climate favorably (Chisengantambu et al., 2017; Sveinsdóttir et al., 2016). Although communication cultivates good peer relationships that increase job satisfaction and decrease the severity of nurse bullying (Purpora & Blegen, 2015), the healthcare team literature has not addressed how interpersonal communication is related to team performance (see Lee & Doran, 2017). The transient nature of the contemporary healthcare labor further complicates the study of communication relationships in healthcare teams. Future research should investigate whether work arrangements affect clinician communication and whether NMs should motivate nurses in AWAs differently than permanent nurses.

Organizations fill staffing gaps and respond to the increasing demand for healthcare with AWAs (North et al., 2013). AWAs represent a distinct form of labor and it is likely that this unique form of labor may be associated with different patterns of communication among nurses in AWAs, patients, and healthcare colleagues. However, most nursing studies tend to sample full-time nurses as opposed to nurses in AWAs (e.g., Van Bogaert et al., 2014). Therefore, it is not clear to what degree, if any, that AWAs influence communication among nurses in AWAs, patients, and healthcare colleagues. This dissertation aims to address this gap in the literature by conducting three studies

that focus on: (1) how NMs manage nurses in AWAs, (2) how nurses in AWAs perceive the communication challenges associated with their positions, and (3) how nurses in AWAs construct their career narratives.

Focus and Rationale for Study #1

Rationale for study. Nurses who work AWAs collectively serve the practical function of supplementing units that need additional nurses. Units employ nurses of different AWAs based on the urgency, duration, and expertise needed. Different types of AWAs have different administrative characteristics, such as tenure to which these nurses will work in the unit or with the organization, the process of hiring them, and the different compensation packages and ways that hospitals will pay them. For example, NMs may prefer to use familiar nurses such as internally-managed nurses because they have already proven their competencies and may already have cultivated relationships with existing nursing staff.

Chapter II focuses on time as a central staffing consideration as hospitals ascertain how and when they recruit nurses. Organizational perceptions of nursing as a time-based labor change along with the changing nursing labor landscape. Two research questions guide this inquiry:

RQ1: *How do NMs categorize and perceive AWAs?*

RQ2: *How do NMs communicate with Nurses in AWAs and Nurses not in AWAs?*

Methodology. Twenty-six NMs participated in one-on-one semi-structured interviews for Study #1. I recruited interviewees using theoretical sampling (Hesse-Biber

& Leavy, 2011), interviewing participants who met two inclusion criteria: (1) RNs who had managed clinical settings, and (2) RNs who had directly supervised other nurses.

Participants shared their perspectives with me on the extent to which AWAs shaped the communication channels and relationships among them and their RNs. Appendix A contains the interview protocol for this sample. The interview protocol provided a structure for me to explore my interviewees' experiences with both permanent and temporary nurses, perceptions of different AWAs, and observations of communication differences and challenges with nurses of different work arrangements. Texas A&M University's Institutional Review Board approved this study.

Most of the interviews were professionally transcribed verbatim. For interviews that were not transcribed by me, I checked the transcripts with the audio to ensure accuracy. I analyzed this set of data using the iterative approach and thematic analysis. Data analysis transpired throughout the data collection process, in which I managed the data, transcripts, and contact records to ensure data trustworthiness. The constant-comparative method of microanalysis (Strauss & Corbin, 1990) provided a rigorous basis for data collection and analysis. I inductively analyzed the data as I conducted interviews until theoretical saturation. I identified emergent themes using open coding (Lindlof & Taylor, 2011; Strauss & Corbin, 1990), which came from initial concepts grouped into categories. I completed iterative readings of the transcript during this process so that codes and themes emerged instead of my imposing preconceived categories on the data. In addition, I also: (1) discussed the data's emerging patterns with other field researchers (Creswell & Miller, 2000); (2) verified emerging themes with

latter interviewees through member checks (Miles & Huberman, 1984; cf. Thomas, 2016); (3) used thick, rich descriptions in the findings section (Creswell & Miller, 2000); and (4) reflected upon my role as the researcher.

Findings. I will provide an overview of the findings here and expand on them in Chapter II. RQ1 focuses on NMs' conception of a permanent-temporary distinction of nurses: my participants categorized temporary nurses in four distinct AWAs: (1) staff-floaters, (2) per diem nurses, (3) agency nurses, and (4) float nurses. The data analysis suggests five major work arrangements, which I present in Table 3 (Typology of Work Arrangements as Perceived by NMs) in Chapter II.

RQ2 reveals instances when my participants would communicate with all nurses in the same way regardless of work arrangements and instances when different work arrangements required different communication approaches. Three themes emerged for RQ2: (1) *You cannot overcommunicate*, (2) *Mentoring*, and (3) *When things go wrong*. For the first theme, NMs use multiple communication media to disseminate multiple copies of the same message to all of their nurses. They do not view this approach as overcommunication because their nurses need that information to perform their tasks. Consequently, the importance of the information equalized the permanent-temporary distinction. Regarding the second and third themes, although NMs intervene differently when their nurses perform poorly, the different feedback channels do not minimize the significance of giving feedback.

Focus and Rationale for Study #2

Rationale for study. Due to human resource and labor changes, the demand for nurses has outpaced the nursing workforce. This phenomenon has ushered in the rise in temporary, nonpermanent, and part-time nurse work arrangements—such arrangements serve temporal needs but affect teamwork and team communication because they disrupt stability and relationships within nursing teams.

Whereas the literature notes perceived communication challenges that permanent nurses have with temporary nurses, temporary nurses may also experience communication challenges with permanent coworkers. Most people experience uncertainty and communication challenges when working with a new colleague for the first time. For example, when hospitals can anticipate when they need additional nurses and the qualifications that replacement nurses must possess, they can acquire necessary replacements based on the most cost-efficient option while keeping quality of care as high as possible (see May et al., 2006). But in unpredictable or unexpected situations, PRN/per diem nurses generally receive the least amount of notice on the availability of shifts because hospitals use these temporary nurses when they cannot muster nurses from their existing nurses (permanent nurses, including float pool nurses) and local agencies. Regardless of the source of temporary nurses, the nurses who work at that given unit and shift can experience communication challenges because of the new team setup. Such a scenario means that both permanent and temporary nurses must adapt the ways in which they coordinate and interact with one another. These concerns –

contextualized in a high-stress, fast-paced, and conflict-prone environment – foreground Study #2 (Chapter III). Study #2 poses the following research question:

RQ: *How do travel nurses manage nurse-to-nurse relationships with permanent nurses?*

Methodology. Chapter III considered the perceived communication challenges experienced by nurses who worked as travel nurses. I recruited 25 participants through contacts whom I had already established prior to or during Study #1. I used a similar interview protocol as the one that I had used for Chapter II (see Appendix B). Study #2 drew its data chiefly from questions 1 through 9 of the interview protocol. This set of questions guided me as I inquired into how travel nurses understood communication challenges between them and their permanent-nurse colleagues. Participants satisfied the inclusion criterion as RNs who had worked in a clinical setting.

The constant-comparative method was used to inductively analyze the data throughout the data collection phase (Strauss & Corbin, 1990). Initial categories were developed as I perused the transcript line-by-line. Subsequent readings of the transcript further developed themes through the *open coding* of initial categories (Strauss & Corbin, 1990). The coding scheme was further developed using *axial coding* where I consolidated the categories by abductively grouping similar categories together.

Findings. My participants experienced two forms of relational challenges: (1) demonstrating professional competence, and (2) fitting in with pre-existing unit culture and relationships. In response, they used the strategies of the *Competent Coworker* and the *Gracious Guest* respectively for these two relational challenges.

Focus and Rationale for Study #3

Rationale for study. Organizational restructuring of nursing policies deviates from the traditional notion of permanent full-time nursing work prevalent in the 1990s and has resulted in the rise in AWAs among younger nurses who could not secure the permanent positions that they wanted (Grinspun, 2003). Concurrently, the retirement of Baby-Boomer nurses will increase exponentially between now and into the near future (Auerbach et al., 2017; Carnevale et al., 2015). While some nurses may not find work that they want or that circumstances require that they leave the profession involuntarily, others may take advantage of AWAs in pursuit of work-life balance. AWAs as a new norm also means that turnover from one work arrangement to another will increase as nurses switch to work arrangements that suit their professional and personal aspirations. The underlying reasons that shape nurse turnover bear serious financial implications for healthcare organizations as healthcare organizations register turnover rates of between 30% and 60% among new nurses in their first couple of post-graduation years and the loss of each nurse costs healthcare organizations on average $25,000 (Price & Reichert, 2017). Consequently, an updated understanding of contemporary nursing and its workforce necessitate another inquiry into AWAs.

Chapter IV contemplated how nurses not only face new challenges but also new opportunities in today's global economy of varied career choices and options. The focus of this study turned to the career narratives that travel nurses articulated as they made sense of the transitions that they experienced through travel nursing. This study centered on two ideas: first, that people have gained sophistication with managing time that

interfaces work life and personal life (Kuhn, 2006); and second, that people constantly reconstruct their identities as they experience work role transitions and use narratives "to instate a sense of continuity between who they have been and who they are becoming, as well as to obtain validation from relevant parties" (Ibarra & Barbulescu, 2010, p. 136). This chapter focused on how personal experiences shaped nurses' career directions in a way that made sense to them as well as how they shared with others their career choices as career narratives.

I grounded Study #3 in career construction theory (CCT). CCT describes how individuals interpretively make meaning and sense of their careers through memorable interpersonal processes (Savickas, 2005); this theory posits a comprehensive framework about individuals' vocational behavior in relation to vocational personality, career adaptability, and life themes that shape their career narratives (Del Corso & Rehfuss, 2011). Study #3 focused on the following research question:

RQ: *How do travel nurses make sense of their careers?*

Methodology. The sample of Study #3 was the same as for Study #2. Questions 10 through 18 of the interview protocol were specifically prepared for Study #3 (See Appendix B). I created all but the final question, which I adapted from Yost, Yoder, Chung, and Voetmann (2015).

I utilized a constant-comparative method to analyze the data inductively (Strauss & Corbin, 1990), reading the transcript line-by-line and creating tentative categories. Iterative readings of the interview transcript yielded themes that emerged through *open coding*, which came from grouped categories of initial concepts, and not through

preconceived categories (Strauss & Corbin, 1990). I then developed my coding scheme using *axial coding*.

Findings. I structured my analysis according to themes, which answered these three questions that mirror career construction theory: (1) Why nursing? (vocational personality), (2) Why travel nursing? (career adaptability), and (3) What keeps them in nursing? (life themes). The six themes were: (1) Family conversations and scientific minds, (2) Become tourists, (3) Make more money, (4) Learn how others do things, (5) Unlimited opportunities, and (6) Make a difference. My participants' personal curiosity drove their career narratives. Finally, I developed the career adaptability sensemaking theory (CAST) as an updated theory that emphasizes the proactivity of contemporary professionals as a manifestation of their values and identities.

Methodology

Researcher Positionality

Researcher's positionality plays a crucial role in qualitative study designs. That means that I as a researcher should practice self-reflexivity by examining my personal assumptions in light of the research process (Hesse-Biber & Leavy, 2011). My research epistemological position is that everyone has different lived experiences and these differences create meanings that are socially constructed (Hesse-Biber & Leavy, 2011). Put differently, the events that we experience can yield different subjective meanings as we make sense of them in light of our preconceived notions. This sensemaking process also means that my participants and I co-construct subjective realities through our interactions. Consequently, my ontological position is that there are multiple versions of

truths just as there are multiple versions of socially-constructed meaning to lived experiences. Because my epistemological and ontological assumptions favor the qualitative methodological viewpoint (Hesse-Biber & Leavy, 2011; Hugh-Jones, 2010), I adopt the interpretive research paradigm for the present work.

Researchers of qualitative studies serve as research tools because they collect and analyze the data. Consequently, my personal experiences are important to this dissertation to the extent that they inform the way I design the studies and interpret the data (Frey, Botan & Kreps, 2000). Specifically, my background as a former combat medic helps me appreciate the contributions made by healthcare professionals and gives me a useful insider's perspective (emic) from the outside (etic) into the concerns of healthcare professionals (Lindlof & Taylor, 2011). Having this background also gives me an advantage of engaging in meaningful interactions with participants.

Limitations of Study

First, the data collection method – one-on-one semi-structured interviews – that I employed limits the inferences that I can draw from the data. The absence of data from individuals whom my interviewees talked about restricts me from accepting wholesale the claims, especially those pertaining to relationships (Fairhurst, 2014), that my interviewees made because the quality and quantity of interactions between parties shape the nature of their relationships. Without interviewing all parties involved in a specific relationship or communication network, interview data only go as far as the accounts as experienced from my interviewees' perspectives. The research design would have captured a better understanding of my interviewees' lived experiences if I also

interviewed those whom they referenced in the interviews. A study conducted at the same site will increase the likelihood of capturing the nuances of its social relations and networks; however, the lack of organizational access makes this research design unfeasible for the given scope and time frame. The total number of interviews (51 for all three studies combined) provided rich and theoretically saturated data, although solely depending upon interview data hindered me from learning about the interactional issues as perceived from the perspectives of my interviewees' counterparts.

Second, my samples comprised cross-sectional participants who experienced the same broad phenomena in disperse geographical locations and organizational settings. This approach increased the difficulty of relating one participant's experience to another. It also made corroboration of data more challenging because participants experienced the same phenomena in different ways. However, this limitation presents a smaller issue that the first limitation because any consistent theme that emerged from a theoretical sample drawn from across the country will likely ring true or have high transferability for readers who experience similar phenomena.

Third, interview-intensive qualitative studies consumed more time than I anticipated or could allocate. A diligently-conducted qualitative study required that I transcribe the interviews verbatim, verify the contents of the interviews, and interpret and present the data in participants' voice instead of mine. On the flipside of conducting interviews, I also experienced difficulty in recruiting participants. Theoretical sampling took up time and energy in finding information-rich participants.

Organization of Dissertation

Chapters II through IV present the three empirical studies as outlined in the study rationales above. Study #1 (Chapter II) investigated how NMs communicated with permanent and temporary RNs. Study #2 (Chapter III) considered the relational challenges of travel nurses. Study #3 (Chapter IV) analyzed the career construction narratives of travel nurses. The fifth and final chapter discussed practical and theoretical implications of these studies and offered future research areas on how the changing nursing labor landscape alters nurse managerial communication as well as nurses' workplace communication and relations.

References

Adams, J., Kaplow, R., Dominy, J., & Stroud, B. (2015). Beyond a Band-Aid® approach: An internal agency solution to nurse staffing. *Nursing Economics, 33*, 51–58.

Aiken, L. H., Xue, Y., Clarke, S. P., & Sloane, D. M. (2007). Supplemental nurse staffing in hospitals and quality of care. *JONA: The Journal of Nursing Administration, 37*, 335–342. doi:10.1097/01.nna.0000285119.53066.ae

Almost, J. (2006). Conflict within nursing work environments: Concept analysis. *Journal of Advanced Nursing, 53*, 444–453. doi:10.1111/j.1365-2648.2006.03738.x

Andreatta, P. B. (2010). A typology for health care teams. *Health Care Management Review, 35*, 345–354. doi:10.1097/hmr.0b013e3181e9fceb

Apker, J., Propp, K. M., & Zabava Ford, W. S. (2005). Negotiating status and identity tensions in healthcare team interactions: An exploration of nurse role dialectics. *Journal of Applied Communication Research, 33*, 93–115. doi:10.1080/00909880500044620

Apker, J., Propp, K. M., Zabava Ford, W. S., & Hofmeister, N. (2006). Collaboration, credibility, compassion, and coordination: Professional nurse communication skill sets in health care team interactions. *Journal of Professional Nursing, 22*, 180–189. doi:10.1016/j.profnurs.2006.03.002

Auerbach, D. I., Buerhaus, P. I., & Staiger, D. O. (2017). How fast will the registered nurse workforce grow through 2030? Projections in nine regions of the country. *Nursing Outlook, 65*, 116–122. doi:10.1016/j.outlook.2016.07.004

Bae, S.-H., Farasat, A., Nikolaev, A., Seo, J. Y., Foltz-Ramos, K., Fabry, D., & Castner, J. (2017). Nursing teams: Behind the charts. *Journal of Nursing Management, 25*, 354–365. doi:10.1111/jonm.12473

Ballard, D. I., & Gossett, L. M. (2007). Alternative times: Temporal perceptions, processes, and practices defining the nonstandard work relationship. *Annals of the International Communication Association, 31*, 274–320. doi:10.1080/23808985.2007.11679069

Ballard, D. I., & Seibold, D. R. (2004). Communication-related organizational structures and work group temporal experiences: The effects of coordination method, technology type, and feedback cycle on members' construals and enactments of time. *Communication Monographs, 71,* 1-27. doi:10.1080/0363452041000169147 4

Barley, S., Bechky, B., & Milliken, F. (2017). From the editors: The changing nature of work: Careers, identities, and work lives in the 21st century. *Academy of Management Discoveries, 3,* 111–115. doi:10.5465/amd.2017.0034

Baumann, A., Hunsberger, M., & Crea-Arsenio, M. (2013). Full-time work for nurses: Employers' perspectives. *Journal of Nursing Management, 21*, 359–367. doi:10.1111/j.1365-2834.2012.01391.x

Bezemer, J., Korkiakangas, T., Weldon, S.-M., Kress, G., & Kneebone, R. (2015). Unsettled teamwork: Communication and learning in the operating theatres of an urban hospital. *Journal of Advanced Nursing, 72*, 361–372. doi:10.1111/jan.12835

Brinkert, R. (2010). A literature review of conflict communication causes, costs, benefits and interventions in nursing. *Journal of Nursing Management, 18*, 145–156. doi:10.1111/j.1365-2834.2010.01061.x

Buerhaus, P. I., Auerbach, D. I., Staiger, D. O., & Muench, U. (2013). Projections of the long-term growth of the registered nurse workforce: A regional analysis. *Nursing Economics, 31*, 13–17.

Burke, R. J., Dolan, S. L., & Fiksenbaum, L. (2014). Part-time versus full-time work: An empirical evidence-based case of nurses in Spain. *Evidence-Based HRM: A Global Forum for Empirical Scholarship, 2*, 176–191. doi:10.1108/ebhrm-02-2013-0001

Carnevale, A. P., Smith, N., & Gulish, A. (2015). *Nursing: Supply and demand through 2020*. Washington, D.C.: Georgetown University Center on Education and the Workforce.

Castronovo, M. A., Pullizzi, A., & Evans, S. (2016). Nurse bullying: A review and a proposed solution. *Nursing Outlook, 64*, 208–214. doi:10.1016/j.outlook.2015.11.008

Cavanagh, S. J. (1991). The conflict management style of staff nurses and nurse managers. *Journal of Advanced Nursing, 16*, 1254–1260. doi:10.1111/j.1365-2648.1991.tb01536.x

Chamberlain-Salaun, J., Mills, J., & Usher, K. (2013). Terminology used to describe health care teams: An integrative review of the literature. *Journal of Multidisciplinary Healthcare, 6*, 65–74. doi:10.2147/jmdh.s40676

Chan, E. A., Jones, A., Fung, S., & Wu, S. C. (2011). Nurses' perception of time availability in patient communication in Hong Kong. *Journal of Clinical Nursing, 21*, 1168–1177. doi:10.1111/j.1365-2702.2011.03841.x

Chisengantambu, C., Robinson, G. M., & Evans, N. (2017). Nurse managers and the sandwich support model. *Journal of Nursing Management, 26, 192–199.* doi:10.1111/jonm.12534

Cicellin, M., Pezzillo Iacono, M., Berni, A., & Esposito, V. (2015). Dealing with resistance in temporary agency nurses. *Journal of Health Organization and Management, 29*, 298–316. doi:10.1108/jhom-02-2013-0044

Clendon, J., & Walker, L. (2016). Nurses aged over 50 and their perceptions of flexible working. *Journal of Nursing Management, 24*, 336–346. doi:10.1111/jonm.12325

Crawford, P., & Brown, B. (2011). Fast healthcare: Brief communication, traps and opportunities. *Patient Education and Counseling, 82*, 3–10. doi:10.1016/j.pec.2010.02.016

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory into Practice, 39*, 124–130. doi:10.1207/s15430421tip3903_2

Del Corso, J., & Rehfuss, M. C. (2011). The role of narrative in career construction theory. *Journal of Vocational Behavior, 79*, 334–339. doi:10.1016/j.jvb.2011.04.003

Deneckere, S., Euwema, M., Van Herck, P., Lodewijckx, C., Panella, M., Sermeus, W., & Vanhaecht, K. (2012). Care pathways lead to better teamwork: Results of a systematic review. *Social Science & Medicine, 75*, 264–268. doi:10.1016/j.socscimed.2012.02.060

Doherty, R. B., & Crowley, R. A. (2013). Principles supporting dynamic clinical care teams: An American College of Physicians position paper. *Annals of Internal Medicine, 159,* 620–626. doi:10.7326/0003-4819-159-9-201311050-00710

Dziuba-Ellis, J. (2006). Float pools and resource teams. *Journal of Nursing Care Quality, 21*, 352–359. doi:10.1097/00001786-200610000-00013

Ellingson, L. L. (2003). Interdisciplinary health care teamwork in the clinic backstage. *Journal of Applied Communication Research, 31*, 93–117. doi:10.1080/0090988032000064579

Erdenk, N., & Altuntaş, S. (2017). Do personality traits of nurses have an effect on conflict management strategies? *Journal of Nursing Management, 25*, 366–374. doi:10.1111/jonm.12474

Fairhurst, G. T. (2014). Exploring the back alleys of publishing qualitative organizational communication research. *Management Communication Quarterly, 28*, 432–439. doi:10.1177/0893318914535784

Faller, M. S., Gates, M. G., Georges, J. M., & Connelly, C. D. (2011). Work-related burnout, job satisfaction, intent to leave, and nurse-assessed quality of care among travel nurses. *JONA: The Journal of Nursing Administration, 41*, 71–77. doi:10.1097/nna.0b013e3182059492

Feo, R., & Kitson, A. (2016). Promoting patient-centred fundamental care in acute healthcare systems. *International Journal of Nursing Studies, 57*, 1–11. doi:10.1016/j.ijnurstu.2016.01.006

Frey, L. R., Botan, C. H., & Kreps, G. L. (2000). *Investigating communication: An introduction to research methods* (2nd ed.). Needham Heights, MA: Allyn & Bacon.

Gittell, J. H. (2016). Rethinking autonomy: Relationships as a source of resilience in a changing healthcare system. *Health Services Research, 51*, 1701–1705. doi:10.1111/1475-6773.12578

González-Martínez, E., Bangerter, A., Lê Van, K., & Navarro, C. (2015). Hospital staff corridor conversations: Work in passing. *Journal of Advanced Nursing, 72*, 521–532. doi:10.1111/jan.12842

Grinspun, D. (2003). Part-time and casual nursing work: The perils of healthcare restructuring. *International Journal of Sociology and Social Policy, 23*(8/9), 54–80. doi:10.1108/01443330310790642

Havlovic, S. J., Lau, D. C., & Pinfield, L. T. (2002). Repercussions of work schedule congruence among full-time, part-time, and contingent nurses. *Health Care Management Review, 27,* 30–41. doi:10.1097/00004010-200210000-00004

Hemann, M., & Davidson, G. (2012). Perspective of a float pool model in ambulatory care. *MedSurg Nursing, 21,* 164–170.

Hesse-Biber, S. N., & Leavy, P (2011). *The practice of qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.

Hocker, J. L., & Wilmot, W. W. (2013). *Interpersonal conflict.* (9th ed.). New York, NY: McGraw-Hill.

Hugh-Jones, S. (2010). The interview in qualitative research. In M. Forrester (Ed.), *Doing qualitative research in psychology* (pp. 77–97). Thousand Oaks, CA: Sage.

Hurst, K., & Smith, A. (2011). Temporary nursing staff - cost and quality issues. *Journal of Advanced Nursing, 67,* 287–296. doi:10.1111/j.1365-2648.2010.05471.x

Ibarra, H., & Barbulescu, R. (2010). Identity as narrative: Prevalence, effectiveness, and consequences of narrative identity work in macro work role transitions. *Academy of Management Review, 35,* 135–154. doi:10.5465/amr.2010.45577925

Institute of Medicine. (2004). *Keeping patients safe: Transforming the work environment of nurses*. National Academies Press.

Jamieson, L. N., Williams, L. M., Lauder, W., & Dwyer, T. (2007). Nurses' motivators to work part-time. *Collegian, 14*(2), 13–19. doi:10.1016/S1322-7696(08)60550-8

Jamieson, L. N., Williams, L. M., Lauder, W., & Dwyer, T. (2008). The “realities” of part-time nursing: A grounded theory study. *Journal of Nursing Management, 16*, 883–892. doi:10.1111/j.1365-2934.2007.00836.x

Johansen, M. L. (2014). Conflicting priorities: Emergency nurses perceived disconnect between patient satisfaction and the delivery of quality patient care. *Journal of Emergency Nursing, 40*, 13–19. doi:10.1016/j.jen.2012.04.013

Johansen, M. L., & Cadmus, E. (2016). Conflict management style, supportive work environments and the experience of work stress in emergency nurses. *Journal of Nursing Management, 24*, 211–218. doi:10.1111/jonm.12302

Johnson, S. L. (2015). Workplace bullying prevention: A critical discourse analysis. *Journal of Advanced Nursing, 71*, 2384–2392. doi:10.1111/jan.12694

Juvé-Udina, M.-E., Pérez, E. Z., Padrés, N. F., Samartino, M. G., García, M. R., Creus, M. C., … Calvo, C. M. (2013). Basic nursing care: Retrospective evaluation of communication and psychosocial interventions documented by nurses in the acute care setting. *Journal of Nursing Scholarship, 46*, 65–72. doi:10.1111/jnu.12062

Kalleberg, A. L. (2000). Nonstandard employment relations: Part-time, temporary and contract work. *Annual Review of Sociology, 26*, 341–365. doi:10.1146/annurev.soc.26.1.341

Katz, L. F., & Krueger, A. B. (2016). *The rise and nature of alternative work arrangements in the United States, 1995-2015*. (NBER Working Paper No. 22667). Cambridge, MA: National Bureau of Economic Research.

Koivunen, M., Niemi, A., & Hupli, M. (2015). The use of electronic devices for communication with colleagues and other healthcare professionals - nursing professionals' perspectives. *Journal of Advanced Nursing, 71*, 620–631. doi:10.1111/jan.12529

Kronos. (2017). *Nurses and fatigue survey report.* Internal Kronos report: unpublished.

Kuhn, T. (2006). A "Demented work ethic" and a "lifestyle firm": Discourse, identity, and workplace time commitments. *Organization Studies, 27*, 1339–1358. doi:10.1177/0170840606067249

Kunie, K., Kawakami, N., Shimazu, A., Yonekura, Y., & Miyamoto, Y. (2017). The relationship between work engagement and psychological distress of hospital nurses and the perceived communication behaviors of their nurse managers: A cross-sectional survey. *International Journal of Nursing Studies, 71*, 115–124. doi:10.1016/j.ijnurstu.2017.03.011

Lamont, S., Brunero, S., Lyons, S., Foster, K., & Perry, L. (2015). Collaboration amongst clinical nursing leadership teams: A mixed-methods sequential explanatory study. *Journal of Nursing Management, 23*, 1126–1136. doi:10.1111/jonm.12267

Lee, C. T.-S., & Doran, D. M. (2017). The role of interpersonal relations in healthcare team communication and patient safety. *Canadian Journal of Nursing Research, 49*, 75–93. doi:10.1177/0844562117699349

Leonard, M. W., & Frankel, A. S. (2011). Role of effective teamwork and communication in delivering safe, high-quality care. *Mount Sinai Journal of*

Medicine: A Journal of Translational and Personalized Medicine, 78, 820–826. doi:10.1002/msj.20295

Leonard, M., Graham, S., & Bonacum, D. (2004). The human factor: The critical importance of effective teamwork and communication in providing safe care. *Quality and Safety in Health Care, 13*(suppl_1), i85–i90. doi:10.1136/qhc.13.suppl_1.i85

Lewicki, R. J., Saunders, D. M., & Barry, B. (2015). *Negotiation* (7th ed.). New York, NY: McGraw-Hill.

Lindlof, T. R., & Taylor, B. C. (2011). *Qualitative communication research methods* (3rd ed.). Thousand Oaks, CA: Sage.

Linzer, P., Tilley, A. M., & Williamson, M. V. (2011). What floats a float nurse's boat? *Creative Nursing, 17*, 130–138. doi:10.1891/1078-4535.17.3.130

Long, M. C., Goldfarb, M. G., & Goldfarb, R. S. (2008). Explanations for persistent nursing shortages. *Forum for Health Economics & Policy, 11*. doi:10.2202/1558-9544.1113

Maenhout, B., & Vanhoucke, M. (2013). An integrated nurse staffing and scheduling analysis for longer-term nursing staff allocation problems. *Omega, 41*, 485–499. doi:10.1016/j.omega.2012.01.002

Mahon, M. M., & Nicotera, A. M. (2011). Nursing and conflict communication. *Nursing Administration Quarterly, 35*, 152–163. doi:10.1097/naq.0b013e31820f47d5

Manias, E., Aitken, R., Peerson, A., Parker, J., & Wong, K. (2003). Agency-nursing work: Perceptions and experiences of agency nurses. *International Journal of Nursing Studies, 40*, 269–279. doi:10.1016/s0020-7489(02)00085-8

Martin, H. A., & Ciurzynski, S. M. (2015). Situation, background, assessment, and recommendation–guided huddles improve communication and teamwork in the emergency department. *Journal of Emergency Nursing, 41*, 484–488. doi:10.1016/j.jen.2015.05.017

Mas, A., & Pallais, A. (2016). *Valuing alternative work arrangements*. (NBER Working Paper No. 22708). Cambridge, MA: National Bureau of Economic Research.

May, J. H., Bazzoli, G. J., & Gerland, A. M. (2006). Hospitals' responses to nurse staffing shortages. *Health Affairs*, *25*, W316-W323. doi:10.1377/hlthaff.25.w316

Miles, M. B., & Huberman, A. M. (1984). *Qualitative data analysis: A sourcebook of new methods* (2nd ed.). Thousand Oaks, CA: Sage.

Moreland, J. J., & Apker, J. (2015). Conflict and stress in hospital nursing: Improving communicative responses to enduring professional challenges. *Health Communication, 31*, 815–823. doi:10.1080/10410236.2015.1007548

Morrison, J. (2008). The relationship between emotional intelligence competencies and preferred conflict-handling styles. *Journal of Nursing Management, 16*, 974–983. doi:10.1111/j.1365-2834.2008.00876.x

Nicotera, A. M., Mahon, M. M., & Wright, K. B. (2014). Communication that builds teams. *Nursing Administration Quarterly, 38*, 248–260. doi:10.1097/naq.0000000000000033

Norful, A., Martsolf, G., de Jacq, K., & Poghosyan, L. (2017). Utilization of registered nurses in primary care teams: A systematic review. *International Journal of Nursing Studies, 74*, 15–23. doi:10.1016/j.ijnurstu.2017.05.013

Norrish, B. R., & Rundall, T. G. (2001). Hospital restructuring and the work of registered nurses. *The Milbank Quarterly, 79*, 55–79. doi:10.1111/1468-0009.00196

North, N., Leung, W., Ashton, T., Rasmussen, E., Hughes, F., & Finlayson, M. (2013). Nurse turnover in New Zealand: Costs and relationships with staffing practises and patient outcomes. *Journal of Nursing Management, 21*, 419–428. doi:10.1111/j.1365-2834.2012.01371.x

O'Sullivan, H., Moneypenny, M. J., & Mckimm, J. (2015). Leading and working in teams. *British Journal of Hospital Medicine, 76*, 264–269. doi:10.12968/hmed.2015.76.5.264

Pecanac, K. E. (2017). Communicating delicately: Introducing the need to make a decision about the use of life-sustaining treatment. *Health Communication, 32*, 1261–1271. doi:10.1080/10410236.2016.1217455

Pew Research Center. (2016). *The state of American jobs: How the shifting economic landscape is reshaping work and society and affecting the way people think about the skills and training they need to get ahead.* Retrieved from http://www.pewsocialtrends.org/2016/10/06/the-state-of-american-jobs/

Price, S., & Reichert, C. (2017). The importance of continuing professional development to career satisfaction and patient care: Meeting the needs of novice to mid- to late-career nurses throughout their career span. *Administrative Sciences, 7*(2), 17. doi:10.3390/admsci7020017

Purpora, C., & Blegen, M. A. (2015). Job satisfaction and horizontal violence in hospital staff registered nurses: The mediating role of peer relationships. *Journal of Clinical Nursing, 24*, 2286–2294. doi:10.1111/jocn.12818

Pytel, C., Fielden, N. M., Meyer, K. H., & Albert, N. (2009). Nurse-patient/visitor communication in the emergency department. *Journal of Emergency Nursing, 35*, 406–411. doi:10.1016/j.jen.2008.09.002

Rabøl, L. I., McPhail, M. A., Østergaard, D., Andersen, H. B., & Mogensen, T. (2012). Promoters and barriers in hospital team communication. A focus group study. *Journal of Communication in Healthcare, 5*, 129–139. doi:10.1179/1753807612Y.0000000009

Rudy, S., & Sions, J. (2003). Floating: Managing a recruitment and retention issue. *JONA: The Journal of Nursing Administration, 33*, 196–198. doi:10.1097/00005110-200304000-00002

Salas, E., & Rosen, M. A. (2013). Building high reliability teams: Progress and some reflections on teamwork training. *BMJ Quality & Safety, 22*, 369–373. doi:10.1136/bmjqs-2013-002015

Savickas, M. L. (2005). The theory and practice of career construction. In S. D. Brown, & R. W. Lent (Eds.), *Career development and counseling* (pp. 42–70). New Jersey: Wiley.

Seo, S., & Spetz, J. (2013). Demand for temporary agency nurses and nursing shortages. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing, 50*, 216–228. doi:10.1177/0046958013516583

Spreitzer, G. M., Cameron, L., & Garrett, L. (2017). Alternative work arrangements: Two images of the new world of work. A*nnual Review of Organizational Psychology and Organizational Behavior, 4*, 473–499. doi:10.1146/annurev-orgpsych-032516-113332

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques* (2nd ed.). Newbury Park, CA: Sage.

Street, R. L. (2016). Measuring the quality of clinician–patient information exchange. *Patient Education and Counseling, 99*, ix–xi. doi:10.1016/j.pec.2016.03.002

Street, R. L., Makoul, G., Arora, N. K., & Epstein, R. M. (2009). How does communication heal? Pathways linking clinician–patient communication to health outcomes. *Patient Education and Counseling, 74*, 295–301. doi:10.1016/j.pec.2008.11.015

Streeter, A. R., Harrington, N. G., & Lane, D. R. (2015). Communication behaviors associated with the competent nursing handoff. *Journal of Applied Communication Research, 43*, 294–314. doi:10.1080/00909882.2015.1052828

Strzalka, A., & Havens, D. S. (1996). Nursing care quality: Comparison of unit-hired, hospital float pool, and agency nurses. *Journal of Nursing Care Quality, 10,* 59–65. doi:10.1097/00001786-199607000-00009

Sveinsdóttir, H., Ragnarsdóttir, E. D., & Blöndal, K. (2016). Praise matters: The influence of nurse unit managers' praise on nurses' practice, work environment and job satisfaction: A questionnaire study. *Journal of Advanced Nursing, 72,* 558–568. doi:10.1111/jan.12849

Thomas, D. R. (2016). Feedback from research participants: Are member checks useful in qualitative research? *Qualitative Research in Psychology, 14*, 23–41. doi:10.1080/14780887.2016.1219435

Tourish, D., & Mulholland, J. (1997). Communication between nurses and nurse managers: A case study from an NHS Trust. *Journal of Nursing Management, 5*, 25–36. doi:10.1046/j.1365-2834.1997.02384.x

U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. (2014). *The future of the nursing workforce: National- and state-level projections, 2012-2025*. Rockville, MD: Author.

Van Bogaert, P., Timmermans, O., Weeks, S. M., van Heusden, D., Wouters, K., & Franck, E. (2014). Nursing unit teams matter: Impact of unit-level nurse practice environment, nurse work characteristics, and burnout on nurse reported job outcomes, and quality of care, and patient adverse events—A cross-sectional

survey. *International Journal of Nursing Studies, 51*, 1123–1134. doi:10.1016/j.ijnurstu.2013.12.009

Vandecasteele, T., Van Hecke, A., Duprez, V., Beeckman, D., Debyser, B., Grypdonck, M., & Verhaeghe, S. (2017). The influence of team members on nurses' perceptions of transgressive behaviour in care relationships: A qualitative study. *Journal of Advanced Nursing, 73*, 2373–2384. doi:10.1111/jan.13315

Wagner, J.-D., Bezuidenhout, M. C., & Roos, J. H. (2015). Communication satisfaction of professional nurses working in public hospitals. *Journal of Nursing Management, 23*, 974–982. doi:10.1111/jonm.12243

Wall, S. (2014). Self-employed nurses as change agents in healthcare: Strategies, consequences, and possibilities. *Journal of Health Organization and Management, 28*, 511–531. doi:10.1108/jhom-03-2013-0049

Wall, S. (2015). Dimensions of precariousness in an emerging sector of self-employment: A study of self-employed nurses. *Gender, Work & Organization, 22*, 221–236. doi:10.1111/gwao.12071

Watson, A. C., & October, T. W. (2016). Clinical nurse participation at family conferences in the pediatric intensive care unit. *American Journal of Critical Care, 25*, 489–497. doi:10.4037/ajcc2016817

Weaver, S. J., Dy, S. M., & Rosen, M. A. (2014). Team-training in healthcare: A narrative synthesis of the literature. *BMJ Quality & Safety, 23*, 359–372. doi:10.1136/bmjqs-2013-001848

West, M. A., & Lyubovnikova, J. (2012). Real teams or pseudo teams? The changing landscape needs a better map. *Industrial and Organizational Psychology, 5*, 25–28. doi:10.1111/j.1754-9434.2011.01397.x

West, M. A., & Lyubovnikova, J. (2013). Illusions of team working in health care. *Journal of Health Organization and Management, 27*, 134–142. doi:10.1108/14777261311311843

Wright, R. R., Mohr, C. D., & Sinclair, R. R. (2014). Conflict on the treatment floor: An investigation of interpersonal conflict experienced by nurses. *Journal of Research in Nursing, 19*, 26–37. doi:10.1177/1744987113485577

Xue, Y., Chappel, A. R., Freund, D. A., Aiken, L. H., & Noyes, K. (2015). Cost outcomes of supplemental nurse staffing in a large medical center. *Journal of Nursing Care Quality, 30*, 130–137. doi:10.1097/ncq.0000000000000100

Xyrichis, A., & Ream, E. (2008). Teamwork: A concept analysis. *Journal of Advanced Nursing, 61*, 232–241. doi:10.1111/j.1365-2648.2007.04496.x

Yost, P. R., Yoder, M. P., Chung, H. H., & Voetmann, K. R. (2015). Narratives at work: Story arcs, themes, voice, and lessons that shape organizational life. *Consulting Psychology Journal: Practice and Research, 67*, 163–188. doi:10.1037/cpb0000043

CHAPTER II

CHANGING TIMES: NURSE MANAGERS ON WORKING WITH NURSES IN ALTERNATIVE WORK ARRANGEMENTS

Overview

The concept of time has significant organizational implications, especially as it pertains to staffing needs. The nursing profession has seen changes in work arrangements as nurses retire, leave the profession, and change employment status. These changes affect how nurse managers recruit and retain qualified and suitable nurses. However, organizational scholars have not adequately studied how work arrangements, particularly the distinction between temporary and permanent work arrangements, affect coordination and feedback among nurse managers and nurses. I conducted one-on-one semi-structured interviews with 26 nurse managers to investigate how nurse managers communicate with temporary and permanent nurses. I offer two analyses that outline nurse managers' descriptions of their nurses' work arrangements and outline the feedback channels between nurse managers and their nurses, both temporary and permanent. These findings reveal that nurse managers communicate with their temporary and permanent nurses in similar ways using comparable media. Professional communication does not vary based on work arrangements, but work arrangements are associated with nurse managers' communication when it pertains to mentoring and performance.

Introduction

There's no such thing as permanent staff. People don't stay in a job for twenty years anymore, so I consider all people pretty much temporary. –Charlotte, Nurse Manager of 22 years

Organizational scholars have an enduring interest in the concept of time (Agypt & Rubin, 2012), partly because organizations and their employees commodify units of clock-based labor in exchange for other resources (Bluedorn & Denhardt, 1988; Butler, 1995). The social construction of time has traditionally framed non-work life around regular blocks of work hours (Ancona, Okhuysen, & Perlow, 2001), idealizing full-time permanent work as 9-to-5 workdays dedicated to a single employer at designated worksites (see Rubery, Earnshaw, Marchington, Cooke, & Vincent, 2002). That practice has evolved as changes to economic activities and structures have continually reshaped our understanding of employee-employer relationships (Foster & Mills, 2013). Perpetuated partly by employers' desire to contain costs and make profits (Ballard & Gossett, 2007; see also Conrad & Poole, 1997), employers have increasingly relied on temporary labor. The shift to temporary labor has necessitated that employees rethink and redefine the work-family boundary (Lambert, 2008; Piszczek & Berg, 2014), because contemporary "workers are now expected to control their uses of time in the simultaneous pursuit of careers and work-life 'balance'" (Kuhn, 2006, p. 1340).

Consequently, the traditional notion of a permanent 9-to-5 workday at fixed worksites is either no longer available to a growing contingent of workers who cannot secure such jobs given changing organizational structures or is not appealing to those workers who have different priorities outside of work. Flexible work policies and arrangements offer workers an employment path: individuals who cannot – or would rather not – commit to full-time work and who prefer alternatives to the traditional work arrangement (see Van Breugel, Van Olffen, & Olie, 2005). Alternative work arrangements (AWAs) constitute a new set of challenges and opportunities for both employers and employees as they negotiate how to best adapt to changing individual and organizational needs (Agypt & Rubin, 2012; Myers, Gailliard, & Putnam, 2013; Peel & Boxall, 2005).

AWAs have become one solution to the perennial problem of the global nursing shortage. For instance, hospitals utilize the versatility and flexibility of temporary labor in the form of float nurses – typically cross-trained with multiple skill sets – by assigning them to understaffed units (Hemann & Davidson, 2012; Larson, Sendelbach, Missal, Fliss, & Gaillard, 2012). Float nurses do not always know ahead of time on which units they will work and they may float to multiple units even within a single shift. Nevertheless, float nurses typically perform competently because they have received similar socialization, orientation, and training that unit-specific permanent nurses receive (Larson et al., 2012). While float pools are a strategic intervention to help hospitals meet staffing needs in a cost-effective manner, scholars have warned that the employment of contingent workers may negatively affect the workload of permanent workers (see

Connelly & Gallagher, 2004). Temporary nurses may also feel disconnected from and unappreciated by their colleagues, despite having the expertise that their temporarily-assigned units need (Jamieson, Williams, Lauder, & Dwyer, 2008).

The short-term temporary nature of AWAs presents a significant challenge that can affect health care delivery and communication. Nursing and management scholars have clearly identified communication as a crucial factor in individual productivity, coordination of work, and the promotion of trust among nurses (Feather, Ebright, & Bakas, 2014; Gittell, 2016; Holland, Cooper, & Sheehan, 2017). However, such research typically samples full-time permanent employees or does not report the employment status of their samples (e.g., Atefi, Abdullah, Wong, & Mazlom, 2014; cf. Lavoie-Tremblay, Fernet, Lavigne, & Austin, 2015). As a result, while we have some understanding of how nurse managers (NMs) may manage full-time healthcare workers and nurses, we have relatively little understanding regarding how NMs manage temporary healthcare workers and nurses in AWAs.

The present study addresses this gap in the literature by focusing on how NMs are similar and different in the way they manage full-time and temporary nurses. I begin by surveying how AWAs may affect the dynamics among nurses and NMs. Building on that scholarship, I then present the study's research design and provide an analysis of 26 NM interviews regarding the way they manage full-time and temporary nurses. I conclude by presenting the study's implications for understanding how nurses' work arrangements may influence how, what, and to whom NMs communicate.

AWAs, Nursing, and Management

Scholars typically categorize temporary or part-time work as "nonstandard" employment relations (Ballard & Gossett, 2007; Davis-Blake, Broschak, & George, 2003; Katz & Krueger, 2016; Van Breugel et al., 2005; see Connelly & Gallagher, 2004), which I collectively refer to as AWAs because such work arrangements supplement the "standard" work arrangement of full-time permanent jobs (see Spreitzer, Cameron, & Garrett, 2017). The use of AWAs has grown over the last two decades, given the emergence of the "gig" economy where full-time employees may work remotely from time-to-time or perform short-term projects on the side. AWAs complement and challenge the conventional, or "standard," boundaries of work and personal time (Ballard & Gossett, 2007). AWAs may influence the way nurses and nurse managers experience work time on relationships as well as organizational outcomes and processes such as patients' overall satisfaction and their satisfaction with how nurses communicate with them.

Work Time and Relationships

Variations in work arrangements shape workers' experience of work time and temporal structures such as schedules and deadlines (Agypt & Rubin, 2012). This is important because worker's experience of work time, in turn, may shape the way temporary workers relate to their colleagues (Ballard & Gossett, 2007). In other words, temporary arrangements make temporary employees have more of a transactional and not relational contract with their employers (see Van Breugel et al., 2005). The employment of temporary/contingent workers can also alter organizational

communication, affect workers' work-life balance, and make permanent workers question traditional work arrangements (Gossett, 2001). Moroever, scholars have widely held that the blended workforce weakens manager-employee relationships. Nationwide data revealed that permanent staff dissatisfied with having colleagues who work AWAs exhibited increased intentions of leaving their organizations, increased intentions of joining labor unions, and decreased organizational loyalty (Davis-Blake et al., 2003).

It seems fairly reasonable then that the ways in which workers talk about workplace commitments in terms of time commitments and allocation may shed light on issues such as identification and identities (Kuhn, 2006; Van Breugel et al., 2005). On one hand, permanent workers may ponder whether their organizations may one day deem them disposable (Conrad & Poole, 1997). Such doubts can affect permanent workers' relationships with colleagues and member identification. Empirical research has shown that the employment of contingent workers increases labor costs associated with absenteeism and turnover among permanent workers (Way, Lepak, Fay, & Thacker, 2010). On the other hand, temporary employees may find themselves caught in a bind when they receive conflicting instructions from their staffing agencies and their temporary organizations (Gossett, 2006; Rubery et al., 2002). In such situations, the member identification of temporary workers may become a contentious issue that has practical implications for all parties involved as managerial practices involving temporary workers may limit them from fostering and maintaining meaningful relationships (Gossett, 2002). Both permanent and temporary workers may have varying types and levels of member identification with the organization which may result with

them cultivating different types of relationships with colleagues, managers, organizations, and their profession.

Work Time and Organizational Outcomes

At the organizational level, job dissatisfaction among nurses influences turnover intention and attrition (Atefi et al., 2014). As hospitals meet the needs of its patient population through flexible labor such as temporary nurses (Larson et al., 2012), who satisfy some of the present staffing demands especially from hospitals that view them as economically-viable (and expendable) alternatives to permanent nurses, staffing issues become a concern because the temporary labor dynamic can profoundly shape institutional stability and development (Lawrence, Winn, & Jennings, 2001). Although nonpermanent nurses help hospitals satisfy regulatory and institutional requirements such as nurse-to-patient ratios, nonpermanent nurses' unfamiliarity with their new environments can cause communication delays and may decrease their and permanent nurses' job satisfaction.

One's tenure at a given organization impacts his/her job satisfaction. A recent analysis of nationally-representative samples collected over four decades noted that workers' job satisfaction decreased as their tenure at any specific organization increased (Dobrow Riza, Ganzach, & Liu, 2016). Workplace interactions offer a possible explanation for this finding. Workers in flexible arrangements may experience delays as work patterns become less linear, resulting in high communication overload and low satisfaction with interdepartmental interactions (Ballard & Seibold, 2006). One may reasonably infer, especially in fast-paced clinical settings where nurses must multitask,

that nurses' conception of time at and in relation to work will affect their job satisfaction (cf. Agypt & Rubin, 2012). For instance, Australian nurses who prefer the night shift reported benefits such as greater nursing autonomy and the avoidance of some conflicts more commonly experienced during the day (Zannini, Ghitti, Martin, Palese, & Saiani, 2015). The duration and events that take place at work therefore affect how nurses describe their work experiences and how they interact with their coworkers, which further shape nurses' perception of time and reinforce preferences for certain work arrangements so that they avoid specific frustrating or negative work experiences.

While stable nursing teams improve patient outcomes (Hudgins, 2016), a high reliance on temporary nurses such as contract nurses can negatively affect not only patients' overall satisfaction but also patients' satisfaction with how nurses communicate with them (Hockenberry & Becker, 2016). Furthermore, since contract nurses only work on temporary or part-time basis, frequent turnovers within nursing teams exacerbate poor communication among nurses (Batch, Barnard, & Windsor, 2009; Batch & Windsor, 2015).

Furthermore, temporary workers who receive instructions from two sets of supervisors pose a unique managerial challenge. This scenario happens most frequently with agency-based temporary workers, who oftentimes find themselves in conflicting employment relationships where both their agencies and client organizations simultaneously exert influence on them (Gossett, 2006). Multi-employer environments blur employment boundaries and can easily create thorny employment relationships muddied by ambiguous communication channels over conflicting issues such as

supervision, discipline, and grievance (Rubery et al., 2002). Hence, the introduction of temporary workers and an external third party complicate managerial practices.

The Present Study

Sparse scholarly knowledge on the effects that AWAs have on workplace communication and relations becomes problematic because it lags developments in the nursing profession. While professional standards guide formal communication such as how nurses must chart patients' records, day-to-day communication among NMs and their nurses do not have similarly regulated guidelines. Much of manager-nurse communication, nevertheless, constitutes professional communication that serves the same patient-centered purpose as formal communication. This dearth of research on how AWAs affect NMs' downward and upward communication as a function of unit/department management limits scholarly and practical insights into whether the employment of nurses in AWAs alters the ways that NMs work and communicate with their nurses.

The purpose of this study is to investigate how NMs work with nurses in AWAs. This essay addresses this concern and advances knowledge by considering nurses' AWAs as a form of labor distinct from employees who work the traditional 9-to-5 work arrangement (see Peel & Boxall, 2005). Research must keep pace with how changes in work arrangements "affect how work is done, how people feel about their work, what their orientation toward work is, and the role of work in their lives" (Spreitzer et al., 2017, p. 486; see also Gossett, 2002). NMs must understand their nurses' needs and

concerns, such as job satisfaction and stress, to effectively interact with their nurses so that work gets done (see Marx, 2014; see also Wei, Chiang, & Wu, 2012).

Scholarship has generated limited insights into how nurse manager-nurse communication facilitates supervisor support and employee engagement in a world of AWAs. Despite the burgeoning interest in how managers should engage and support their nurses (e.g., Holland et al., 2017; Marx, 2014), the literature has broadly bundled AWAs in nursing as a concern with issues like cost and quality of care (Institute of Medicine, 2004; Maenhout & Vanhoucke, 2013; May, Bazzoli, & Gerland, 2006; Xue, Chappel, Freund, Aiken, & Noyes, 2015). In other words, scholarship has not only largely neglected the effects of NMs' communication behaviors on nurses (Kunie, Kawakami, Shimazu, Yonekura, & Miyamoto, 2017) but has also neglected nurses' AWAs as a managerial communication concern. Indeed, studies conducted on the quality of manager-nurse interactions have broadly focused on organizational hierarchies and structural dynamics, but not communication dynamics (see Marx, 2014; see also Agypt & Rubin, 2012). The surprisingly light scholarly discourse on how AWAs may influence NMs' communication with their nurses in different work arrangements (i.e., the channels they use, whether topics vary between nurses in different work arrangements, as well as the depth and quality of those interactions) does not promote a deep understanding of AWAs' impact on how NMs engage with their nurses.

Transient work relations can affect not only coordination among nurses (see Gittell, 2016) but also the way NMs work, especially since giving feedback is an important managerial responsibility (Sveinsdóttir, Ragnarsdóttir, & Blöndal, 2016). NMs

who provide insightful feedback must pay careful attention to the extent of their nurses' past and present clinical experience because those experiences can have an impact on patient outcomes. Variations in duration and clinical exposure afforded by different AWAs complicate NMs' evaluation of the qualifications that new nurses bring to their units. A nurse who works on a low census unit will have a different experience than a nurse working on the same shift but with high acuity patients; one can also conceive possible differences in workload and responsibilities among shifts based on whether nurses receive adequate support such as onsite nurse educators and nursing assistants (West, Rudge, & Mapedzahama, 2016). Thus, AWAs complicate the calculus of whether, how, and whom NMs mentor.

Given the lack of research exploring the relationships among NMs, nurses, and AWAs, two research questions guided this line of inquiry.

RQ1: *How do NMs categorize and perceive AWAs?*

RQ2: *How do NMs communicate with Nurses in AWAs and Nurses not in AWAs?*

Method

Because scholars know relatively little of NMs' communication effects and practices on nurses (Kunie et al., 2017; Marx, 2014), I conducted this investigation using an interpretive approach. This approach allowed me to inductively explore the lived experiences of a target population. The open-ended nature of the semi-structured interview protocol I employed also gave me flexibility to refine and include additional questions, in line with theoretical sampling. In-depth, semi-structured interviews were an appropriate method for this study because "individuals have unique and important

knowledge about the social world that is ascertainable and that can be shared through verbal communication" (Hesse-Biber & Leavy, 2011, p. 94; see also Hugh-Jones, 2010).

Ethical Considerations

Researchers' moral integrity ensures the trustworthiness and validity of the research findings (Hesse-Biber & Leavy, 2011). I first sought approval from my institution's Institutional Review Board (IRB). Upon receiving IRB approval and in accordance with the approved IRB procedure, my colleagues at several professional nurses' organizations disseminated the recruitment statement to their members. Interested members contacted me directly to schedule interviews. As part of the informed consent process, I explained to them how I would use the data and protect their identities (Hesse-Biber & Leavy, 2011): quotations used in this essay do not have identifiable details and I refer to my participants using pseudonyms. Before the interviews, I reminded participants about the voluntary nature of research and that they may freely decline or end the interview at any time. Finally, I asked them if I may audio record the interviews for transcription and data verification purposes.

Sampling

Initial participants who informed me on my research question concerning NMs' communication patterns came through *purposeful sampling* (Lincoln & Guba, 1985). I recruited subsequent participants via *theoretical sampling*, which yielded informants whose insights added relevant data to the emerging themes and grounded theory (Gordon-Finlayson, 2010). The iterative process of on-going analysis involving theoretical sampling ended when I reached *theoretical saturation*, which signified the

point where my participants began to repeat information that did not add to my conceptual categories (Glaser & Strauss, 1967). At this point, I concluded the participant-recruitment phase.

Data Collection

The intentional selection of participants through purposeful sampling and theoretical sampling allowed me to learn from multiple purposive perspectives on the central phenomenon and to immerse myself into my participants' culture (Hesse-Biber & Leavy, 2011). I conducted the interviews at times that worked best for my participants. Several interviews did not take place in one session due to emergencies or interruptions; at my participants' choosing, we rescheduled and continued those interviews at another time. Most of the interviews took place over the telephone, with the exception of one Skype interview and one face-to-face interview. My participants chose their preferred interview media based on practical considerations.

The interview guide centered around questions that would help me gain insights into how they worked with their nurses. My participants spoke on topics such as: their communication patterns with nurses in different work arrangements; situations where work arrangements may yield different communication patterns; topics and issues that nurses in different work arrangements would raise to them; communication patterns that they observed among nurses in different work arrangements; and the concerns that nurses in different work arrangements have.

Table 2 Participants' Demographic Information.

Pseudonym	Location (USA)	Age	Highest Education Obtained	Gender	Ethnicity
Emma	South Atlantic	58	Masters	Female	White
Olivia	South Atlantic	51	Doctorate	Female	White
Ava	South Atlantic	65	Masters	Female	White
Sophia	Middle Atlantic	56	Doctorate	Female	White
Isabella	Middle Atlantic	56	Masters	Female	--
Mia	Middle Atlantic	61	Masters	Female	White
Charlotte	East North Central	62	Masters	Female	White
Harper	Middle Atlantic	39	Bachelors	Female	White
Amelia	West South Central	54	Bachelors	Female	White
Abigail	South Atlantic	67	Masters	Female	White
Emily	South Atlantic	55	Masters	Female	White
Lily	South Atlantic	58	Bachelors	Female	White
Ella	Middle Atlantic	29	Masters	Female	White
Avery	Middle Atlantic	66	Doctorate	Female	White
Evelyn	South Atlantic	55	Bachelors	Female	--
Jessica	Middle Atlantic	49	Masters	Female	White
Amanda	West North Central	45	Bachelors	Female	White
Ashley	Middle Atlantic	36	Masters	Female	White
Sarah	West South Central	40	Bachelors	Female	Asian
Stephanie	South Atlantic	51	Bachelors	Female	White
Heather	South Atlantic	46	Bachelors	Female	Asian
Elizabeth	Pacific	52	Bachelors	Female	White
Michelle	East North Central	31	Bachelors	Female	White
Tiffany	West South Central	33	Bachelors	Female	White
Kimberly	West South Central	44	Bachelors	Female	White
Erin	South Atlantic	46	Masters	--	--

The best and most appropriate participants must be willing to readily share their stories and satisfy the inclusion criteria (Hesse-Biber & Leavy, 2011), namely: (1) participants must be registered nurses (RNs) who were managing or had managed clinical settings and (2) were directly supervising or had supervised other nurses. Twenty-six NMs participated in this study. Each participant had between 4 and 46 years of RN experience (M = 25.17, SD = 11.26); each participant had between 2 and 36 years

of experience as a NM (M = 10.73, SD = 9.08). All participants had at least a Bachelor of Science in Nursing. Table 2 provides the demographics of my participants.

Excluding time used for administrative tasks such as acquiring informed consent and conducting post-interview debrief, the interviews lasted between 26 and 69 minutes (average time 46.99 minutes). The interviews generated 1,221.86 minutes of data. Verbatim transcription yielded 206 single-spaced pages. All but one participant gave audio-recording permission; I documented the unrecorded interview by taking detailed notes throughout and after the interview.

Data Analysis and Trustworthiness of the Data

Data analysis transpired throughout the data collection process, in which I managed the data, transcripts, and contact records to ensure data trustworthiness. The constant-comparative method of microanalysis (Strauss & Corbin, 1990) provided a rigorous basis for data collection and analysis. I inductively analyzed the data as I conducted interviews until theoretical saturation. I identified emergent themes using *open coding* (Lindlof & Taylor, 2011; Strauss & Corbin, 1990), which came from initial concepts grouped into categories. I completed iterative readings of the transcript during this process so that codes and themes emerged instead of my imposing preconceived categories on the data. In addition, I also: (1) discussed the data's emerging patterns with other field researchers (Creswell & Miller, 2000); (2) verified emerging themes with latter interviewees through member checks (Miles & Huberman, 1984; cf. Thomas, 2016); (3) used thick, rich descriptions in the findings section (Creswell & Miller, 2000); and (4) reflected upon my role as the researcher, as expanded upon in the next section.

Researcher's Role

Researchers' positionalities play a crucial role in qualitative research because qualitative researchers design their studies and interpret their data through the lens of their lived experiences (Frey, Botan & Kreps, 2000). That means that I, the researcher, must practice self-reflexivity as I examine my personal assumptions in light of the research process (Hesse-Biber & Leavy, 2011). My background as a former combat medic helps me appreciate the contributions made by healthcare professionals and gives me a useful insider's perspective (*emic*) from the outside (*etic*) into the concerns of healthcare professionals (Lindlof & Taylor, 2011). I take the epistemological position that everyone has different lived experiences and that these differences create socially-constructed meanings (Hesse-Biber & Leavy, 2011). The events that different people experience can yield different subjective meanings as they make sense of those experiences in light of their preconceived notions. This sensemaking process also means that my participants and I co-construct subjective realities through our interactions. Consequently, I hold an ontological view that there are multiple versions of "truths" just as there are multiple socially-constructed versions of lived experiences. My epistemological and ontological assumptions align with the interpretive, qualitative methodology.

Findings

RQ1: How Do NMs Categorize and Perceive AWAs?

To understand whether AWAs would impact how NMs work and communicate with their nurses, I first investigated how NMs described work arrangements. One of the

first questions on my interview guide was to learn what "temporary nurses" meant to my participants. Their collective definition of temporary nurses is best expressed as *nurses who are "not part of our core team" (Elizabeth, 141) "but they come in to fill holes" (Emma, 1).* Lily, a pediatric oncology nurse with 36 years of RN experience, put it succinctly, "having travelers go in while you're trying to look for permanent employees, it helps your permanent staff." (91). From a practice perspective, their definition mirrors the increasing prevalence of team-based care observed in international healthcare systems (Doherty & Crowley, 2013; Norful et al., 2017). The similar ways that my participants categorized their nurses in terms of teams created a permanent-temporary distinction by way of using their units' staff nurses as the reference point as well as nurses' tenure and anticipated tenure on their units. Intuitively, participants viewed temporary nurses as non-staff nurses.

An appreciation of how NMs explicate their conception of temporary nurses gives an insight into a key presupposition: NMs think of their nurses in terms of teams. My participants and their staff nurses expect that temporary nurses will adapt expeditiously and contribute as part of the team. They typically provide temporary nurses with an abbreviated orientation to get them off "on the right foot" (Emily, 83) and "up to speed" (Abigail, 68; Emily, 80; Michelle, 173; Olivia, 18). Their emphasis on getting temporary nurses "up and running" very quickly (Abigail, 79; Sophia, 26) "right out of the gate" (Harper, 56) underscores that time is of the essence, therefore acknowledging AWAs as a clinical approach toward meeting patient care standards as

well as a strategic organizational feature of cost containment and human resources management.

My participants' definition offers two fundamental insights into how they view their nurses. First, NMs view permanent nurses as those who work exclusively/mostly for their units; put differently, they express a degree of belongingness of permanent nurses as invested members that provide dependable and long-term stability to their respective units. By implication, individuals share common work identities, appreciate one another's personalities, and foster workplace relationships developed over time and into the future as they can reasonably anticipate continued interactions as colleagues on the same units. Note that only two participants referred to their nurses as family: While nurses do get comfortable with one another over time, the high-stakes work that they perform may require that they keep a professional distance between one another. Second, NMs shoulder the responsibility of finding replacement nurses – whether temporary or permanent – for their understaffed teams. The second insight reinforces the previous insight regarding the seriousness of nursing work. It also alludes to key managerial responsibilities of maintaining nurse-to-patient ratios and performing human resource functions such as recruitment and retention.

Participants are concerned about whether temporary nurses' personalities will fit in with their teams. Just as they intuit the permanent-temporary distinction from their units' perspective, NMs are concerned about how their staff nurses will receive temporary nurses because staff nurses "usually raise issues about teaming… Supplies, equipment, teaming, and staffing—I would say are the four big ones." (Ashley, 139).

Ashley summarized that the temporary nurses whom her staff nurses enjoyed working with were "so good at being a nurse they then can just jump in and be a regular part of the team" (134). Harper (nonprofit hospital, level-2 trauma) also stated similarly,

> If within their [i.e., temporary nurses] personality they buy-in to the type of care that we wish to have for out-patient, we do not have an issue with them. If they are doing their best, if they are competent and they buy-in to the team concept of being helpful to other nurses in reciprocal as being helpful, we do not have a problem. If we have a nurse that does not have the personality, they're just coming in there for maybe the money and doing the job and they're not wholeheartedly buy-in into the best patient care, it's just a job to them, then we have an issue. (23-24)

Thus, whenever possible, NMs interview temporary nurses carefully to ascertain their personalities and they assign incoming nurses (if within their control and when circumstances permit) to work with nurses whom they believe will work well together.

The permanent-temporary distinction becomes most salient when participants talked about their expectations of temporary nurses. Charlotte, who has 22 years of NM experience and works at a 500+-bed teaching hospital, had this expectation, "They need to view their role as being part of *a team member*, whether it's for a day or for a year" (43). Michelle, a Millennial in her second year as a NM, narrated her recollection of a temporary nurse when she was a nurse assistant:

> [W]e had an agency nurse who worked in our unit for a long time. Her contract was up and they renewed it so she was there. Everyone respected her. *She really*

> *became part of the team* because she was there for several months and that's how I knew she was an agency nurse. (172)

Productive temporary nurses must not only want to "be a part of the team" (Emma, 2; Erin, 201), but must also onboard quickly to become "part of the team" (Heather, 160). Thus, my participants instinctively classified temporary nurses as those who *do not originally belong to their units and whose purpose is to serve immediate needs.*

Participants acknowledged that "to bring everyone together as a team to work is a challenge" (Erin, 205). One way that NMs onboard temporary nurses is to treat and communicate with them like their staff nurses:

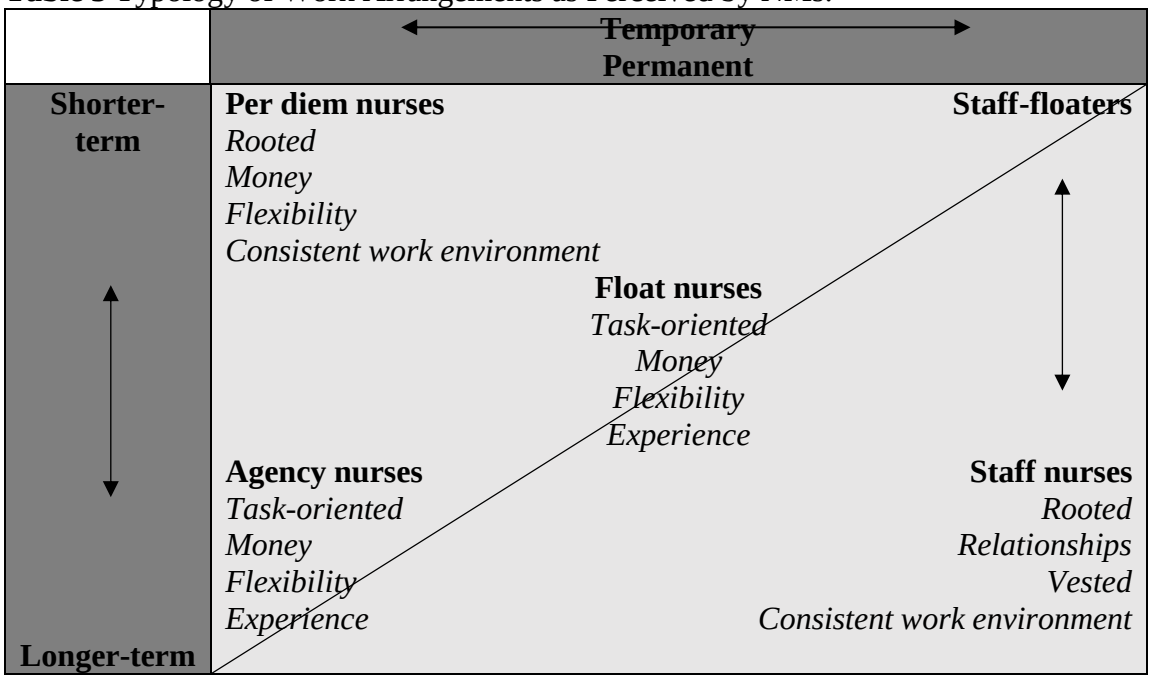
> We have huddles every shift so we bring them in where we can introduce them to all the people on their team that are coming on right then. And then give them assignments and so that they can all work out there as a team. And we include them, you know, wearing an emergency department jacket is a feather in their caps. They get things like that to be part of the team. (Emma, 3)

The exemplar-quotations considered so far reveal NMs' conception of patient care delivery as a collective team effort. NMs and their nurses work toward that goal when staff nurses welcome the help that temporary nurses bring to their units while temporary nurses adapt quickly and perform tasks diligently. Since current team members (i.e., permanent, staff nurses) and new team members (i.e., temporary, non-staff nurses) support one another in different ways, this insight suggests that nurses of different work arrangements serve different functions. The next section illustrates the representative features of different work arrangements that make them uniquely attractive to nurses.

Distinguishing among types of temporary and permanent work arrangements. The second part of my RQ1 analysis builds on the permanent-temporary distinction and presents Table 3 as a visual summary of the distinction between different types of permanent and temporary nurses as well as their similarities and differences. This model highlights two considerations that NMs used to differentiate among different types of work arrangements. The vertical axis represents a continuum of shorter-term nurses (who may work a complete shift or a part of it) to longer-term nurses (who are scheduled to work for a number of shifts, if not for perpetuity). The horizontal axis represents a permanent-temporary continuum. Although per diem and agency nurses are generally more temporary than float and staff nurses, staff nurses may occasionally float to understaffed units, thereby making staff nurses "temporary" in those instances. Float nurses occupy the center of this framework because one may view float nurses as permanent (from the perspective of float pool units) yet temporary (from the perspective of the units that utilize float nurses). A diagonal line cuts across from the lower-left corner through the upper-right corner to emphasize the notion that units customarily employ temporary nurses on a shorter-term basis and permanent nurses on a longer-term basis.

Nurses whom my participants labeled as temporary nurses fall under four distinct AWAs: (1) staff-floaters, (2) per diem nurses, (3) agency nurses, and (4) float nurses. The data analysis suggests five major work arrangements. My participants' descriptions of these five types of work arrangements aligned with broad categories of temporary nurses reported in the literature (e.g., Hemann & Davidson, 2012).

Table 3 Typology of Work Arrangements as Perceived by NMs.



Participants consistently described agency, float, and per diem nurses using the descriptors of *Money* and *Flexibility*. Other practitioners and researchers have also identified these two descriptors in their work on these AWAs (e.g., Adam, Kaplow, Dominy, & Stroud, 2015; Shinners, Alejandro, Frigillana, Desmond, & LaVigne, 2016). *Money* refers to the differential pay that nurses on AWAs receive in comparison to what permanent or staff nurses receive. *Flexibility* refers to both employment flexibility (there are many configurations of work schedules in which nurses are employed) and nurses' flexibility (to adapt themselves to the challenges they find at work). I will provide illustrative support for these five work arrangements below.

Staff nurses. *Rooted.* Similar to per diem nurses, staff nurses opt for a work arrangement that keeps them in their communities. Although nurses know that they can earn differential allowances by picking up additional shifts as per diem nurses or by performing 13-week travel-contracts as agency nurses, Ella (a NM in a 42-bed post-operative joint-replacement unit) said that some nurses preferred permanent positions chiefly because obligations "like family responsibility" keep them rooted in their local areas (106). Sophia, who works at a 900+-bed nonprofit acute care hospital, shared her analysis with me, "travelers are the ones that don't have family obligations at home because it is very difficult when you have children …Usually, travelling is seen as an early job entry or work after kids are grown" (27). Emma, employed by a large level-1 trauma tertiary care center, recognized the same reasons and in the same breath disclosed the curiosity that almost every nurse has about the adventures of travel nursing:

> [Permanent nurses] don't have the ability to go anywhere. You've got kids in school. You don't want to be out there traveling. You have home obligations. Quite frankly, we have lost a fair number of nurses [who have become travel nurses]. Some are older. Some of the ones who have left are younger. …sometimes you can't blame them for why they go out to see what's out there. (7)

Indeed, travel nurses may talk about what "it was like someplace else. The nurse that's just in this hospital all the time sometimes gets fascinated by all the stories they [travel nurses] have to tell" (Abigail, 75). Mia, who supervises other NMs at a 200+-bed community hospital, concurred, "Most of them have family connections or whatever that

keeps them here. Most travel nurses, while they'll share their stories and the glamor of traveling all over the world, don't try to influence the nurses here to go travel" (41). It seems that staff nurses will try travel nursing if they can but they ultimately value relationships the most.

Mia's account reinforces the notion that temporary employees do make permanent employees rethink traditional work arrangements (Gossett, 2001). Participants' view of *rooted* staff nurses appears negatively-framed, as they perceive staff nurses would have travelled or worked elsewhere if they did not have family obligations. It also seemed that staff nurses shouldered a significant financial burden, which required them to work permanently in full-time staff positions as opposed to more flexible arrangements of shorter hours.

Relationships. NMs see staff nurses as not only valuing familial relationships but also as valuing the establishment of relationships with colleagues. Three participants identified their staff nurses as "my people," suggesting that this descriptor embeds an us-them premise in the permanent-temporary distinction. Kimberly (third-year NM with 20 years of RN experience) established a work culture based on trust and open communication:

> I'm a little more transparent with the people that belong to me. Because they're mine and they understand that's the way I am. I am a big believer that you should be very transparent in all aspects of the organization – fiscal, regulatory – everything that I know, my people know. (188)

Participants build relationships through open communication with their staff nurses, especially with increased proximity and interactional frequency. Olivia, who works at a 1000+-bed teaching hospital and has 8 years of NM experience, discerned these relational differences:

> [Y]ou tend to know your permanent employees better. I think a permanent employee's more likely to tell you things than the temporary [employee]. The temporary people don't know you, they're only there for a short period of time, so they might not be as forthcoming. You also don't know their background as well, you don't know their personalities as well. (11)

Nevertheless, "When they wanted to join us, it was because they recognized that the teaming and the culture we had on our units was something that they wanted to be a part of" (Ashley, 134). The right work culture keeps nurses and cultivates those relationships.

The relationships that NMs foster with their staff nurses have a greater social and personable element, in contrast to the more transactional approach usually observed in temporary workers (see Van Breugel et al., 2005). NMs treat their staff nurses at a higher interpersonal level because they view them as integral members who are long-term contributors to their core teams.

Vested. Because of their rootedness and relationships, staff nurses demonstrate a vested interest in their organizations and they voluntarily articulate ways that their units can change or improve. Lily explained:

> [T]hey sometimes raise more things that have to do with the unit and the team and they look at issues in the unit… because they're going to be there for the

> long haul, if there's something that's frustrating in the workflow… they are more engaged at trying to improve those things, whereas the traveler knows that he or she will be gone in 13 weeks. (97)

Staff nurses' commitment reveals their high member identification with their organizations (Kuhn, 2006; Van Breugel et al., 2005). They communicate their thoughts more frequently because they take ownership of the concerns that they have – or problems that they observe – in their work environments. If they remained silent, they must then bear with the consequences or accept their work conditions. However, this descriptor indicates that the anticipated permanence of one's job will make the person more vocal about improvements as compared to more itinerant employees and those with less frequent or shorter footholds.

Consistent work environment. Finally, staff nurses find comfort in familiarity. Abigail categorized them this way:

> They don't like to get outside of their box. They are very comfortable in their geographical location, they have four walls, they know the patient population that they're dealing with, they know their coworkers, they know where their stuff is, they know predictably what's going to happen on any given day; they may have a busy day or a slow day, whatever, but the days are pretty much the same, and that comfort level is good for some people. Some people like that, some people need that. (71)

This final descriptor ties together the preceding descriptors and provides an overarching explanation as to why permanent nurses stay as permanent nurses, despite the attractive features of temporary-nurse work arrangements.

Staff-floaters. The second work arrangement is staff-floaters, who are one of the four AWAs (top-right quadrant on Table 3). Staff-floaters are temporarily a subset of staff nurses who float to understaff units only when there are greater needs in other units. Functionally, they become temporary nurses when they fill gaps in other units.

Hospitals may float their staff nurses when required, said Sarah, "At our facility you have to float. If it's within your scope, you really don't have a choice. It follows a rotation in each department. … [an] overstaffed floor will send a nurse to the floor needing help" (142). Amelia disclosed, "I am a working manager, meaning that I will actually go along and work beside them. So, if we're short-staffed, I'll be that float person to go in and work with that team through the day" (64). Hence, they are characteristically staff nurses and they retain their staff-nurse descriptors because their main responsibilities are still with their primary units.

Per diem nurses. *Rooted.* These nurses live in the local area and work part-time mostly for work-life balance. Elizabeth (18th-year NM with 31 years of RN experience) exemplified a conversation she recently had with a nurse who chose to work per diem:

> [S]he's so happy doing that. … that position lends itself to even more control over her schedule. … [referring to this Millennial] she wants to have this perfect work-life balance. So, she doesn't want to work any Tuesdays because that's when her sons have soccer. Well, she doesn't want to work any Fridays because

> that's the day she takes yoga. And so, she can work per diem, she can completely control when she works …and she gets paid a tiny bit more to do that. So, I think there's a financial incentive as well as complete control over her schedule. (165)

Michelle also gave a similar account based on her experience with temporary nurses in general and per diem nurses in particular, "Their husbands are working so they're kind of bringing in extra income but they don't have to work full-time and they need the flexibility to work around their child care" (172). Per diem nurses cherish flexibility because they prioritize their non-work lives over their work identities; they prefer to dedicate their energies to family responsibilities and to participate in personal activities meaningful to them.

NMs construed per diem nurses' rootedness more positively than how they characterized staff nurses' rootedness. They interpreted a higher degree of choice for per diem nurses' preferred work arrangement, implying that per diem nurses "work to live" as they valued engagements outside of work while staff nurses "live to work" because of family and financial obligations. Participants' perception of per diem nurses chiefly reflected young mothers who do not mind not working a full-scheduled week because they have an active excise regiment and they want direct childrearing involvement. This descriptor alludes to the value that these nurses place on their local communal relationships, such as those with their nuclear families and non-work engagements at a gym. Thus, NMs perceived per diem nurses as those who embrace work-life balance, who do not shoulder the main financial burden of their families, and who view the extra income an added benefit.

Money. Aligned with the analysis for the earlier descriptor, participants perceived per diem nursing as an alternative to earn supplemental income. Erin, who works at a Veterans Affairs hospital, commented, "They're there for the money, to make extra money. They're there, they're out." (197). Just as in Michelle's comments in the earlier descriptor, some of the per diem nurses work so that they supplement their families' main income source.

Flexibility. Elizabeth gave a hypothetical example where per diem nurses at her hospital could choose their schedules, "[Y]ou can call Sue and say, 'Hey can you pick up a shift tomorrow? We're really busy.' And then she can say yes or no as long as she's already met her other monthly requirements" (165). This descriptor ties back to the *Money* descriptor and that these nurses can pick up last-minute shifts because their *Rooted* presence in the local community makes proximity less of an issue.

Consistent work environment. They not only get to choose when they work but also where they work. Tiffany, who works in an intensive care unit at a level-1 trauma teaching hospital, analyzed, "PRNs usually tend to fall into two different groups. There're nurses that only work for us and they're PRN for us, or they're nurses who have another full-time job, and they'll work PRN for us" (183). Michelle had a personal example, "I have one who is a nurse practitioner who wants to stay on in our unit after she has finished nurse practitioner school." (172). Nurses may also view per diem nursing as a way "to get their foot in the door" (200), as Erin told me about a nurse who worked a once-a-week schedule for her even though this nurse had a full-time position at a hospital closer to where she lived. Per diem nurses commonly want a consistent work

environment because they value familiarity with the organizations, community, and people. They also work per diem so that they increase their access to alternative employment opportunities that may become available in the future. The other benefits listed in the above three descriptors also appeal to these nurses.

Agency nurses. *Task-oriented.* Participants normally compliment agency nurses – also known as travel nurses or travelers – as competent and independent. However, they noticed that agency nurses had less interest in cultivating relationships with patients than nurses in other work arrangements. Stephanie, who has 40 direct reports and works in a neurosurgery department of a level-1 trauma hospital, remarked, "They're not very concerned about individual care of patients. They do the orders. They follow the orders but …they know they're just there a short time. They're not very attached to the patients at all" (152). This criticism seemed largely consistent among other participants. Lily praised travelers as "relatively good nurses" but that they only "do their job on the unit" and not engage with others as much as permanent nurses (88). Abigail had an explanation as to why travelers kept mostly to themselves, "Now some of them are very gregarious but some of them are rather quiet, and they may have been burned somewhere else, and so they sort of stay to themselves until they know that they're welcomed" (74). It seemed plausible that agency nurses only focused on completing tasks because units would employ them because they need their expertise. Because agency nurses possess sought-after expertise, they also command a higher hourly rate.

Money. Agency nurses seek employment opportunities that will pay them well, as Charlotte told me about the situation at her hospital. Charlotte works for a hospital

network in an urban but rather isolated Northeastern location. That region had some difficulty in retaining nurses:

> We don't typically get local nurses, we get nurses that like to travel home for a week at a time. … They want to go back home and to their families, which we completely understand …they're really doing it financially, because maybe there aren't local opportunities, or the salaries locally are so low. These are primary breadwinners. (47)

Similarly, Olivia qualified the perception that travelers "make a lot more money, because they're willing to go at a moment's notice" (9). But to earn that higher remuneration, they must have the tenacity to adapt quickly to different geographical and work environments.

Flexibility. Olivia stated, "They tend to be very well-trained, they can jump right in" (9), and that meant that they do not require the lengthier orientation that new graduate nurses would need. Evelyn, a NM at an orthopedic hospital, agreed, "They are expected to adapt really quickly to their roles. They don't need a lot of orientation. They have learned to how to get you through a rough patch in your staffing" (115). Much of their flexibility comes from having gained exposure to and experience in different settings.

Experience. They travel and work as a lifestyle choice. Lily outlined two types of agency nurses, "the two groups of travelers—there's the one that travels for money and the one that travels so that they can travel. They go to places that they wouldn't ordinarily be able to go to." (92) This descriptor shares similarities with the same

namesake for float nurses: Agency nurses thrive in working in geographically dispersed locations while float nurses thrive in working in different units within their organizations.

Float nurses. *Task-oriented.* Participants generally had a positive impression of float nurses' competency, but they also remarked that float nurses seemed less interested in patient care than nurses in other work arrangements other than agency nursing. Stephanie, recognizing float nurses' permanent employment status and affiliation with their hospitals, concluded, [T]hey are a little more involved with taking care of their patients, so a little bit more involved with knowing the staff and speaking to the staff. Traveler nurses pretty much come in, do their job and leave" (152). Mia shared the same view. She opined that float nurses had higher levels of ownership than travel nurses and would strive "to interact very positively with the patients no matter [which] unit they're working on." (36).

Money. By Stephanie's estimation, "travelers are probably the highest rate of pay and the temporary float pool nurses are the next highest rate of pay" (153). This descriptor appears for three of the temporary AWAs, but not for staff-floaters because staff-floaters are essentially staff nurses who float (and become temporary nurses temporarily) not by their choice but due to fluctuating patient acuity and census. This descriptor explains that nurses who voluntarily work AWAs receive a differential allowance in recognition of their versatility in clinical and social skills as well as their flexibility and adaptability to work in different clinical settings and teams on very little notice. Expressed differently, hospitals value nurses who can fill gaps.

Flexibility. They provide their organizations with added staffing flexibility, "float nurses came up pretty much through shortage and through seeing agencies out there doing this. It was a way of mimicking the agencies" (Avery, 108). Nevertheless, Jessica (progressive care unit, level-1 trauma) observed that float nurses must adapt quickly to new environments, "[W]hen you are a float nurse, you should have the ability to step into any situation, orient quickly, and be able to take over the job" (118). This descriptor connects back to the earlier descriptor because the differential allowance partly compensates nurses for their flexibility in meeting units' pressing needs.

Experience. Jessica continued, "They like the excitement of going from place to place. They enjoy the mix of patients: Taking care of a transplant patient one day, and taking care of a neuro patient another day, and a cardiology patient another day" (112). Float nurses look forward to the challenge of working with a different patient mix and applying different skills. They also get to experience novel settings and in this sense are adventurous like agency nurses: they can explore different clinical specialties within their hospitals without traveling afar.

RQ2: How do NMs communicate with Nurses in AWAs and Nurses not in AWAs?

RQ1 explored how NMs conceptualized different types of AWAs. RQ2 investigates how NMs manage permanent and temporary nurses. This second analysis reveals instances when my participants would communicate with all nurses in the same way regardless of work arrangements and instances when different work arrangements required different communication approaches. Three themes emerged for RQ2: (1) *You cannot overcommunicate*, (2) *Mentoring*, and (3) *When things go wrong*.

For the first theme, NMs use multiple communication media to disseminate multiple copies of the same message to all of their nurses. They do not view this approach as overcommunication because their nurses need that information to perform their tasks. Consequently, the importance of the information equalized the permanent-temporary distinction. Regarding the second and third themes, although NMs intervene differently when their nurses perform poorly, the different feedback channels do not minimize the significance of giving feedback.

Same communication: You cannot overcommunicate. AWAs make communication more challenging because not every nurse works the same shifts as their NMs. Temporal structures such as night shifts complicate communication because NMs do not get to see their night-shift nurses frequently. NMs repeat their messages through different channels – phone, text, emails, huddles, notice boards – to increase the odds of reaching all of their nurses.

NMs communicate with their nurses similarly, regardless of work arrangements, in order to promote transparency about work expectations and messaging consistency. Michelle explained:

> It is better to overcommunicate than to assume people knew something or heard something. …I may have said something at a huddle before, [but] I realized that not everyone who was even in the huddle absorbed all the information. So, it's better to repeat that over a few days. (173)

Other participants also used this "overcommunicate" communication approach because it reaches their nurses, especially with those who work infrequently or on alternate

days/weeks. Nevertheless, Tiffany retorted, "I overcommunicate and they still say they don't know" (181). Therefore, successful message delivery does not mean that the recipients understood or have read the messages.

Different communication: Mentoring. NMs invest resources (preceptors, training, and orientation) in nurses in their core teams (namely, their new nurses and their staff nurses). Temporary nurses receive less, if any, resources because of the expectation that they will adapt quickly and contribute productively with little support. Elizabeth explained:

> If I had an agency nurse starting that same day and I had a new staff nurse that I knew was going to be with us for years and years to come… and I only had two preceptors and one was a great preceptor and one was just learning, yes I might take the person who is great – my top preceptor – and put him with the person who's going to be with me for years. (168)

Elizabeth's narrative resonated with other participants' view of temporary nurses as needing less supervision (because they are experienced nurses) and receiving limited mentoring (because NMs' mentoring responsibility is toward their core teams). While constraints in resources present mentoring limitations, this practical approach may become a larger problem because nurses who do not receive adequate mentoring will bring those deficiencies to other hospitals. In turn, uncorrected deficiencies will eventually become a perpetual problem for the profession at large.

Different communication: When things go wrong. NMs use different communication channels when nurses do not perform. Noncompliant nurses who are

directly employed by healthcare facilities face remedial/disciplinary actions from their NMs and their human resources departments. The same process applies also to float and per diem nurses, because their respective facilities directly employed them. Jessica gave an example about a nurse: "He was very frightened of my patients. …I had to release him from my unit because I could not have him make errors or be that uncomfortable dealing with a very sick patient" (118). Agency nurses, on the hand, face remedial/disciplinary actions from their agencies. Olivia differentiated the feedback channels that she would use when she must discipline her nurses:

> If I had to formally discipline them, or dismiss them, that would be very different. With a permanent employee, there's very different processes that you have to go through. With a temporary person, if he or she was really not working out, he or she would just be gone. I would just call the agency. (16)

NMs will therefore leave the disciplining and firing of such nurses to their agencies.

Discussion

As demonstrated by my analysis in RQ1, NMs are aware of the nuances among AWAs and the reasons why nurses choose certain work arrangements. Although NMs have little to no control over how nurses craft their careers through work arrangements, my analysis in RQ2 shows that AWAs directly affect the way NMs work because they must adapt how they manage and communicate in response to changes in their staffing mix. The ways that NMs adapt their managerial communication styles are important, as they directly demonstrate the level of supervisor support NMs provide to their nurses

(Holland et al., 2017; Marx, 2014). Based on my analysis, I summarize the differences in feedback by NMs in Figure 1.

Feedback Channels

Figure 1 NM-RN Feedback Channels.

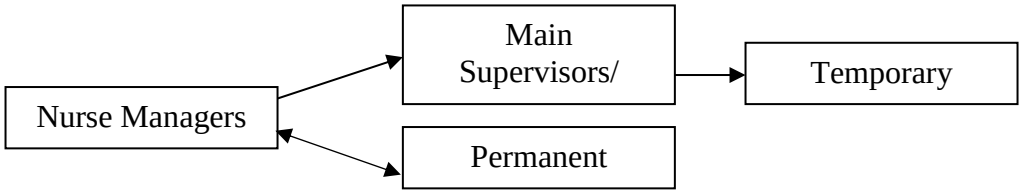


Figure 1 summarizes the bidirectional feedback channel between NMs and their permanent nurses whereas NMs do not have a direct mentoring responsibility toward temporary nurses. Alternatively, in cases where the main supervisors or agencies seek NMs' input on temporary nurses' performance, NMs will oftentimes provide a unidirectional, one-time feedback, "[T]he agency will ask for a feedback report on the traveler and it's usually a little web form that you fill out" (Ashley, 136). Similarly, Figure 1 outlines the indirect feedback that NMs provide to temporary nurses, as they leave the disciplinary actions to those nurses' main supervisors and agencies. Ashley continued:

> [T]here have been many times that I've had to communicate with the agency about a traveler's tardiness, absenteeism, or other performance issues. We've had multiple travelers with performance issues related to patient complaints, related to safety concerns, related to potential drug diversion. We have a conduit within the organization that helps us get to the right HR people at the agency. (136)

In other words, NMs' responsibility is with the managers/supervisors of those temporary nurses, resulting in them communicating about those nurses' performance directly only to their managers/supervisors.

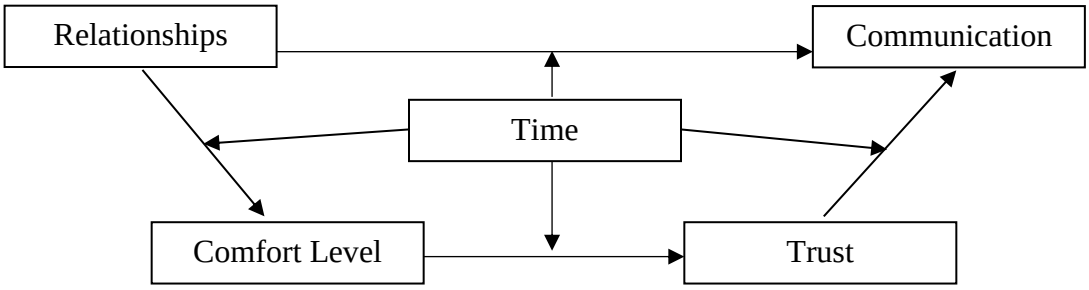
Mentoring Responsibility

Nurses in AWAs supplement core teams (that is, nurses not in AWAs). NMs help temporary nurses get "up to speed" and expect temporary nurses to "hit the ground running," "immediately jump in" and "carry a full load" "right out of the gate." However, the commodification of time has diluted trust, relationships, and communication comfort level. Figure 1 shows that NMs have direct and networked communication channels with permanent nurses than with temporary nurses to communicate both positive (mentoring) and negative (remedial/disciplinary) issues. Although the category of "temporary nurses" encompasses a variety of work arrangements pursued by different motivations, the feedback channel that NMs have with temporary nurses remains inadequate. NMs' relationship with their staff nurses makes both professional and interpersonal communication easier. Such relationships develop over time and in light of future interactions. Transpired and anticipated interactions are two factors less prominent in NMs' weaker relationship with temporary nurses.

Figure 2 provides a summary of my analysis for RQ1 and RQ2 by showing my participants' workplace relationships with their nurses, moderated by time and mediated by comfort level and trust, affect how they communicate positive and negative topics with their nurses. As coordination of work develops trust over time (Feather et al., 2014;

Gittell, 2016; Holland et al., 2017), we should recall that Kimberly talked about trust and open communication when I overviewed the descriptor *relationship* for staff nurses. Similarly, the descriptor *consistent work environment* for staff nurses highlights that relationships built over time create comfort in familiarity with colleagues and environments. Stronger relationships raise comfort levels, improve trust, and therefore increase communication.

Figure 2 NM-RN Communication Model.



Limitations and Future Research

First, the broad category of AWAs collapses the unique factors and circumstances surrounding each work arrangement. Just as contract and temporary workers may differ in employment tenure (Davis-Blake et al., 2003), agency and per diem nurses work under very different conditions. Future studies should focus on a specific work arrangement (float nurse, travel nurse, etc.) so that a fuller exploration of its nuances may mature and advance this research agenda.

Second, the use of phone interviews removed nonverbal cues that could have facilitated deeper and more insightful conversations. Phone interviews took away some

of the media richness that I could have captured in face-to-face interviews. However, the diverse geographical locations that I drew the sample from strengthen the findings because the interviewees expressed consistent themes across their lived experiences.

Third, while this essay directly addresses the important gaps that Kunie and colleagues (2017) as well as Marx (2014) have identified, the "one-sided" sample reveals only the experiences of NMs but not their nurses. The lack of data from nurses limits the claims made by my interviewees, especially since relationships develop from multiple parties involved in a phenomenon (Peel & Boxall, 2005). Although some may contend that such "one-sided" samples privilege the managerial perspective, the present study instead places the emphasis on nurses' choice of working AWAs and this phenomenon's influence on NMs. A sample that includes nurses will enrich the data and analysis, but that will also divert the study's focus—to advance knowledge on how NMs appreciate the changing needs of their nurses and how they adapt their communication in response to the effects that their interactions have with nurses who work varied work arrangements.

While organizations embrace flattened hierarchies for greater employment flexibility (Agypt & Rubin, 2012), this development generates nested complexities due to new temporal structures. For instance, contemporary managers understand that relationships and informal networks, as opposed to relying solely upon their formal authority, foster better environments for getting things done (Wei et al., 2012). Future research should investigate the communication structures of the NM-RN Feedback Channels (Figure 1), specifically the link that staffing agencies perform as a liaison and

conduit between their employees (i.e., temporary nurses) and their clients (i.e., NMs). This communication structure hinders effective communication and productivity because it increases distance and adds indirect communication channels among these entities. Moreover, it also affects the development of relationships as shown in the NM-RN Communication Model (Figure 2). Hence, scholarship must assist NMs in the search of practical strategies such that NMs can effectively position themselves as a supportive resource in nurses' networks (see Marx, 2014).

References

Adams, J., Kaplow, R., Dominy, J., & Stroud, B. (2015). Beyond a Band-Aid® approach: An internal agency solution to nurse staffing. *Nursing Economics, 33*, 51–58.

Agypt, B., & Rubin, B. A. (2012). Time in the new economy: The impact of the interaction of individual and structural temporalities on job satisfaction. *Journal of Management Studies, 49*, 403–428. doi:10.1111/j.1467-6486.2011.01021.x

Ancona, D. G., Okhuysen, G. A., & Perlow, L. A. (2001). Taking time to integrate temporal research. *Academy of Management Review, 26*, 512–529. doi:10.5465/amr.2001.5393887

Atefi, N., Abdullah, K. L., Wong, L. P., & Mazlom, R. (2014). Factors influencing registered nurses perception of their overall job satisfaction: A qualitative study. *International Nursing Review, 61*, 352–360. doi:10.1111/inr.12112

Ballard, D. I., & Gossett, L. M. (2007). Alternative times: Temporal perceptions, processes, and practices defining the nonstandard work relationship. *Annals of the International Communication Association, 31*, 274–320. doi:10.1080/23808985.2007.11679069

Ballard, D. I., & Seibold, D. R. (2003). Communicating and organizing in time: A meso-level model of organizational temporality. *Management Communication Quarterly, 16*, 380–415. doi:10.1177/0893318902238896

Ballard, D. I., & Seibold, D. R. (2004). Communication-related organizational structures and work group temporal experiences: The effects of coordination method,

technology type, and feedback cycle on members' construals and enactments of time. *Communication Monographs, 71*, 1–27. doi:10.1080/03637520410001691474

Ballard, D. I., & Seibold, D. R. (2006). The experience of time at work: Relationship to communication load, job satisfaction, and interdepartmental communication. *Communication Studies, 57*, 317–340. doi:10.1080/10510970600845974

Batch, M., Barnard, A., & Windsor, C. (2009). Who's talking? Communication and the casual/part-time nurse: A literature review. *Contemporary Nurse, 33*, 20–29. doi:10.5172/conu.33.1.20

Batch, M., & Windsor, C. (2015). Nursing casualization and communication: A critical ethnography. *Journal of Advanced Nursing 71*, 870–880. doi:10.1111/jan.12557

Bluedorn, A. C., & Denhardt, R. B. (1988). Time and organizations. *Journal of Management, 14*, 299–320. doi:10.1177/014920638801400209

Butler, R. (1995). Time in organizations: Its experience, explanations and effects. *Organization Studies, 16*, 925–950. doi:10.1177/017084069501600601

Connelly, C. E., & Gallagher, D. G. (2004). Emerging trends in contingent work research. *Journal of Management, 30*, 959-983. doi:10.1016/j.jm.2004.06.008

Conrad, C., & Poole, M. S. (1997). Introduction: Communication and the disposable worker. *Communication Research, 24*, 581–592. doi:10.1177/009365029702400600l

Cornelissen, J. P. (2005). Beyond compare: Metaphor in organization theory. *Academy of Management Review, 30*, 751–764. doi:10.5465/amr.2005.18378876

Cornelissen, J. P., Oswick, C., Thøger Christensen, L., & Phillips, N. (2008). Metaphor in organizational research: Context, modalities and implications for research — Introduction. *Organization Studies*, *29*, 7–22. doi:10.1177/0170840607086634

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory into Practice*, *39*, 124–130. doi:10.1207/s15430421tip3903_2

Davis-Blake, A., Broschak, J. P., & George, E. (2003). Happy together? How using nonstandard workers affects exit, voice, and loyalty among standard employees. *Academy of Management Journal, 46*, 475–485. doi:10.2307/30040639

Dobrow Riza, S., Ganzach, Y., & Liu, Y. (2016). Time and job satisfaction. *Journal of Management*, OnlineFirst. doi:10.1177/0149206315624962

Doherty, R. B., & Crowley, R. A. (2013). Principles supporting dynamic clinical care teams: An American College of Physicians position paper. *Annals of Internal Medicine, 159*, 620–626. doi:10.7326/0003-4819-159-9-201311050-00710

Feather, R. A., Ebright, P., & Bakas, T. (2014). Nurse manager behaviors that RNs perceive to affect their job satisfaction. *Nursing Forum, 50*, 125–136. doi:10.1111/nuf.12086

Foster, J., & Mills, A. J. (2013). Construction work: Evolving discourses of the "worker" in management textbooks, 1920s to the first decade of the 21st. *Journal of Workplace Rights, 17*, 443–466. doi:10.2190/wr.17.3-4.l

Frey, L. R., Botan, C. H., & Kreps, G. L. (2000). *Investigating communication: An introduction to research methods* (2nd ed.). Needham Heights, MA: Allyn & Bacon.

Gittell, J. H. (2016). Rethinking autonomy: Relationships as a source of resilience in a changing healthcare system. *Health Services Research, 51*, 1701–1705. doi:10.1111/1475-6773.12578

Glaser, B. G., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago, IL: Aldine.

Gordon-Finlayson, A. (2010). Grounded theory. In M. Forrester (Ed.), *Doing qualitative research in psychology* (pp. 154–176). Thousand Oaks, CA: Sage.

Gossett, L. M. (2001). The long-term impact of short-term workers. *Management Communication Quarterly, 15*, 115–120. doi:10.1177/0893318901151007

Gossett, L. M. (2002). Kept at arm's length: Questioning the organizational desirability of member identification. *Communication Monographs, 69*, 385–404. doi:10.1080/03637750216548

Gossett, L. M. (2006). Falling between the cracks: Control and communication challenges of a temporary workforce. *Management Communication Quarterly, 19*, 376–415. doi:10.1177/0893318905280327

Hemann, M., & Davidson, G. (2012). Perspective of a float pool model in ambulatory care. *MedSurg Nursing, 21*, 164–170.

Hesse-Biber, S. N., & Leavy, P (2011). *The practice of qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.

Hockenberry, J. M., & Becker, E. R. (2016). How do hospital nurse staffing strategies affect patient satisfaction? *ILR Review, 69*, 890–910. doi:10.1177/0019793916642760

Holland, P., Cooper, B., & Sheehan, C. (2017). Employee voice, supervisor support, and engagement: The mediating role of trust. *Human Resource Management, 56*, 915–929. doi:10.1002/hrm.21809

Hudgins, T. A. (2016). Resilience, job satisfaction and anticipated turnover in nurse leaders. *Journal of Nursing Management, 24*, E62–E69. doi:10.1111/jonm.12289

Hugh-Jones, S. (2010). The interview in qualitative research. In M. Forrester (Ed.), *Doing qualitative research in psychology* (pp. 77–97). Thousand Oaks, CA: Sage.

Institute of Medicine. (2004). *Keeping patients safe: Transforming the work environment of nurses*. National Academies Press.

Jamieson, L. N., Williams, L. M., Lauder, W., & Dwyer, T. (2008). The 'realities" of part-time nursing: A grounded theory study. *Journal of Nursing Management, 16*, 883–892. doi:10.1111/j.1365-2934.2007.00836.x

Katz, L. F., & Krueger, A. B. (2016). *The rise and nature of alternative work arrangements in the United States, 1995-2015*. (NBER Working Paper No. 22667). Cambridge, MA: National Bureau of Economic Research.

Kuhn, T. (2006). A "Demented work ethic" and a "lifestyle firm": Discourse, identity, and workplace time commitments. *Organization Studies, 27*, 1339–1358. doi:10.1177/0170840606067249

Kunie, K., Kawakami, N., Shimazu, A., Yonekura, Y., & Miyamoto, Y. (2017). The relationship between work engagement and psychological distress of hospital nurses and the perceived communication behaviors of their nurse managers: A

cross-sectional survey. *International Journal of Nursing Studies, 71*, 115–124. doi:10.1016/j.ijnurstu.2017.03.011

Lambert, S. J. (2008). Passing the buck: Labor flexibility practices that transfer risk onto hourly workers. *Human Relations, 61*, 1203–1227. doi:10.1177/0018726708094910

Larson, N., Sendelbach, S., Missal, B., Fliss, J., & Gaillard, P. (2012). Staffing patterns of scheduled unit staff nurses vs. float pool nurses: A pilot study. *MedSurg Nursing, 21*, 27–39.

Lavoie-Tremblay, M., Fernet, C., Lavigne, G. L., & Austin, S. (2015). Transformational and abusive leadership practices: Impacts on novice nurses, quality of care and intention to leave. *Journal of Advanced Nursing, 72*, 582–592. doi:10.1111/jan.12860

Lawrence, T. B., Winn, M. I., & Jennings, P. D. (2001). The temporal dynamics of institutionalization. *Academy of Management Review, 26*, 624–644. doi:10.5465/amr.2001.5393901

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

Lindlof, T. R., & Taylor, B. C. (2011). *Qualitative communication research methods* (3rd ed.). Thousand Oaks, CA: Sage.

Marx, M. (2014). Examining the structural challenges to communication as experienced by nurse managers in two US hospital settings. *Journal of Nursing Management, 22*, 964–973. doi:10.1111/jonm.12091

Maenhout, B., & Vanhoucke, M. (2013). An integrated nurse staffing and scheduling analysis for longer-term nursing staff allocation problems. *Omega, 41*, 485–499. doi:10.1016/j.omega.2012.01.002

May, J. H., Bazzoli, G. J., & Gerland, A. M. (2006). Hospitals' responses to nurse staffing shortages. *Health Affairs, 25*, W316-W323. doi:10.1377/hlthaff.25.w316

Miles, M. B., & Huberman, A. M. (1984). *Qualitative data analysis: A sourcebook of new methods* (2nd ed.). Thousand Oaks, CA: Sage.

Myers, K. K., Gailliard, B. M., & Putnam, L. L. (2013). Reconsidering the concept of workplace flexibility: Is adaptability a better solution? *Annals of the International Communication Association, 36*, 195–230. doi:10.1080/23808985.2013.11679132

Norful, A., Martsolf, G., de Jacq, K., & Poghosyan, L. (2017). Utilization of registered nurses in primary care teams: A systematic review. *International Journal of Nursing Studies, 74*, 15–23. doi:10.1016/j.ijnurstu.2017.05.013

Peel, S., & Boxall, P. (2005). When is contracting preferable to employment? An exploration of management and worker perspectives. *Journal of Management Studies, 42*, 1675–1697. doi:10.1111/j.1467-6486.2005.00562.x

Piszczek, M. M., & Berg, P. (2014). Expanding the boundaries of boundary theory: Regulative institutions and work-family role management. *Human Relations, 67*, 1491–1512. doi:10.1177/0018726714524241

Rubery, J., Earnshaw, J., Marchington, M., Cooke, F. L., & Vincent, S. (2002). Changing organizational forms and the employment relationship. *Journal of Management Studies, 39,* 645–672. doi:10.1111/1467-6486.00306

Shinners, J., Alejandro, J. A. N., Frigillana, V., Desmond, J., & LaVigne, R. (2016). Quality improvement: Creating a float pool specialty within a new graduate residency. *MedSurg Nursing, 25*(2), 79–84.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques* (2nd ed.). Newbury Park, CA: Sage.

Thomas, D. R. (2016). Feedback from research participants: Are member checks useful in qualitative research? *Qualitative Research in Psychology, 14,* 23–41. doi:10.1080/14780887.2016.1219435

Spreitzer, G. M., Cameron, L., & Garrett, L. (2017). Alternative work arrangements: Two images of the new world of work. *Annual Review of Organizational Psychology and Organizational Behavior, 4,* 473–499. doi:10.1146/annurev-orgpsych-032516-113332

Sveinsdóttir, H., Ragnarsdóttir, E. D., & Blöndal, K. (2016). Praise matters: The influence of nurse unit managers' praise on nurses' practice, work environment and job satisfaction: A questionnaire study. *Journal of Advanced Nursing, 72,* 558–568. doi: 10.1111/jan.12849

Van Breugel, G., Van Olffen, W., & Olie, R. (2005). Temporary liaisons: The commitment of "temps" towards their agencies. *Journal of Management Studies, 42,* 539–566. doi:10.1111/j.1467-6486.2005.00508.x

Way, S. A., Lepak, D. P., Fay, C. H., & Thacker, J. W. (2010). Contingent workers' impact on standard employee withdrawal behaviors: Does what you use them for matter? *Human Resource Management, 49,* 109–138. doi:10.1002/hrm.20336

Wei, L.-Q., Chiang, F. F. T., & Wu, L.-Z. (2012). Developing and utilizing network resources: Roles of political skill. *Journal of Management Studies, 49*, 381–402. doi:10.1111/j.1467-6486.2010.00987.x

West, S., Rudge, T., & Mapedzahama, V. (2016). Conceptualizing nurses' night work: An inductive content analysis. *Journal of Advanced Nursing, 72*, 1899–1914. doi:10.1111/jan.12966

Xue, Y., Chappel, A. R., Freund, D. A., Aiken, L. H., & Noyes, K. (2015). Cost outcomes of supplemental nurse staffing in a large medical center. *Journal of Nursing Care Quality, 30,* 130–137. doi:10.1097/ncq.0000000000000100

Zannini, L., Ghitti, M. G., Martin, S., Palese, A., & Saiani, L. (2015). Narratives, memorable cases and metaphors of night nursing: Findings from an interpretative phenomenological study. *Nursing Inquiry, 22*, 261–272. doi:10.1111/nin.12091

CHAPTER III

TEMPORARY WORK AND RELATIONAL CHALLENGES WITHIN THE NURSING PROFESSION

Overview

This study focuses on travel nurses' experiences with managing their relationships with permanent nurses. To understand the relational experiences of travel nurses, I conducted one-on-one semi-structured interviews with 25 registered nurses in the United States who had travel nursing experience. The data analysis suggests that travel nurses encounter two primary challenges when negotiating their relationships with permanent nurses: (1) demonstrating professional competence, and (2) fitting in with a unit's pre-existing culture and work practices. These challenges are managed through the strategies of the *Competent Coworker* and the *Gracious Guest*. Future research directions may include the way that organizationally designed "traveler-friendly facilities," envy, and the length of temporary work assignments may influence how travel and permanent nurses negotiate their relationships.

Introduction

Globalization, new technologies, and a nursing labor shortage has spurred an international trend where facilities prefer flexible staffing practices emphasizing the use of temporary nurses instead of employing permanent teams of full-time staff nurses (Baumann, Hunsberger, & Crea-Arsenio, 2013; Berg Jansson & Engström, 2017; Rispel & Moorman, 2015). A temporary nurse is typically defined as "a nurse employed by an external agency and contracted through a staffing agency or employed on a temporary/supplemental basis" (Mazurenko, Liu, & Perna, 2015, p. 34). This definition mirrors the evolving configurations of work arrangements known as alternative work arrangements that are performed within definitive start-end dates or that fall outside the traditional 9-to-5, 5-day workweek (Katz & Krueger, 2016; Spreitzer, Cameron, & Garrett, 2017). Alternative work arrangements not only benefit organizations, they also benefit employees. Nurses who choose alternative work arrangements can earn better monetary compensation and have greater control of their work schedules (Faller, Gates, Georges, & Connelly, 2011; Hurst & Smith, 2010). Temporary labor also benefits permanent nurses as they have a greater chance of taking time off when facilities can fill permanent nurses' shifts using temporary nurses (Berg Jansson & Engström, 2017).

Travel nursing is a distinct temporary work arrangement where nurses work on a contracted basis at facilities typically not in their home communities or that require a substantial commute. Travel nurses are temporary nurses who bring needed expertise and short-term labor to units and typically earn a comparatively higher remuneration for doing the same work as permanent nurses (Hurst & Smith, 2010). Although travel nurses

serve an important role of maintaining adequate nurse-to-patient ratios, the practice of travel nursing has received sharp criticism due to its high indirect costs and the lack of close collaboration between travel nurses and permanent nurses (Berg Jansson & Engström, 2017; Rispel & Moorman, 2015). One might theorize that the combination of high task interdependence and the short-term nature of the job appointments may partially explain the lack of close collaboration. Since travel nurses must adapt quickly to different policies and procedures at various facilities in order to coordinate care delivery, their relatively short-term appointments may work against them learning the practices they need to work well with other permanent nurses (Berg Jansson & Engström, 2017).

Delivering patient care and supporting fellow nurses are essentially communicative acts that occur as travel and permanent nurses coordinate their relationships (Gittell, 2016; Wagner, Bezuidenhout, & Roos, 2015). However, scholars generally pay little attention to nurses in alternative work arrangements such as travel nurses while healthcare administrators typically deem workplace relationships as inconsequential to facilities' financial health and unworthy of substantial resource allocation (Zealand, Larkin, & Shron, 2016). This is surprising as nurses' workplace relationships have been demonstrated to affect clinical outcomes (American Association of Critical-Care Nurses [AACN], 2005). If work relationships are important to achieving positive clinical outcomes and work is inherently communicative in nature, it is important to study how nurses use communication to manage their work relationships. This is particularly true when new work arrangements such as temporary nursing

emerge. Therefore, the focus of this essay is to examine how travel nurses manage their relationships with permanent nurses at their place of employment.

Relationships, Communication, and Nursing

The American Association of Critical-Care Nurses has defined communication, or the "2-way dialogue in which people think and decide together" (2005, p. 190), and has identified it as one of six key contributors to healthy work environments. The existing research suggests constructive communication improves professional nursing relationships and that nurses find their work rewarding when teams coordinate effectively toward shared goals (Moore, Leahy, Sublett, & Lanig, 2013; Moore, Sublett, & Leahy, 2017; Zealand et al., 2016). This section explores how nurses perceive nursing relationships and use communication to create, sustain, and manage nurse-to-nurse relationships.

Nurse-to-Nurse Relationships

The ways that nurses manage their workplace relationships increase in importance as delivery of care becomes more team-based and necessitates significant nurse-to-nurse task coordination (Berg Jansson & Engström, 2017; Gittell, 2016; Lee & Doran, 2017; Norful, Martsolf, de Jacq, & Poghosyan, 2017). Nurses not only must possess individual competencies that are related to task performance but also strong communication competencies because the quality of their coordination with others affects patient care (AACN, 2005; Moore et al., 2013). Hence, scholars have expressed concern about the influence that interpersonal relationships have on teams in general and the quality of care provided by transient nursing teams in particular because transient

teams lack stability found in teams comprising predominantly permanent nurses (Heaphy et al., 2018; Maenhout & Vanhoucke, 2013).

Work shifts have a profound impact on how nurses collaborate and manage relational challenges. Many facilities typically have more nurses during the day shift than on other shifts (Bae et al., 2017), partly because many interactions such as patient visitation and diagnostic testing happen during the day. While having more people during the day may complicate communication networks, it also allows for more nurse-to-nurse interactions and greater social support because the development of support networks among nursing teams will likely increase the sharing of physical and emotional resources among nurses (Bae et al., 2017). Indeed, nurses do not necessarily seek help from experts but from those whom they consider accessible and trustworthy (Hofmann, Lei, & Grant, 2009) and increased access to a network of nurses is likely to increase the number of nurses that an individual nurse considers to be accessible and trustworthy.

At the same time, increased engagement with other nurses may lead to conflict. Interpersonal tensions resulting in bullying and disruptive relational behaviors have pervaded much of the literature on nurse-to-nurse communication (Moore et al., 2013). Communication challenges abound in nurse-to-nurse communication as environmental factors such as changes in patient acuity and workload stimulate conflict and stress among nurses (Johansen, 2014; Johansen & Cadmus, 2016; Morrison, 2008). As a result, some nurses may choose night shifts because they want greater autonomy whereas other nurses do so to avoid interpersonal tensions (Zannini, Ghitti, Martin, Palese, & Saiani, 2015).

Both qualitative and quantitative studies have noted nurses' general preference for using the avoidance style when managing conflict (Cavanagh, 1991; Johansen, 2014; Mahon & Nicotera, 2011; Vandecasteele et al., 2017). A recent review found that a majority of studies on nurses in the United States stated that they prefer the avoidance style while nurses mostly in Arab countries tend to prefer an integrative style (Labrague, Al Hamdan, & McEnroe-Petitte, 2018). Furthermore, nurse managers recognize that while some nurses prefer avoidance but will still report issues to them, other nurses seek advice on how they should confront relational issues constructively (Moore et al., 2017). These studies suggest that nurses in the United States may perceive and manage workplace relationships differently than international nurses.

Communication and Nurse-to-Nurse Relationships

Management and nursing literatures underscore the importance of communication in how nurses coordinate and establish trust with one another (Gittell, 2016; Holland, Cooper, & Sheehan, 2017). However, competition among fellow nurses for finite resources limits horizontal communication and the sharing of existing resources such as information (Labrague et al., 2018). Anticipated interdependence among individuals increases communication frequency and potential conflicts (Hocker & Wilmot, 2013); however, nurses may reduce interdependence so that they reduce the possibility of experiencing conflict, which may then result in poor collaboration (Berg Jansson & Engström, 2017; Rispel & Moorman, 2015). Given that the inclusion of temporary workers can potentially change established organizational communication practices (Gossett, 2001), varied work arrangements can alter employees' work

experiences and relations with colleagues (Agypt & Rubin, 2012; Ballard & Gossett, 2007). Because the ubiquity of nursing teams increases nurse-to-nurse communication and the likelihood of relational issues among nurses (Lee & Doran, 2017), it is important to acknowledge the role of formal and informal communication channels and their connection to nurse-to-nurse communication and relationships.

Formal communication. Formal communication refers to the coordination of nursing tasks where nurses collaborate as well as disseminate patient information and related nursing policies through standardized communication practices. In the nursing profession, a formal communication system is reflected in the use of specific communication channels and practices including documentation and handoffs. Formal communication practices involve structured forms of messaging and interaction that enhances the clear and consistent transmission of information to perform nursing-related tasks (Coiera, Jayasuriya, Hardy, Bannan, & Thorpe, 2002). Sharing task-oriented information involves sharing information across time (for instance, multiple handoffs across several shifts of nurses) and space (for example, electronic health records made accessible at different facilities). Consistency means that nurses document patient information in a standardized manner that makes information retrieval easier.

Having a formal communication system that concisely disseminates policies helps nurses do their work and increases their communication satisfaction (Wagner et al., 2015). A recent study of Swedish permanent and temporary nurses reported relatively smooth coordination across work arrangements occurs when a strong formal communication system was in place (Berg Jansson & Engström, 2017). Permanent

nurses in that study noted communication improvements in the quality of documentation as emanating from their desire to help temporary nurses find information quickly (Berg Jansson & Engström, 2017). Other studies investigating formal communication channels in nursing teams highlight continued interest in handoffs because the complexity in conveying nuanced patient information oftentimes get omitted during handoffs and miscommunication in those instances create costly patient care errors (Abraham et al., 2017; Staggers & Blaz, 2013). Developments such as electronic handoffs, which have improved communication by increasing the frequency of complete documentation of patient records (Panesar, Albert, Messina, & Parker, 2016), underscore the importance of formal nursing communication.

Informal communication. Unlike formal communication channels, informal communication does not have a predetermined format and the interacting parties determine the message structures (Coiera et al., 2002). Informal communication sprouts organically among individuals who desire social interactions and typically revolves around casual topics such as one's family and hobbies. It may also involve work-related issues discussed privately as illustrated by "behind-the-scenes" conversations that take place away from patients and other clinicians (Ellingson, 2003). For instance, Belgian nurses talk about unappreciative patients through informal communication (Vandecasteele et al., 2017), while Italian nurses have a disposition for mutual support with nurses in the same work arrangement (Cicellin, Pezzillo Iacono, Berni, & Esposito, 2015). Conversely, poor informal communication channels have led to communication

and job dissatisfaction among South African nurses (Wagner et al., 2015), implying that weak support networks among nurses weaken internal communication capacity.

Rationale for this Study

One of nursing management's top responsibilities is to ensure an adequate nurse-to-patient ratio by meeting staffing needs which they increasingly accomplish through the employment of temporary nurses (AACN, 2005; Kortbeek, Braaksma, Burger, Bakker, & Boucherie, 2015; Mazurenko et al., 2015). When nurse managers supplement their units with temporary nurses, the existing permanent and incoming temporary nurses must negotiate how work is performed and how they manage their relationships. Incoming temporary nurses must adapt to new policies, procedures, and work relationships at their temporary units while permanent nurses must make sense of the competencies and personalities of their new teammates whom they might have never met to sort out how to accomplish work and manage those new relationships. Such situations create informational deficiencies for all nurses, necessitating a sensemaking process whereby nurses must interact and exchange information to work collaboratively. As team-based care becomes more prevalent in many healthcare systems across the globe (Bae et al., 2017; Berg Jansson & Engström, 2017; Norful et al., 2017), the increasingly interdependent tasks that nurses perform place a greater emphasis on communication and work coordination (Gittell, 2016).

Relatively little research has explored the connections between temporary nurses' work arrangements and nurse-to-nurse relationships, which has limited our understanding of the implications of travel nursing on nurse communication. This lack of

research may be due to an emphasis on exploring economic outcomes versus relational outcomes in nursing research (Harris et al., 2015; Maenhout & Vanhoucke, 2013). This study focuses on travel nurses' work experience because the temporal nature of their employment contract has the potential of disrupting work relationships (Mazurenko et al., 2015). The perspectives of travel nurses regarding the types of challenges they engage when working with permanent nurses and the strategies they employ to manage those challenges has not been explored. The following research question guides my inquiry into travel nurses' work experience:

RQ: *How do travel nurses manage nurse-to-nurse relationships with permanent nurses?*

Method

An inductive, interpretive approach was appropriate to help me understand how my target population co-constructs similar and different "meanings of work and work relationships" (Fritz, 2014, p. 464). I collected data through semi-structured interviews because of this method's ability to unfold how travel nurses made sense of their work and work relationships (Hesse-Biber & Leavy, 2011).

Participants

Purposeful sampling was used to specifically recruit nurses who had travel nursing experience in the United States (Creswell, 2013). The inclusion criteria were: (1) participants had to have travel-nursing experience within the United States, and (2) participants must be registered nurses, which established a minimum professional qualification among participants. After receiving Institutional Review Board approval, I

informed personal contacts across the United States that I was recruiting participants for this study. Two participants came through referrals while the rest came through my personal contacts.

The final sample included 25 registered nurses from across the United States. The majority of the sample was female (20 females, five males), with each participant having between two and 22 years (M = 9.34) of registered-nurse experience and ranging from one to 16 years of travel-nursing experience (M = 4.03). Table 4 summarizes the sample's demographic information. Pseudonyms were assigned to participants to protect their identities.

Data Collection

A semi-structured interview guide was constructed to generate data for the study. The semi-structured interview guide allowed me to not only to collect my participants' demographic information – such as how long they have worked as registered nurses – but more importantly, to learn about how they manage nurse-to-nurse relationships. This specific study was part of a larger interview study designed to explore the experiences of travel nurses. For this study, I created questions that focused on participants' perception of nurses in different work arrangements (*How are permanent and temporary nurses similar? What are your perceptions of the permanent nurses at the place you work?*) and communication differences (*How do you communicate with permanent/temporary nurses? How do temporary nurses and permanent nurses communicate differently/similarly with one another?*).

Table 4 Participants' Demographic Information.

Pseudonym	Specialty	Highest Education Earned	Experience		Ethnicity
			Registered Nurse (Years)	Travel Nurse (Years)	
Lisa	Critical care	Associates	12	11	White
Michael	Intermediate care/Telemetry	Bachelors	4½	2	White
Mary	Med-surg/Telemetry	Bachelors	4	2¼	White
John	Interventional radiology	Associates	17	6	Cajun
David	Interventional radiology	Bachelors	22	16	White
Karen	Emergency	Masters	9½	1	African-American
Kimberly	Critical care	Associates	11	4	White
Susan	Med-surg/Telemetry	Associates	13	4½	White
Patricia	Operating room	Bachelors	20	½	White
Donna	Critical care	Masters	13	10	African-American
Linda	Operating room	Bachelors	11	3	White
Cynthia	Interventional radiology	Diploma	12	1	White
Angela	Critical care	Bachelors	11	6	White
Tammy	Critical care	Masters	11	3	White
James	Emergency	Bachelors	4½	2	African-American
Deborah	Med-surg/Telemetry	Bachelors	3	½	African-American
Julie	Med-surg/Telemetry	Associates	2	1	Mexican-American
Sandra	Critical care	Bachelors	11	3	White
Robert	Critical care	Bachelors	7	5	Asian
Michelle	Med-surg/Telemetry	Bachelors	6	2½	Asian/ White
Laura	Critical care	Bachelors	6	4	White
Jennifer	Critical care	Bachelors	4	1	White
Sharon	Critical care	Bachelors	6	2½	Asian
Brenda	Critical care	Masters	10	8	White
Teresa	Critical care	Bachelors	3	1	White

I collected 1,006 minutes of audio data. The interviews were between 16 and 64 minutes each (M = 40.24). A total of 441 single-spaced pages of interview data were professionally transcribed.

Data Analysis

The constant-comparative method was used to inductively analyze the data throughout the data collection phase (Strauss & Corbin, 1990). Initial categories were developed as I perused the transcript line-by-line. Subsequent readings of the transcript further developed themes through the *open coding* of initial categories (Strauss & Corbin, 1990). The coding scheme was further developed using *axial coding* where I consolidated the categories by abductively grouping similar categories together. During the primary-cycle coding phase, I wrote memos on each interview transcript to record initial thoughts about potential codes. For example, I wrote, "Demonstrate Competency" followed by how my participants tactfully managed nurse-to-nurse relationships as a communicative act of performing their work (see Table 5). Square brackets that follow quotations contain page numbers on the interview transcript.

Table 5 Data Analysis Example.

Concepts	Categories	Theme (Strategy)
…she knew I was doing what was **best for the patient**… not just going there to collect a paycheck. [13]	**Demonstrate Competency (overcome prejudice and challenges)**	The Competent Coworker
Sometimes people are accepting of you and sometimes people are not but it's always **challenging** when you work in a new facility. The work is the same but still it's the people and the culture that change. [120]		
…certain travelers have given a **bad impression** of us. They probably were **incompetent** and did a terrible job. Because of that, they [staff nurses] think all travelers are like that. So when they got to know me, they saw that I was a very **skilled** person. [377]		
They're very **happy** to get travel nurses because they're very **understaffed**. … [Having] travel nurses alleviate many of their problems. [35]	**Demonstrate Competency (repay appreciation from staff)**	
…they're **appreciative** when you come in. The teamwork's there and it's just very accepting overall. [128]		
…if you're in the right team, they'll **accept** you into their little family for the time that you're there and try to include you as much as they can. [267]		
…you do run into nurses who're not as competent as they should be …and that's part of why you're there—to be able to **do the work** and give some guidance and mentoring. [58]	**Demonstrate Wisdom (active participation)**	The Gracious Guest
If you want me to take three lefts instead of turning right, **I'll do that**. I'll do that because I'm getting to the same place anyway. If you tell me that I need to give this medicine when I know it's gonna kill the patient, well, that's where we split ways. If it's gonna get to the same outcome, **I'll do it your way**, even if I think your way is less efficient. [51]	**Demonstrate Wisdom (passive participation)**	

Three steps were taken to establish the credibility of my analysis. First, member checks were used to verify emerging themes. This process is widely acknowledged to increase credibility by allowing participants to interact with the data (Thomas, 2016). I used member checks by asking later participants the same questions as I had asked earlier participants as well as posing themes that were emerging from my analysis; later participants would then tell me whether the emerging themes rang true to their experiences. Second, thick, rich descriptions were used to offer exemplars of participants' perspectives and for readers to ascertain transferability of this study (Creswell, 2013; Creswell & Miller, 2000). Third, negative evidence was sought to systematically examine my partiality for confirming evidence – as researchers tend to cherry-pick confirming evidence (Creswell & Miller, 2000) – to fit preconceived narratives. For example, regarding the theme of the *Competent Coworker,* several nurses disconfirmed the common notion that permanent nurses do not welcome travel nurses as permanent nurses did express appreciation for travel nurses in certain instances.

Analysis

This study's purpose was to investigate the kinds of relational challenges that travel nurses experience in their relationships with permanent nurses and how they manage them. Two relational challenges emerged from my analysis: (1) demonstrating professional competence, and (2) fitting in with pre-existing unit culture and relationships.

Demonstrating Professional Competence

A primary relational challenge highlighted by travel nurses was demonstrating their professional competence to their new co-workers in the nursing unit. Sharon commented, "One of the biggest challenges is getting familiar with the unit and proving yourself [402]." Angela also made a similar observation, "I have noticed that permanent nurses take a while to respect travelers. …They might be a little more passive-aggressive, withhold information, or unofficially test a [travel] nurse's knowledge before they trust her [197]." These accounts illustrate that travel nurses are often viewed by permanent nurses as out-group members with unknown and untested professional competencies.

Travel nurses have a strong desire to be viewed as competent professionals. Cynthia indicated that she wanted her professional competence to be recognized and validated,

> We all want to be treated with respect. We want to be compensated for our hard work. We want to be respected for our hard work and what we do. … I find what works best is just going in humble and receptive, "I'm here to help," eventually they'll see you're not an idiot. You actually know what you're doing and you gain their respect over time. [168]

John suggested that permanent nurses often assume the worst of travel nurses, "When you get there, they always assume that you don't know a thing. As soon as you don't know a thing, they assume you're dumb and you have to earn their respect [50]."

The *Competent Coworker* strategy mitigates some of the negativity that results from permanent nurses being skeptical about travel nurses' clinical skills and abilities. The *Competent Coworker* strategy requires travel nurses to demonstrate – in both word and deed – that they can function and perform the job competently, if not better than permanent nurses. There are several ways that they demonstrate their competence. As mentioned by Cynthia, one way to demonstrate task competence is by volunteering to help. Other ways to demonstrate one's task competence include prioritizing patient care even in unsupportive environments. Lisa elucidated,

> This [permanent] nurse would give me all kinds of tasks to do. She'd say, "I gave the patient laxative 30 minutes ago. You probably should go check on him now because he needs to be cleaned up. ... She called me the high-paid nurse… I said, "That's fine that you left that for me to do. I'm okay with that. But it's the patient you're harming, not me." I said, "Because I'm here to make my paycheck and to take care of my patients. [12]

Lisa's example underscores the importance of professionalism in nursing work, where nurses must place their patients' welfare above almost everything else despite adversity. Professionalism requires that nurses set aside differences among coworkers and not pettily compare among one another about assignments. As Lisa reasoned, she does not mind the unpleasant tasks that other nurses relegate to her because those tasks create opportunities for her to demonstrate her competency. Upholding high professionalism also means that travel nurses must have a resilient outlook despite working in hostile environments, as Donna expressed, "I've been thrown underneath the bus and I've been

dumped on. I just have to brush it off and refocus… because everyone's at a different level of his or her career and everyone's at a different level of nursing [126]." Therefore, travel nurses who demonstrate high clinical competencies also exhibit a high level of professionalism.

It is surprising that travel nurses mentioned the need to demonstrate one's professional competence, given that nursing work is highly structured and utilizes formal communication procedures and practices to ensure quality care delivery. My participants reported few communication challenges when interacting with other nurses using formal communication channels, chiefly because nurses share the same professional ethics, jargon, and knowledge. Such commonalities create communication shortcuts that help them coordinate efficiently (Kramer & Bisel, 2017). As Robert said, "Nursing care, no matter where you are in the country or in the world, it is essentially the same [310]." Similarly, Karen observed, "There's not a big difference as far as communication between staff and contract nurses. We share the same language [74]." Similarly, travel nurses usually experience consistent messages that their manager shares with permanent nurses. Lisa noted that most nurse managers whom she had worked with in her 11-year experience as a travel nurse would share the same information with relevant nurses, regardless of work arrangements, via email, "That way everybody has the opportunity to see the same communication at the same time [8]." Formal communication tools such as group emails allow consistency in both format and messaging (Coiera et al., 2002), equalizing information asymmetry and reducing miscommunication.

The formal communication processes that are in place to help share patient information and document patient health care are also fairly standard, which should permit travel nurses to quickly and easily fit into the professional practices of a health unit. For example, Kimberly stated, "There's generally a way of giving a handoff [report] or communicating information that's kind of standard [84]." Standardized ways of documenting patient information might explain why my participants do not experience major challenges when using formal written communication. Karen explained, "We're all trained on the same documentation style and the same platform and format. So, we all document and communicate the same way. Whether you're a contract or staff, we all deliver the same kind of [patient] care [74]." Likewise, Donna stressed that the same professional ethics undergird the consistent communicative style, "The [communication] basics are there because we have to make sure that patient care is not compromised and I hope that's our priority [130]."

While sharing the same professional ethics, jargon, and knowledge create a degree of familiarity among permanent and travel nurses as well as uniformity in care delivery, my participants nevertheless emphasized that they must demonstrate high proficiency in their clinical competencies to earn permanent nurses' respect and trust, particularly when delivering patient care. My participants use the strategy of the *Competent Coworker* to adapt to their new work environments and to earn the acceptance of their new colleagues.

Fitting in with Pre-existing Unit Culture and Relationships

A second challenge that travel nurses highlight when managing their relationships with permanent nurses is fitting in with their new facilities' culture. Donna stated,

> The tone of the unit is already set when I get there and I've to acclimate myself to that tone and I may be able to fit in and I may not but for me being an outsider, the tone is already set when I get there. [126]

Cynthia noted, "There's that camaraderie that staff nurses have amongst themselves; you're just this interloper. They've their own little language because they've their shared experiences that I haven't had with them" [172]. Travel nurses recognize that a pre-existing culture and set of relationships are present within any health unit and this may generate challenges for them as they work to fit within a unit.

However, travel nurses observe that the challenge of fitting into pre-existing unit culture and relationships varies. Michael noted, "It's hard to blanket statement the permanent staff because there're people who don't wanna be bothered and there're people who're very bubbly and friendly. …I've been at facilities where it was very us-versus-you kind of mentality [23]". Donna agrees with Michael, as she believes that a travel nurse's acceptance into a unit depends on the individual personalities of the permanent nurses, "I've been to places where nobody wanted to talk to me because I'm a temporary nurse. I can't make them talk to me… [But] it goes from facility to facility, from nurse to nurse. It could go either way [130]."

Two issues emerged that drive the challenge that travel nurses have fitting into a unit's pre-existing culture and relationships. First, permanent nurses may not be motivated or have the time to develop relationships with travel nurses. Patricia highlighted this very issue:

> I built some good relationships with travel nurses because we're all in the same boat. We're away from our spouses, we're away from home, and none of us knew the area. We'd go out quite frequently together …the relationships were better with travelers than with regular staff because they've got their families, they got friends, they got stuff that they're gonna do after work. They don't wanna have to entertain a traveler. [112]

Patricia notes that permanent nurses already have personal lives that they need to manage and that they need to give attention to those parts of their lives versus establishing new relationships with travel nurses. As a result, travel nurses gravitate toward socializing with other travel nurses because they find themselves in a similar situation and they engage in leisure activities together because permanent nurses have their own activities to pursue.

Second, differences in travel nurse compensation and expectations may lead to travel nurses having difficulty fitting into a unit's culture. Several of my participants highlighted the fact that travel nurses are compensated at a higher level than permanent nurses:

> They think the travelers make too much money and they want the travelers to do all the work; the staff members want to sit around and do nothing. They're not appreciative of the fact that there's somebody there to help them. [David, 63]
>
> You get paid more when you're a contractor so they can give you the patients that other people don't want or more patients. [Kimberly, 84]
>
> She [another travel nurse] looked at my contract and I said, "I don't think that it's important for you to look at my contract. I don't want somebody saying, "I got a better deal than you did" or, "Did you get a better deal than I did?" [Patricia, 113]
>
> One of the probably biggest differences is travelers discuss pay, where staff nurses don't usually discuss their pay amongst each other. And, travelers don't usually discuss their pay with staff nurses either. [Sandra, 279]

The above quotations highlight how permanent nurses recognize that a significant pay differential separates them from travel nurses. As a result, permanent nurses may feel that it is legitimate to treat travel nurses differently in terms of workload by giving them less desirable or more patients. As Michelle stated, "I haven't experienced [communication challenges] too much, but I know others have experienced some negative interactions from permanent nurses: pay difference and different expectations that are put on temporary nurses [322]."

Travel nurses manage the challenge of fitting in a unit's pre-existing culture and relationship by being a *Gracious Guest*. Many of my participants use the metaphor of the unit being a "house" where travel nurses are a "guest." John put it bluntly, "You're a

guest in their house. You can't come in and tell them that their house is ugly or they're washing their dishes wrong" [52]. Cynthia spoke in similar terms, "The last thing you do is criticize their house by telling them it's dirty or it's disorganized… permanent employees take pride in their work and they've worked hard, they're showing you their home, and they're proud of their home" [170]. Karen stated, "They [permanent nurses] feel like others are coming to their house and they probably don't want to welcome the contract nurses" [75]. Lisa also had similar experiences with permanent nurses, "They want to feel you out before they become your friends… but some of them will be like, 'I don't want travelers in my room'" [6].

The strategy of being a *Gracious Guest* occurs is associated with not criticizing the clinical practice of the work unit and giving control to the permanent nurses as to how the relationships between permanent and travel nurses are negotiated. In terms of not criticizing the clinical practice of the work unit, travel nurses recognize that permanent nurses take pride in their unit's practices and may be resistant to criticism. The exception is when travel nurses believe their "hosts" are not providing good care or are compromising patient safety. Linda points out,

> I'm pretty direct. I think it's very important we remember it's about the patients and not us. I don't communicate with other nurses the way they want to be, especially women who want their hands held and you be very sweet to them or maybe not say anything at all or just let it slide. I'm not that nurse. My son had major surgeries. I'm that nurse who really cares about the patients. [147]

Being a *Gracious Guest* also involved travel nurses letting permanent nurses determine how the relationship would unfold which depends on the permanent nurses' levels of motivation and interest:

> It always depends on their personalities because the other nurses don't have to accept you. …There're ones who have flat out told me, "I don't want to get to know you because you'd leave and I'll miss you. So I don't wanna get to know you," I understand that and that's fine. [John, 50]

Permanent nurses may guard against developing relationships with travel nurses to avoid personal pain. Regardless of the motivation or interest, travel nurses give control to the permanent nurses over the way the relationship unfolds.

Discussion

This study explored the experiences of travel nurses and the strategies that they use when they encounter relational challenges at work. The first strategy – the *Competent Coworker* – is employed to manage perceptions regarding the clinical competence of travel nurses. The strategy of being a *Competent Coworker* typically occurs within formal communication practices such as documentation or shift hand-offs and is made possible because nurses share a common set of professional socialization experiences (Price, McGillis Hall, Murphy, & Pierce, 2018; Strouse, Nickerson, & McCloskey, 2018) and share a common goal of delivering quality patient care (Moore et al., 2013; Moore et al., 2017; Zealand et al., 2016). Travel nurses display their clinical competence by extending help readily to appreciative permanent nurses who welcome them. When they work with permanent nurses who doubt their abilities, travel nurses

remain resiliently focused on prioritizing the delivery of quality care even amidst hostile coworkers. Their professionalism shows others that they can perform effectively despite having to adapt to unfamiliar environments and colleagues. The second strategy – the *Gracious Guest* – addresses how travel nurses work to fit within a unit's pre-existing culture and professional practices. Using the metaphor of the work unit as a "house," my participants avert offending other nurses by avoiding conflict that would be generated by critiquing the work of the unit. Simply, they adapt to the work practices of permanent nurses and their temporary facilities' culture as long as they can still deliver quality patient care. They also let permanent nurses take the lead in developing relationships as a way of respecting permanent nurses' interactional preferences, as not every permanent nurse welcomes travel nurses.

My analysis suggests three major implications: (1) professional socialization may mitigate potentially negative effects when temporary workers negotiate the task dimension of their relationships, (2) contributions to unit innovation and learning by travel nurses are discouraged, and (3) creating travel-permanent nurse relationships involves managing dialectical tensions.

First, professional socialization may mitigate the potentially negative effects when temporary workers negotiate the task dimension of their relationships. A key finding from this study was that travel nurses felt they needed to establish their professional competence in the eyes of the permanent nurses when entering a new work assignment. In some ways, this is a fairly easy task as the professional socialization of nurses is relatively standard involving attending accredited nursing schools with a fairly

set curriculum and meeting licensure requirements (Price et al., 2018; Strouse et al., 2018). This common socialization process produces registered nurses who share a common body of knowledge and understanding of clinical work.

What is interesting about the role of professional socialization in managing work relationships is that it primarily mitigates the potentially negative impacts of temporary work for the task dimension of relationship that has significant implications for patient outcomes but not the personal dimension of the relationship. While professional socialization may help offset potential difficulties in relation to task relationships, it does not offset potential difficulties in the personal relationships that travel nurses may engage when they engage in informal communication with permanent nurses. While professional socialization may lead to acceptance of travel nurses by permanent nurses when performing tasks, it seems to have little impact on the personal nature of those relationships. The strategy of the *Gracious Guest* highlights relational issues such as being a friend and offering social support, which may not be easily captured in the professional training of nurses. Whereas it is possible to train nurses how they should work independently and collaborate with others, it is much harder to create a set of socialization experiences that facilitate the development of deep personal relationships.

Second, contributions to unit innovation and learning by travel nurses are discouraged. The strategy of the *Gracious Guest* suggests that travel nurses do share their observations of their temporary units among themselves, especially when permanent nurses have no interest in learning new techniques that are potentially more effective. Travel nurses may be a rich source of information for units to develop new

practices, but they may not volunteer this information fearing they be viewed negatively as sharing such information may be viewed as a critique of the unit's current practices.

A future line of inquiry worth pursuing is to investigate how permanent nurses perceive travel nurses and their reasons for and against undermining travel nurses' contribution to the development of new work practices. Some research has suggested that current employees may perceive newcomers as threats to their present and future status (Reh, Tröster, & Van Quaquebeke, 2018). In the case of travel nurses, this may be particularly important if they become viewed as more than "hired hands" to fill staffing needs to important contributors to innovations in practice that permanent nurses may perceive as threats to their status and/or fear of losing something important such as job security.

Third, creating travel-permanent nurse relationships involves managing dialectical tensions. The current analysis suggests that travel nurses must manage several dialectical tensions as they develop their relationships with permanent nurses. For example, the Competent Worker strategy suggests that travel nurses must manage a tension between demonstrating their competence by conforming to normal work practices (fitting in) versus going beyond what is called for and doing something innovative (standing out). The latter may appear as disrespectful or offend permanent nurses as it may be perceived as a critique of their work practice. Similarly, the *Gracious Guest* strategy suggests that travel nurses manage a proactive-reactive dialectic where they manage the need to be reactive by letting permanent nurses control the development of the relationship and proactive by forming relationships with other travel nurses. It is

not surprising that travel nurses may have to manage various dialectics with relating to permanent nurses as relational dialectic theory suggests that all relationships are marked by dialectical tensions (see Baxter, 2004). Nonetheless, additional inquiry into the types of dialectics and how they are managed may be needed. The successful maintenance of dialectics may contribute to developing strong task and personal relationships between travel nurses and permanent nurses.

Future Research

I identify three areas for future research. The focus of this study has focused on how individual travel nurses navigate temporary work assignments. First, future research might explore how organizations can create and design "traveler-friendly" facilities. A body of research suggests that nurses who are adequately supported by their managers exhibit stronger organizational commitment and hold a more favorable view of their work environment (Chisengantambu, Robinson, & Evans, 2017; Sveinsdóttir, Ragnarsdóttir, & Blöndal, 2016), which may help reduce turnover. Yet, relatively few studies explore the unique dilemmas and challenges to work and workplace relationships that alternative work arrangements pose for nurse managers, namely ways that nurse managers can communicatively foster supportive work environments (see Marx, 2014). Future research that examines how organizations may create "traveler-friendly" facilities by deliberatively altering work and management practices through training is warranted.

Second, future research might investigate the role that social comparison and envy play in how travel nurses manage their relationships with permanent nurses. My analysis suggests that social comparison processes regarding money and work

expectations may occur making permanent nurses envious of travel nurses. The common practice of paying temporary nurses a higher remuneration than permanent nurses sets up a potentially contentious issue because nurses feel most envious when they earn less than what other nurses earn (Heikkinen, Nikkonen, & Aavarinne, 1998; Hurst & Smith, 2010). Scholarship on envy concurs that competition for scarce resources – such as money and promotion opportunities – can evoke negative emotions such as feeling insecure (Cohen-Charash & Larson, 2017; Reh et al., 2018). Money as a potential cause of envy can create issues for nurse managers because they must balance the need to employ temporary nurses and possible negative repercussions from permanent nurses. One direction worth investigating is to understand the extent that travel nurses perceive themselves as envied individuals and how they manage those perceptions. Such research may generate insights into ways that nurse managers might help foster collaborative travel-permanent nurse relationships while reducing perceived differences arising from social comparisons.

Third, future research might consider whether the length of the temporary appointments influences how travel nurses may manage their relationships with permanent nurses. This is important as short-term and long-term temporary nurses have different roles within health facilities (Berg Jansson & Engström, 2017). For instance, how would the responsibilities of temporary nurses employed for several months differ from weeklong temporary nurses? How might these responsibilities influence how relationships are negotiated with permanent nurses? Regardless of official job scopes, different contract lengths may influence temporary nurses' proactivity and reactivity in

terms of relationship building. Future research should explore how the length of the appointment might influence the types of issues or tensions travel nurses might experience and how they manage them.

References

Abraham, J., Kannampallil, T. G., Srinivasan, V., Galanter, W. L., Tagney, G., & Cohen, T. (2017). Measuring content overlap during handoff communication using distributional semantics: An exploratory study. *Journal of Biomedical Informatics, 65*, 132–144. doi:10.1016/j.jbi.2016.11.009

Agypt, B., & Rubin, B. A. (2012). Time in the new economy: The impact of the interaction of individual and structural temporalities on job satisfaction. *Journal of Management Studies, 49*, 403–428. doi:10.1111/j.1467-6486.2011.01021.x

American Association of Critical-Care Nurses. (2005). AACN standards for establishing and sustaining healthy work environments: A journey to excellence. *American Journal of Critical Care, 14*, 187–197.

Bae, S.-H., Farasat, A., Nikolaev, A., Seo, J. Y., Foltz-Ramos, K., Fabry, D., & Castner, J. (2017). Nursing teams: Behind the charts. *Journal of Nursing Management, 25*, 354–365. doi:10.1111/jonm.12473

Ballard, D. I., & Gossett, L. M. (2007). Alternative times: Temporal perceptions, processes, and practices defining the nonstandard work relationship. *Annals of the International Communication Association, 31*, 274–320. doi:10.1080/23808985.2007.11679069

Baumann, A., Hunsberger, M., & Crea-Arsenio, M. (2013). Full-time work for nurses: Employers' perspectives. *Journal of Nursing Management, 21*, 359–367. doi:10.1111/j.1365-2834.2012.01391.x

Baxter, L. A. (2004). Relationships as dialogues. *Personal Relationships, 11*, 1–22. doi:10.1111/j.1475-6811.2004.00068.x

Berg Jansson, A., & Engström, Å. (2017). Working together: Critical care nurses experiences of temporary staffing within Swedish health care: A qualitative study. *Intensive and Critical Care Nursing, 41*, 3–10. doi:10.1016/j.iccn.2016.08.010

Cavanagh, S. J. (1991). The conflict management style of staff nurses and nurse managers. *Journal of Advanced Nursing, 16*, 1254–1260. doi:10.1111/j.1365-2648.1991.tb01536.x

Chisengantambu, C., Robinson, G. M., & Evans, N. (2017). Nurse managers and the sandwich support model. *Journal of Nursing Management, 26*, 192–199. doi:10.1111/jonm.12534

Cicellin, M., Pezzillo Iacono, M., Berni, A., & Esposito, V. (2015). Dealing with resistance in temporary agency nurses. *Journal of Health Organization and Management, 29*, 298–316. doi:10.1108/jhom-02-2013-0044

Cleary, M., Walter, G., Halcomb, E., & Lopez, V. (2016). An examination of envy and jealousy in nursing academia. *Nurse Researcher, 23*, 14–19. doi:10.7748/nr.2016.e1405

Cohen-Charash, Y., & Larson, E. C. (2017). An emotion divided. *Current Directions in Psychological Science, 26*, 174–183. doi:10.1177/0963721416683667

Coiera, E. W., Jayasuriya, R. A., Hardy, J., Bannan, A., & Thorpe, M. E. (2002). Communication loads on clinical staff in the emergency department. *The Medical Journal of Australia, 176,* 415–418.

Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five tradition.* (3rd ed.). Thousand Oaks, CA: Sage.

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory into Practice, 39,* 124–130. doi:10.1207/s15430421tip3903_2

Ellingson, L. L. (2003). Interdisciplinary health care teamwork in the clinic backstage. *Journal of Applied Communication Research, 31,* 93–117. doi:10.1080/0090988032000064579

Faller, M. S., Gates, M. G., Georges, J. M., & Connelly, C. D. (2011). Work-related burnout, job satisfaction, intent to leave, and nurse-assessed quality of care among travel nurses. *JONA: The Journal of Nursing Administration, 41,* 71–77. doi:10.1097/nna.0b013e3182059492

Fritz, J. H. (2014). Researching workplace relationships. *Journal of Social and Personal Relationships, 31,* 460–466. doi:10.1177/0265407514522888

Gittell, J. H. (2016). Rethinking autonomy: Relationships as a source of resilience in a changing healthcare system. *Health Services Research, 51,* 1701–1705. doi:10.1111/1475-6773.12578

Gossett, L. M. (2001). The long-term impact of short-term workers. *Management Communication Quarterly, 15,* 115–120. doi:10.1177/0893318901151007

Harris, R., Sims, S., Parr, J., & Davies, N. (2015). Impact of 12h shift patterns in nursing: A scoping review. *International Journal of Nursing Studies, 52*, 605–634. doi:10.1016/j.ijnurstu.2014.10.014

Heaphy, E. D., Byron, K., Ballinger, G. A., Gittell, J. H., Leana, C. R., & Sluss, D. M. (2018). The changing nature of work relationships. *Academy of Management Review, 43*, 1–12. doi:10.5465/amr.2018.0222

Heikkinen, E., Nikkonen, M., & Aavarinne, H. (1998). 'A good person does not feel envy': Envy in a nursing community. *Journal of Advanced Nursing, 27*, 1069–1075.

Hesse-Biber, S. N., & Leavy, P (2011). *The practice of qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.

Hocker, J. L., & Wilmot, W. W. (2013). *Interpersonal conflict.* (9th ed.). New York, NY: McGraw-Hill.

Hofmann, D. A., Lei, Z., & Grant, A. M. (2009). Seeking help in the shadow of doubt: The sensemaking processes underlying how nurses decide whom to ask for advice. *Journal of Applied Psychology, 94*, 1261–1274. doi:10.1037/a0016557

Holland, P., Cooper, B., & Sheehan, C. (2017). Employee voice, supervisor support, and engagement: The mediating role of trust. *Human Resource Management, 56*, 915–929. doi:10.1002/hrm.21809

Hurst, K., & Smith, A. (2010). Temporary nursing staff - cost and quality issues. *Journal of Advanced Nursing, 67*, 287–296. doi:10.1111/j.1365-2648.2010.05471.x

Johansen, M. L. (2014). Conflicting priorities: Emergency nurses perceived disconnect between patient satisfaction and the delivery of quality patient care. *Journal of Emergency Nursing, 40,* 13–19. doi:10.1016/j.jen.2012.04.013

Johansen, M. L., & Cadmus, E. (2016). Conflict management style, supportive work environments and the experience of work stress in emergency nurses. *Journal of Nursing Management, 24,* 211–218. doi:10.1111/jonm.12302

Katz, L. F., & Krueger, A. B. (2016). *The rise and nature of alternative work arrangements in the United States, 1995-2015*. (NBER Working Paper No. 22667). Cambridge, MA: National Bureau of Economic Research.

Kilmann, R. H., & Thomas, K. W. (1977). Developing a forced-choice measure of conflict-handling behavior: The "mode" instrument. *Educational and Psychological Measurement, 37,* 309–325. doi:10.1177/001316447703700204

Kortbeek, N., Braaksma, A., Burger, C. A. J., Bakker, P. J. M., & Boucherie, R. J. (2015). Flexible nurse staffing based on hourly bed census predictions. *International Journal of Production Economics, 161,* 167–180. doi:10.1016/j.ijpe.2014.12.007

Kramer, M. W., & Bisel, R. S. (2017). *Organizational communication: A lifespan Approach*. New York, NY: Oxford.

Kramer, M. W., & Miller, V. D. (1999). A response to criticisms of organizational socialization research: In support of contemporary conceptualizations of organizational assimilation. *Communication Monographs, 66,* 358–367. doi:10.1080/03637759909376485

Labrague, L. J., Al Hamdan, Z., & McEnroe-Petitte, D. M. (2018). An integrative review on conflict management styles among nursing professionals: Implications for nursing management. *Journal of Nursing Management*. doi:10.1111/jonm.12626

Lange, J., & Crusius, J. (2015). Dispositional envy revisited. *Personality and Social Psychology Bulletin, 41*, 284–294. doi:10.1177/0146167214564959

Lange, J., Paulhus, D. L., & Crusius, J. (2018). Elucidating the dark side of envy: Distinctive links of benign and malicious envy with dark personalities. *Personality and Social Psychology Bulletin, 44*, 601–614. doi:10.1177/0146167217746340

Lee, C. T.-S., & Doran, D. M. (2017). The role of interpersonal relations in healthcare team communication and patient safety. *Canadian Journal of Nursing Research, 49*, 75–93. doi:10.1177/0844562117699349

Lee, K., Duffy, M. K., Scott, K. L., & Schippers, M. C. (2018). The experience of being envied at work: How being envied shapes employee feelings and motivation. *Personnel Psychology, 71*, 181–200. doi:10.1111/peps.12251

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

Lindlof, T. R., & Taylor, B. C. (2011). *Qualitative communication research methods* (3rd ed.). Thousand Oaks, CA: Sage.

Maenhout, B., & Vanhoucke, M. (2013). An integrated nurse staffing and scheduling analysis for longer-term nursing staff allocation problems. *Omega, 41*, 485–499. doi:10.1016/j.omega.2012.01.002

Mahon, M. M., & Nicotera, A. M. (2011). Nursing and conflict communication. *Nursing Administration Quarterly, 35*, 152–163. doi:10.1097/naq.0b013e31820f47d5

Marshall, C., & Rossman, G. B. (1995). *Design qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.

Marx, M. (2014). Examining the structural challenges to communication as experienced by nurse managers in two US hospital settings. *Journal of Nursing Management, 22*, 964–973. doi:10.1111/jonm.12091

Mazurenko, O., Liu, D., & Perna, C. (2015). Patient care outcomes and temporary nurses. *Nursing Management, 46*(8), 32–38. doi:10.1097/01.numa.0000469351.33893.61

Miles, M. B., & Huberman, A. M. (1984). *Qualitative data analysis: A sourcebook of new methods* (2nd ed.). Thousand Oaks, CA: Sage.

Moore, L. W., Leahy, C., Sublett, C., & Lanig, H. (2013). Understanding nurse-to-nurse relationships and their impact on work environments. *MedSurg Nursing, 22*, 172–179.

Moore, L. W., Sublett, C., & Leahy, C. (2017). Nurse managers speak out about disruptive nurse-to-nurse relationships. *JONA: The Journal of Nursing Administration, 47*, 24–29. doi:10.1097/nna.0000000000000665

Morrison, J. (2008). The relationship between emotional intelligence competencies and preferred conflict-handling styles. *Journal of Nursing Management, 16*, 974–983. doi:10.1111/j.1365-2834.2008.00876.x

Norful, A., Martsolf, G., de Jacq, K., & Poghosyan, L. (2017). Utilization of registered nurses in primary care teams: A systematic review. *International Journal of Nursing Studies, 74*, 15–23. doi:10.1016/j.ijnurstu.2017.05.013

Panesar, R. S., Albert, B., Messina, C., & Parker, M. (2016). The effect of an electronic SBAR communication tool on documentation of acute events in the pediatric intensive care unit. *American Journal of Medical Quality, 31*, 64–68. doi:10.1177/1062860614553263

Patient, D., Lawrence, T. B., & Maitlis, S. (2003). Understanding workplace envy through narrative fiction. *Organization Studies, 24*, 1015–1044. doi:10.1177/01708406030247002

Pillemer, J., & Rothbard, N. P. (2018). Friends without benefits: Understanding the dark sides of workplace friendship. *Academy of Management Review*. doi:10.5465/amr.2016.0309

Price, S. L., McGillis Hall, L., Murphy, G. T., & Pierce, B. (2018). Evolving career choice narratives of new graduate nurses. *Nurse Education in Practice, 28*, 86–91. doi:10.1016/j.nepr.2017.10.007

Reh, S., Tröster, C., & Van Quaquebeke, N. (2018). Keeping (future) rivals down: Temporal social comparison predicts coworker social undermining via future status threat and envy. *Journal of Applied Psychology, 103*, 399–415. doi:10.1037/apl0000281

Rispel, L. C., & Moorman, J. (2015). The indirect costs of agency nurses in South Africa: A case study in two public sector hospitals. *Global Health Action, 8*(1), 26494. doi:10.3402/gha.v8.26494

Seitovirta, J., Lehtimäki, A. V., Vehviläinen-Julkunen, K., Mitronen, L., & Kvist, T. (2017). Registered nurses' perceptions of rewarding and its significance. *Journal of Nursing Management, 26*, 457–466. doi:10.1111/jonm.12571

Seitovirta, J., Vehviläinen-Julkunen, K., Mitronen, L., De Gieter, S., & Kvist, T. (2016). Attention to nurses' rewarding – an interview study of registered nurses working in primary and private healthcare in Finland. *Journal of Clinical Nursing, 26*, 1042–1052. doi:10.1111/jocn.13459

Spreitzer, G. M., Cameron, L., & Garrett, L. (2017). Alternative work arrangements: Two images of the new world of work. *Annual Review of Organizational Psychology and Organizational Behavior, 4*, 473–499. doi:10.1146/annurev-orgpsych-032516-113332

Staggers, N., & Blaz, J. W. (2013). Research on nursing handoffs for medical and surgical settings: An integrative review. *Journal of Advanced Nursing, 69*, 247–262. doi:10.1111/j.1365-2648.2012.06087.x

Strouse, S. M., Nickerson, C. J., & McCloskey, E. M. (2018). We don't miter the sheets on the bed: Understanding the preceptor role in the enculturation of nursing students. *Nurse Education in Practice, 32*, 21–27. doi:10.1016/j.nepr.2018.06.014

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques* (2nd ed.). Newbury Park, CA: Sage.

Sveinsdóttir, H., Ragnarsdóttir, E. D., & Blöndal, K. (2016). Praise matters: The influence of nurse unit managers' praise on nurses' practice, work environment and job satisfaction: A questionnaire study. *Journal of Advanced Nursing, 72,* 558–568. doi:10.1111/jan.12849

Thomas, D. R. (2016). Feedback from research participants: Are member checks useful in qualitative research? *Qualitative Research in Psychology, 14,* 23–41. doi:10.1080/14780887.2016.1219435

Van de Ven, N., Zeelenberg, M., & Pieters, R. (2011). Why envy outperforms admiration. *Personality and Social Psychology Bulletin, 37,* 784–795. doi:10.1177/0146167211400421

Vandecasteele, T., Van Hecke, A., Duprez, V., Beeckman, D., Debyser, B., Grypdonck, M., & Verhaeghe, S. (2017). The influence of team members on nurses' perceptions of transgressive behaviour in care relationships: A qualitative study. *Journal of Advanced Nursing, 73,* 2373–2384. doi:10.1111/jan.13315

Vidaillet, B. (2007). Lacanian theory's contribution to the study of workplace envy. *Human Relations, 60,* 1669–1700. doi:10.1177/0018726707084304

Wagner, J.-D., Bezuidenhout, M. C., & Roos, J. H. (2015). Communication satisfaction of professional nurses working in public hospitals. *Journal of Nursing Management, 23,* 974–982. doi:10.1111/jonm.12243

Zannini, L., Ghitti, M. G., Martin, S., Palese, A., & Saiani, L. (2015). Narratives, memorable cases and metaphors of night nursing: Findings from an interpretative phenomenological study. *Nursing Inquiry, 22*, 261–272. doi:10.1111/nin.12091

Zealand, R., Larkin, D., & Shron, M. (2016). Building relationship-based care among nurses: A holistic, exploratory project. *Creative Nursing, 22*, 185–195. doi:10.1891/1078-4535.22.3.185

CHAPTER IV

TRAVEL NURSES' CONSTRUCTION OF CAREER NARRATIVES: A QUALITATIVE STUDY ON CAREER SENSEMAKING

Overview

Contemporary workers are increasingly expressing their aspirations through their careers. The proliferation of alternative work arrangements and the rise of travel nursing have raised the need to understand how travel nurses construct their career narratives and identities. Guided by career construction theory to understand the career sensemaking of travel nurses, I conducted one-on-one semi-structured interviews with 25 registered nurses with travel nursing experience in the United States. The data analysis reveals six themes that outline how travel nursing connects my participants' past, present, and future. My participants did not become nurses solely for financial remuneration, but they became travel nurses after learning as staff nurses that travel nursing could increase their earning potential in certain circumstances. I extend career construction theory by advancing a theory that highlights the adaptability and proactivity of contemporary professionals whose frequent job changes manifest their intrinsic values and identities while developing their careers.

Introduction

The global nursing shortage, vocational professionalization, and new ways of organizing work constantly reshape employment relations and how employees make sense of their careers (Hall, Yip, & Doiron, 2018; Leineweber et al., 2016; Maitlis & Christianson, 2014; Mainiero & Sullivan, 2005; Jeong & Leblebici, 2018; Tomlinson, Baird, Berg, & Cooper, 2018). These developments influence the human resource management of nurses and create an economy where facilities maximize staffing flexibility by employing nurses in diverse work arrangements. Such arrangements not only benefit facilities, they may also benefit nurses as they can create their desired work-life balance by choosing how much, when, and which facilities they work for (Baumann, Hunsberger, & Crea-Arsenio, 2013; de Ruyter, 2007; Rispel & Blaauw, 2015). As a result, nurses who prefer employment flexibility often find travel nursing appealing—an alternative work arrangement where facilities manage their staffing needs by employing nurses contracted through temporary staffing agencies (Mazurenko, Liu, & Perna, 2015). Travel nurses may find such work arrangements attractive given the higher remuneration levels than permanent nurses (de Ruyter, 2007; Hurst & Smith, 2010) as well as the ability to avoid difficult work environments and to gain greater control of their schedules. It is not surprising, therefore, that travel nurses report high job satisfaction and less burnout (Faller, Gates, Georges, & Connelly, 2011).

Travel nursing represents a form of "nonstandard" or alternative work arrangement distinct from the conventional "standard" work arrangement of permanent positions (Katz & Krueger, 2016; Mas & Pallais, 2016; Spreitzer, Cameron, & Garrett,

2017). Although alternative work arrangements of varied shifts are not new to the nursing profession (Gifkins, Loudoun, & Johnston, 2017), the literature in this area is relatively sparse as it focuses on economic and patient outcomes (Institute of Medicine, 2004; Harris, Sims, Parr, & Davies, 2015; Maenhout & Vanhoucke, 2013; Xue, Chappel, Freund, Aiken, & Noyes, 2015). Current scholarship has neither fully understood the effects of shift work on nurses' wellbeing (Dall'Ora, Ball, Recio-Saucedo, & Griffiths, 2016; Harris et al., 2015; Rodwell & Fernando, 2016) nor nurses' career sensemaking (Price, McGillis Hall, Angus, & Peter, 2013a). Understanding how nurses weave together and make sense of significant experiences to create a master narrative that constructs a meaningful, coherent, and credible identity is important because that insight reveals what matters to nurses (Bujold, 2004; Ibarra & Barbulescu, 2010; LaPointe, 2010; Price et al., 2013a). For the purposes of this study, a narrative is defined as people's storying of their lives as they make sense of how early memories motivate them to overcome present and future challenges (Del Corso & Rehfuss, 2011).

The career construction narratives of travel nurses – highly mobile professionals whose careers comprise multiple short-term assignments – are the concern of this study. Contemporary workers are increasingly expressing their aspirations through their careers (Hall et al., 2018), implying that some travel nurses may choose this distinct work arrangement as an expression of their values. I adopt constructionism as this study's epistemological perspective, which highlights individuals' cognitive processing of what constitutes knowledge and how the meaning of knowledge helps them make sense of their experiences (Bujold, 2004; Burns, Garcia, Smith, & Goodman, 2016). The

constructionist viewpoint of careers denotes the active meaning-making process of creating life themes using one's past, present, and future (Savickas, 2006). Career narratives represent an organized series of curated life experiences that reflect one's identity (LaPointe, 2010). I begin by reviewing the relevant careers literature, then outline the study's research methodology, and finally discuss the study's findings and implications.

Career Sensemaking and Communicating Life Experiences

Sensemaking refers to the interpretation of one's life experiences as identity construction and subsequently communicated to others as descriptions of his or her social world (Brown, Stacey, & Nandhakumar, 2008). It is a retrospective consideration of social cues whereby one authors an emerging story through constructed plausible meanings amidst ambiguity (Ibarra & Barbulescu, 2010; Weick, 1995). Sensemaking's central function as an organizing activity makes it appropriate not only for understanding one's social interactions but also the events in one's organizational life (Maitlis & Christianson, 2014; Weick, Sutcliffe, & Obstfeld, 2005). Career sensemaking performs a crucial role in helping professionals project positive identities to others as they forge new meanings at and through work (Jorgenson, 2016), especially when such career passages take them on novel paths.

Many nurses and the communities that they come from view nursing as a profession that makes a difference (Price et al., 2013a). Empirical research suggests that nurses typically have friends and family members who encourage them to pursue a nursing career because they exhibit extraordinary care for others' wellbeing and that

they appreciate how their family members received quality nursing care (Kristoffersen & Friberg, 2016). The support that nurses receive from friends, families, and colleagues helps them overcome workplace challenges and cement their decision to stay in the profession (Gifkins et al., 2017). Nurses from different generational cohorts have different expectations of the profession but they also make complementary contributions to support one another at work (Christensen, Wilson, & Edelman, 2018). While nurses may have at least a significant life event that motivates them to become and continue working as nurses, any combination of other factors throughout their lives may also influence their career choice. For example, stereotypes can shape nurses' perceptions of their profession and their interactions with other healthcare professionals (Price & McGillis Hall, 2014). The construction of career narratives through career-shaping experiences reveal some of the complex considerations of one's career behavior such as overcoming obstacles and unforeseen events as well as how one understands work in relation to other individuals and organizations (Bujold, 2004; Del Corso & Rehfuss, 2011).

Career Construction Theory

Career Construction Theory (CCT) views narratives as clarifications and interpretations articulated by individuals who feature themselves as the protagonists of their personal stories (Del Corso & Rehfuss, 2011). CCT uses a constructionist view to explore the meaning of vocational behavior by asking three important questions: (1) *What* do individuals prioritize in terms of work preference?, (2) *How* do individuals adapt to vocational transitions?, and (3) *Why* do individuals incorporate work

into their lives in the way that they have done so? (Savickas, 2006). This theory has four dimensions of career adaptability: (1) the extent of one's *concern* about his or her vocational future, (2) the extent of one's assertiveness in maintaining career *control*, (3) the extent of one's *curiosity* of career possibilities, and (4) the extent of one's *confidence* in overcoming challenges and pursuing that future (Savickas, 2006). The critical events storied by individuals answer the above questions. As people undergo work role transitions, they revise their self-narratives that reconstructs their identities, which further refines their career narratives (Ibarra & Barbulescu, 2010).

CCT provides a useful framework for the study of today's highly mobile workers who may not view employment as a lifelong commitment to an employer but as a series of contracts or projects that meaningfully contribute to their personal and professional aspirations including better remuneration, work-life balance, and preparation for the next contract or project (Savickas, 2006). Researchers have recently applied this theory to diverse international samples from full-time workers in China (Xie, Xia, Xin, & Zhou, 2016) and refugees in Germany (Wehrle, Kira, & Klehe, 2018), but they typically do not detail their samples' industries and that makes it difficult to ascertain the typical tenure of their sample's profession. While CCT centers on how individuals adapt to career challenges for personal wellbeing (Perera & McIlveen, 2017; Rudolph, Lavigne, Katz, & Zacher, 2017), CCT does not specifically address frequent job changes in a career progression.

Dominant Career Concepts

Frequent job changes observed in contemporary careers have popularized the boundaryless career and protean career concepts (Akkermans & Kubasch, 2017; Kostal & Wiernik, 2017; Rodrigues, Guest, Oliveira, & Alfes, 2015; Tomlinson et al., 2018). Although a full discussion on the similarities and differences between boundaryless careers and protean careers is beyond the present study's scope, these two concepts give frequent job changes more attention than CCT and they spotlight workers' proactive pursuit of the careers they deem most desirable in their individual contexts (Jeong & Leblebici, 2018; Kostal & Wiernik, 2017).

A boundaryless career entails both physical and psychological mobility as it characterizes career development as comprising physical mobility where one may switch from one enactment of work to another – such as changing organizations, occupations, or geographical locations – as well as psychological mobility, which refers to how one may perceive his or her capacity of making potential career transitions beyond the present job (Arthur, 1994; Arthur & Rousseau, 2001; Sullivan & Arthur, 2006; Tomlinson et al., 2018). This career concept underscores workers' pursuit of independence from traditional advancements within a single organizational hierarchy (Arthur, 1994; see Tams & Arthur, 2010). Boundaryless careers shift the traditional focus of building entire careers with a single employer to a focus where professionals construct their ideal careers and chart nontraditional career paths unconstrained by organizational boundaries. Individuals in boundaryless careers value autonomy and

desire intellectual stimulation across professional and organizational settings (Abessolo, Hirschi, & Rossier, 2017).

In contrast to boundaryless careers, protean careers refer to career reinvention based on each individual's psychological or subjective motivations toward career success (Hall, 1976; Hall et al., 2018; see Tomlinson et al., 2018). This notion views careers as "self-determined, driven by personal values rather than organizational rewards" (Hall, 2004, p. 2; cf. Arthur, 1994). Workers who pursue protean careers usually cherish work values such as independence and autonomy (Abessolo et al., 2017), where workers perform work that helps them become the kind of people they want to be. Protean careers emphasize the permeability of ever-changing boundaries instead of merely crossing established boundaries posited in the boundaryless career concept (Tomlinson et al., 2018). Protean careers are similar to CCT in the sense that they both value self-reflexivity. Protean professionals who feel strongly about the economic, political, and social upheavals around them abandon well-charted organizational paths in search of self-directed work progressions as a personal calling that expresses their intrinsic values (Hall et al., 2018). Yet, this distinction revolves around individual proactivity and less about career adaptability. In sum, autonomous workers envision their protean careers based on individual motivations where they determine what their boundaryless careers will entail and how they may transpire.

Although scholars have applied the boundaryless and protean career concepts throughout the last two decades, these two career orientations remain relatively underdeveloped research areas because contemporary careers not only become less

permanent but also increasingly characterized by low employer-employee loyalty (Gubler, Arnold, & Coombs, 2014; Rodrigues et al., 2015). Moreover, these two concepts focus on individuals as free agents in control of their destinies but pay less attention to the details that contextualize how external actors and institutions carve out one's career experiences and life trajectories (Hall et al., 2018; Jeong & Leblebici, 2018; Tams & Arthur, 2010; Tomlinson et al., 2018). While the kaleidoscope career concept breaks away from that mold and recognizes human relations as an element capable of changing other aspects of life (Mainiero & Sullivan, 2005), it does not specifically acknowledge the career-shaping effect of institutions (Tomlinson et al., 2018).

Rationale for the Present Study

Workers have traditionally articulated their careers as a linear progression of experiences within the same organizational setting (LaPointe, 2010; Tomlinson et al., 2018). However, travel nurses utilize a distinct form of alternative work arrangement to seek flexible and temporary work on a continuous basis. CCT centers on exploring individuals' storying of self-perceptions and their threading their experiences as coherent narratives to build their identities (Del Corso & Rehfuss, 2011). However, most studies using CCT have tended to look at career development within the same organizational setting or presume that individuals stay in different organizational settings for long periods of time. These assumptions do not hold for travel nurses as the career path for temporary nurses are characterized by numerous relatively short job postings making their careers transient. This means that travel nurses develop their career through numerous short work assignments in multiple settings, where each job assignment gives

them new insights into how different facilities do things differently and each experience solidifies their foundation for future nursing endeavors. Temporary arrangements such as travel nursing apply CCT to temporary work, work that is characterized by strong individual agency – the notion of proactivity that individuals actively pursue physical and psychological mobility – as found in boundaryless and protean careers.

This study joins a growing literature that investigates nontraditional career choices (Akkermans & Kubasch, 2017). It adds to this literature by focusing on career sensemaking as an individualized representation of one's career identity within the context of temporary work arrangements (e.g., Jorgenson, 2016). Unlike organizational and professional identities, career identity refers to a series of work-related experiences that are not tied to a specific role or location (LaPointe, 2010; cf. Bayerl et al., 2018).

Because travel nursing has become a growing trend in the nursing profession (Colduvell, 2017; Flanagan, 2016), the recent surge in travel nursing has exposed knowledge gaps in how nurses construct their career narratives and identities through this increasingly popular work arrangement. This leads to the following research question:

RQ: *How do travel nurses make sense of their careers?*

Method

This study investigates how travel nurses make sense of their career choices using an inductive interpretive approach to articulate the prototypical themes and critical life events in their career sensemaking (LaPointe, 2010; Yost, Yoder, Chung, & Voetmann, 2015). Consistent with this study's constructionist paradigm, I collected data

using semi-structured interviews so that my participants' lived experiences and identities might surface naturally through interactions (Hesse-Biber & Leavy, 2011; LaPointe, 2010).

Participants

Participants were selected using purposeful sampling to specifically recruit nurses who had first-hand experience as travel nurses (Creswell, 2013). The inclusion criteria required that participants need to be registered nurses who had travel nursing experience in the United States. Their licensure as registered nurses established a common level of competence and responsibility among the participants. Upon receiving Institutional Review Board approval, I began participant recruitment by informing past participants of a study I conducted about the present study. Subsequently, I contacted personal and mutual contacts who satisfied the inclusion criterion. Two participants were recruited through mutual contacts while the other participants were recruited through either existing or new personal contacts.

The intentional use of purposeful sampling focused attention on the central phenomenon of investigation and immersed me in my target population's world (Hesse-Biber & Leavy, 2011). Twenty-five registered nurses based in the United States participated in this study (Female =20 participants; Male = 5 participants). Each participant had between two and 22 years (M = 9.34) of experience as a registered nurse and between one and 16 years (M = 4.03) of travel nursing experience. Table 6 summarizes the demographic information of the sample.

Table 6 Participants' Demographic Information.

Pseudonym	Specialty	Highest Education Earned	Experience		Ethnicity
			Registered Nurse (Years)	Travel Nurse (Years)	
Lisa	Critical care	Associates	12	11	White
Michael	Intermediate care/Telemetry	Bachelors	4½	2	White
Mary	Med-surg/Telemetry	Bachelors	4	2¼	White
John	Interventional radiology	Associates	17	6	Cajun
David	Interventional radiology	Bachelors	22	16	White
Karen	Emergency	Masters	9½	1	African-American
Kimberly	Critical care	Associates	11	4	White
Susan	Med-surg/Telemetry	Associates	13	4½	White
Patricia	Operating room	Bachelors	20	½	White
Donna	Critical care	Masters	13	10	African-American
Linda	Operating room	Bachelors	11	3	White
Cynthia	Interventional radiology	Diploma	12	1	White
Angela	Critical care	Bachelors	11	6	White
Tammy	Critical care	Masters	11	3	White
James	Emergency	Bachelors	4½	2	African-American
Deborah	Med-surg/Telemetry	Bachelors	3	½	African-American
Julie	Med-surg/Telemetry	Associates	2	1	Mexican-American
Sandra	Critical care	Bachelors	11	3	White
Robert	Critical care	Bachelors	7	5	Asian
Michelle	Med-surg/Telemetry	Bachelors	6	2½	Asian/ White
Laura	Critical care	Bachelors	6	4	White
Jennifer	Critical care	Bachelors	4	1	White
Sharon	Critical care	Bachelors	6	2½	Asian
Brenda	Critical care	Masters	10	8	White
Teresa	Critical care	Bachelors	3	1	White

Data Collection

The interview guide contained demographic questions as well as questions intended to generate insights into how travel nurses made sense of their career choices. The initial questions help me learn about details such as how long my participants had been registered nurses and the work arrangements in which they were currently working. I asked my participants about memories or experiences that influenced them in becoming nurses, what kept them in the profession, and how they envisioned their future in the profession. The data for this article came from a larger project that yielded 1,006 minutes of audio data and a professionally-transcribed transcript of 441 single-spaced pages. These interviews lasted between 16 and 64 minutes each (M = 40.24), excluding time spent to gain informed consent and on other interactions.

Data Analysis

I utilized a constant-comparative method to analyze the data inductively (Strauss & Corbin, 1990), reading the transcript line-by-line and creating tentative categories. Iterative readings of the interview transcript yielded themes that emerged through *open coding*, which came from grouped categories of initial concepts, and not through preconceived categories (Strauss & Corbin, 1990). I then developed my coding scheme using *axial coding*.

In the primary-cycle coding phase, I added comments on the transcript that served as memos that captured thoughts on potential codes as I interacted with the data.

For instance, I wrote “travel to…” followed by the reason why my participants did travel nursing (see Table 7).

Table 7 Data Analysis Example.

Concepts	Categories	Theme
…you’re able to **see** different parts of the country that you probably would normally not be able to **see** [102]	Travel **to travel (sightseeing)**	Become tourists
I was there ten months. I was able to learn how to **sail**. I **volunteered** on the weekends to be a deckhand. …I also was **waiting tables** on the weekends at a nice little restaurant right on Lovers Point… [141]	Travel **to travel (new experiences)**	
make about double what I used to as a perm staff employee [82]	Travel **to make money (gross income)**	Make more money
My profession enables me to be a single mom, have a **house**, and pay for my **bills** [97]	Travel **to make money (net income)**	
…in my permanent position, I was **not improving** at all. ... I had reached my potential in that particular environment [21]	Travel **to learn (plateaued at old job)**	Learn how others do things
You have to be a very **fast learner** because you don’t get any training [31]	Travel **to learn (steep learning curve at new job)**	

I took three steps to establish the validity of my analysis. First, I verified emerging themes with later interviewees through member checks. Member checks are widely held as a process to ensure credibility and to involve participants during data analysis (Thomas, 2016). I used it to invite participants' comments on findings, first by asking them the same questions that I asked previous participants and then asking later participants to what extent they agreed with the emerging themes. Second, I used thick, rich descriptions in the analysis section (Creswell, 2013). The purpose for using quotations is to provide substantive details so that readers can decide on the validity of the analysis and potential transferability of the findings (Creswell & Miller, 2000). Third, I used negative case analysis to challenge my interpretations of the data. The co-construction of my participants' collective narrative created a sensemaking process for both my participants and I (Brown et al., 2008). For example, the theme *make more money* is an example where I compared disconfirming or negative evidence to systematically check my biases of seeking only confirming evidence – that is, travel nurses do earn more money – that would fit what I know about this topic (Creswell & Miller, 2000). In that example, some nurses said that made substantially more money while others concluded that they did not earn much more after factoring in additional costs.

Analysis

Building upon CCT's three-part structure, I organized my analysis according to themes that answered the following three questions: (1) Why nursing? (vocational personality), (2) Why travel nursing? (career adaptability), and (3) What keeps them in

nursing? (life themes). These questions outline three distinctive periods of past, present, and future in nurses' work experience. Table 8 presents a summary of the thematic findings.

Table 8 Summary of Themes.

Why nursing?	**Why travel nursing?**	**What keeps them in nursing?**
• Family conversations and scientific minds	• Become tourists • Make more money • Learn how others do things	• Unlimited opportunities • Make a difference

Why Nursing?

Research conducted internationally consistently identifies family members as a profound influence on individuals' decision in becoming nurses (Duffield, Pallas, & Aitken, 2004; Maor & Cojocaru, 2018; Wu, Low, Tan, Lopez, & Liaw, 2015). My analysis affirms the importance of familial influence on nurses' career decisions.

More than two thirds of my participants described childhood events and conversations as key factors that directed them toward joining the nursing profession. Specifically, they credited early exposure to nursing and healthcare through family members. Michael's early exposure to nursing came from a hospitalization experience, "I was hospitalized [during high school] so that definitely had some impact in my interest in nursing. … prior to that, my mother had worked in the hospital … So, the environment was familiar to me [25]." Mothers who worked healthcare-related jobs have

a significant influence on my participants' career choice. Deborah remembered the conversations she had with her mother and her uncles, who encouraged her to become a nurse. She noted,

> My mom was a housekeeper in a hospital so a lot of times she would bring me to work and I remember being there and looking at things, "What's this medical equipment? What's that?" That influenced me unconsciously. And my family saying, "You should go into nursing." [253]

Sometimes, having nurses in their families puts nursing on their list of career options. For example, Jennifer suggested that having nurses as role models in her family shaped her career narrative:

> I was in sixth grade and my whole family [worked as farmers] except for one aunt who was a nurse. She asked me if I wanted to do her rounds with her before church, I said sure. …The fact that she was doing it so lovingly, I wanted to do just that. I wanted to help people out, be in their lives and make a difference that didn't involve just sitting at a computer all day… using my knowledge to help and since then I pursued that. I never wavered on becoming a nurse. [379-380]

Teresa also came from a family of nurses and heard stories about the nursing profession as a child that partly influenced her early career decision,

> As a kid growing up, at one point I thought about being a doctor but what attracted me to nursing was that I wanted to care for people instead of being the person to diagnose them. …my grandmother and two aunts were nurses, so

> seeing their experiences and seeing their lives influenced me. …I pretty much decided I wanted to be a nurse my freshman year of high school. [439]

These quotations give a glimpse into how family members have significant influence on nurses' career choice (Christensen et al., 2018; Gifkins et al., 2017; Maor & Cojocaru, 2018).

Families also influenced nurses' career choice by sharing a common interest in the sciences. One's exposure to family members' aptitude for the sciences – through family conversations and/or observation of family members' science-based careers – cultivated an appreciation for the sciences and made those subjects more likeable. Early and frequent exposure to family conversations about the sciences and nursing have been demonstrated to influence peoples' decisions to choose nursing (Maor & Cojocaru, 2018). Laura recounted,

> I grew up in a family of people working in the healthcare field, so I kind of knew I wanted to go in that direction. I did like science in school and working with people. Going into college I was considering more of a speech pathology route, but then was still pretty undecided, so freshman year of college spring break I went and shadowed a nurse, and that's when I decided that [nursing] was for me. [325]

Many traditional students who enjoyed the sciences took a similar path to Laura's as they found their inspiration about healthcare professions relatively early in college. Others, such as Mary, brought more life experiences to nursing. Mary described nursing as her 3rd career after having served in the military and worked in the retail

industry. She took a less traditional path to nursing and she found her love for science only during college. She recalled,

> I didn't go to college until I was 26. When I was younger and in school I was really bad at math and I was really bad at science. I was not interested in them. So, I didn't consider science-based professions. It wasn't until I got older and went to college and started caring about what I was learning that I realized that I was actually good at math and science. [38]

Mary excelled in science after she became more interested in her studies; her late-developing aptitude for the sciences changed her career path. Both David and James also became nurses later in their careers, also attributing their interest in the sciences as a key reason. David became a nurse as a mid-career professional during the economic downturn in the 1980s. He summarized,

> I always loved biology. I was a little too old to go to medical school. So, the nurse avenue was the second-best option, in order to keep feeding the kids and keep a roof over the family's head. …it was a very good choice. You find yourself trying to be as technically proficient as you can, yet very passionate and caring at the same time. You don't necessarily find that with physicians. It's been very rewarding to me. [64]

James switched to nursing initially for physical fitness,

> I was having conversations with people about working out and taking care of my body. One of my coworkers started mentioning nursing and doing something else besides [previous industry]. And I thought to myself, "I do like to stay healthy,

> and I like to help other people, let's see what this is about."… I loved biology, with the prerequisites, and then I got into the program and I never looked back. [239]

Nurses joined the profession primarily because of early exposures to the healthcare sector and their interest in the sciences. While not all participants had familial role models who inspired their interest in the sciences, mid-career nurses eventual (re)found science intriguing and that is what made them interested in nursing.

Why Travel Nursing?

My participants made conscious initial decisions to become travel nurses based on strategic reasons, specifically sightseeing opportunities, better remuneration, and an overall desire to learn things.

Become tourists. The prospect of visiting places they had never visited before motivated my participants to become travel nurses. Sandra told me about her adventures of working at destination cities and how staff nurses sometimes become her local guides by telling her about tourist attractions that she should visit and the places that locals frequent, "'When you go out to dinner with your family, where do you go?' That way you get to experience some of the local places, especially in Alaska, where there're a lot of touristy places [280]." Cynthia, who grew up in a major cosmopolitan city in Southern United States, also enjoyed sightseeing on her days off. She said,

> Travel nursing not only offers you – okay, yes, you get paid more money – but it gives you an opportunity to explore different areas, and it's more than just like, when you go on a vacation, you have a week or so to explore the area, but when

> you actually live there for three months, it gives you a chance to really immerse yourself in the area and really get to know, not just the touristy stuff, but really hang out with the locals and really be exposed to that area. [159]

Just like Cynthia, Jennifer, who is in her mid-twenties, succinctly summarized, "I get to travel across the country and explore. I call myself a long-term tourist—I can explore for 13 weeks but at the same time getting paid to do it" [371].

Make more money. Nurses usually cite money as a motivator in becoming travel nurses (de Ruyter, 2007; Hurst & Smith, 2010); all but one participant said they became travel nurses for better salaries. Bearing in mind that all clinical nurses start their careers in staff positions, this observation is significant because many nurses perceived that travel nurses made more money. The only participant who did not mention that she did travel nursing for money was in a unique situation as she did travel nursing in addition to her regular job. Mary epitomized the essence of this theme:

> The money as a staff nurse was pretty terrible so I was looking at ways to increase my pay. At first, I was going to take a 2nd job and then I realized that travel nurses make twice the amount that staff nurses make. [33]

Earning remuneration about twice their previous salaries seems fairly common, as Kimberly said, "[I would] make about double what I used to as a perm staff employee [82]." David also acknowledged the substantial financial incentive, "The compensation package is about 65% to 70% better than what I would get as a staff nurse. I started traveling to help my kids get through college [57]."

While travel nurses do earn more money than staff nurses in many instances by filling staffing gaps (Colduvell, 2017; de Ruyter, 2007; Flanagan, 2016; Hurst & Smith, 2010), having more work experience also partly explains the increased remuneration because nurses' salaries are also tied to experience and qualifications. Teresa explained,

> People were curious about how much I was paid as a travel nurse. People envy in the sense of what I was paid as a travel nurse to be in that particular area in comparison to what some staff nurses were paid. The staff nurses that were I guess, quote-unquote, envious of the pay, were entry-level nurses just starting off in the profession. It's a little bit harder for them to earn more hourly pay because they don't have enough experience yet. In that sense, kind of just a tough lesson of realizing that it takes time to accrue a higher paycheck as a nurse, and so in their eyes, they see me as a travel nurse and I have only maybe a year more of experience than them but nonetheless, because it's a year more, that equals more pay…. the only envy or jealousy I've experienced was when it came to a paycheck. [431]

Although travel nurses generally earn more money than nurses who have less experience, they sometimes conclude that the additional bonuses that they receive do not compensate them adequately for their sacrifices. Cynthia shared this thought,

> When you break down everything that we do, everything that we have to put up with, no, we don't really make that much money. If you break it down to every task that we do and what we get paid, we don't get paid enough [174].

As I tried to make sense of what Cynthia meant, I recalled that she mentioned her next transition,

> I'd signed a lease on an apartment here in Nashville and it was through June 19th. But they wouldn't let me out of the contract, so I've to pay for this apartment and the housing in Atlanta. So, I kind of got burned on this one. [158]

Laura gave a similar example where housing usually creates a financial burden, "I do make more [money], but I also have to pay for housing. I am paying for two households [334]." This insight suggests that life circumstances, such as those who financially support their families, necessitate that my participants capitalize on their earning potential. Furthermore, it appears that nurses who are not in financial debt and do not have familial obligations will potentially reap the greatest financial gains from travel nursing because they have fewer expenditures that will draw down from their higher remuneration.

Some of my participants do travel nursing because they are their families' breadwinners. While they dislike spending extended periods of time away from their families, they know they are providing for their families.

Learn how others do things. While the delivery of nursing care follows set policies and practices, my participants highlighted that there are a number of ways to perform tasks differently and that travel nursing builds their knowledge about nursing practice that can enhance their future employability. They constantly improvise techniques as they overcome inadequate resources and become more efficient, "I like to see how they [other facilities] do things… I've been able to learn a million different

ways to do one thing [Mary, 36].” Travel nurses also serve as resources whenever they share what they have learned from other facilities, John noted, “As people get to know me and I earn the respect of my peers, a lot of times they’ll say, ‘You’ve been to forty different facilities. How do they do it? How could we do it more efficiently?’[48].” Such interactions benefit both travel and staff nurses, as Sandra attested, “Nursing changes constantly. I think that even if you’ve been a nurse for thirty years, you still have a lot to learn [276].”

But a workplace culture that values learning requires nurses who are willing to support one another, which happens less often than what my participants prefer. Cynthia stated,

> It definitely helps when you go into a facility as a travel nurse that you’ve permanent employees that’ve been there for a while, that’re very knowledgeable, that’re supportive of travel nurses and take their time to explain things and to orient you. That’s a wonderful situation to come into: It all comes down to being flexible, professional, [and] supportive. [166]

Nurses who support one another not only share “best practices” but also build a community of caring individuals who feel encouraged by their colleagues and intend to stay in the profession (Christensen et al., 2018; Gifkins et al., 2017).

Nurses generally prefer to perform tasks in familiar ways. John, who worked in various nursing capacities, previously as a licensed practical nurse and now as a registered nurse, explained, “Nurses in general hate change. Hate it, because we’ve learned it this way. It’s worked this way. Why do we wanna change? [48]” Brenda, with

a decade of nursing experience, would agree, “They’re [staff nurses] set in their ways because they’re afraid of change and they’re gonna try to make everybody else afraid [426].”

David noted that staff nurses “do the same thing the same way over and over again, despite the lack of results [59].” Staff nurses with that perspective annoy David because he believes that nurses can always learn better ways of performing tasks. For instance,

> When I was in New York, I was scrubbing with the doctor and I said, “You know, there’s a different way of doing this. You could have a closed system so you never introduce air into the system. Therefore, it’s more sterile and less likely to have problems.” And he said, “Well, show me.” He was very interested in it, and I showed him, he loved the way it worked. As soon as that case was over, three of the staff nurses came in and said they couldn’t do it for a number of reasons but the doctor said none of those reasons were valid. They just did not want to change. [59]

These observations surface a dilemma where nursing practice constantly changes yet nurses dislike change. Much of that resistance to change takes root in the stability and predictability of one’s career and workplace. Linda put it,

> You go into some hospitals that have been operating for quite a while and you’ve nurses that have been there thirty, forty years. And some of those are like trees that have been grounded. They don’t want to move no matter which way the winds are blowing. They just don’t want to move. …They’re very territorial

> sometimes that way. You'd have to have a team that's willing to change and learn and grow and lift each other up instead of putting them down and stepping on each other so they can look better in the eyes of the doctors or whoever they're trying to impress. [142]

Although my participants perceived that some staff nurses resisted change, three quarters of my participants articulated a learning attitude because they believed in enacting change that would improve the way they deliver care.

> They're [staff nurses] used to the status quo. … Just because that's the way they've done it. "That's how things are done here and that's how we're going to do it." I think travel nurses are much more willing to embrace change. We're so used to constantly having to learn new things and learn how things are done so differently in different places that we do embrace change. We accept it, we are willing to try new things and question old standards, which I think is a big crux between permanent and travelers because we question them and they get angry that we're questioning their status quo. [Jennifer, 375]

It may initially seem paradoxical that travel nurses pursue this work arrangement so that they can learn how other nurses perform tasks at other facilities, as several participants highlighted that nurses in general dislike change and that they prefer to perform tasks in familiar ways. However, their curiosity makes sense when considered in the context of career construction (Savickas, 2006), because exposure to different ways of doing things enhances their marketability and sharpens their skills. In turn, experienced nurses ensure that they can demand competitive remuneration and maintain

their desired work-life balance. The learning that experienced travel nurses undergo underscores the career-shaping effects of institutions (Tomlinson et al., 2018), whereby different facilities enforce different policies as safeguards and in response to local challenges.

What Keeps Them in Nursing?

Travel nurses' propensity for learning keeps their *unlimited opportunities* open so that they can *make a difference* through their work. My participants narrated how they strategically construct their careers using travel nursing not only to sightsee and to maximize their earning potential, but also to further develop their clinical competencies for future career progression. Participants' stories reflect the same altruism that brings many nurses into the profession (Duffield et al., 2004; Price et al., 2013a; Wu et al., 2015), but they have also expressed their strong desire of staying in the profession whether as travel nurses or in other capacities. The broader nursing identity buttresses their career identity (LaPointe, 2010; cf. Bayerl et al., 2018).

Unlimited opportunities. My participants indicated that they thrive in the nursing profession because of the almost endless career possibilities afforded by the range of specialty areas. John, who had almost two decades of nursing experience, spoke enthusiastically that "nursing is so diverse. There's so much you can do [49]." The range of nursing specialties creates many career possibilities, "I'm constantly evolving. I'm never at a place where I know everything about nursing [Karen, 80]." Cynthia has worked twelve years as a registered nurse and also constantly finds refreshing challenges,

> This profession provides me with that opportunity to always be learning, always be growing, changing, being dynamic, never getting bored. I never get bored doing what I do. Then, at the end of the day, I can walk out of there and feel like I honestly made a difference in somebody's life. [173]

Travel nursing provides an avenue for nurses to enact their values and identities through work and their careers (Hall et al., 2018; Jorgenson, 2016).

Although some nurses looked forward to unlimited opportunities in terms of travel assignments and specialties, Linda found contentment in working in her specialty when I inquired what kept her in the profession, "It's funny because patients ask me that all the time. Do you like your job? Obviously, I love my job because I'm still doing it. I feel like I make that difference [151]." As it turns out, nurses can usually find a niche in the profession's unlimited opportunities to make a difference.

Make a difference. Twenty participants emphasized that they continue working as nurses, despite acknowledging that nursing is mentally and physically exhausting work, because they make a difference in the profession and patients' lives. This aspiration resonates with the findings of other empirical studies (e.g., Price et al., 2013a).

Many nurses become nurses because they personally witnessed the difference that nurses could make in the lives of their patients. For example, I asked Linda what influenced her in becoming a nurse and she shared this powerful episode,

> That'd be what happened to my son when he was sixteen. He's now 33. … He had a horrible, horrific trauma where he lost his whole face and became permanently blind. So, I got to see what nurses were from the receiving care side

> for quite a while. [One time], he used his nurse call light, and it was probably two or three in the morning, because he wanted something to drink; he was thirsty. When the nurse came in, she yelled at my son for bothering her because his glass of water was sitting right in front of him and why he rang the nurse station for something that simple. She didn't realize he was blind. She didn't know her patient. [149]

That episode made Linda wish that nurses knew their patients so that they could make a positive difference in their patients' lives. Linda also had an exceptionally touching encounter earlier in her son's long-term hospitalization,

> When I was first in the hospital, I was sitting in a chair in the ICU in an area where you aren't even supposed to be in there but they knew the situation, how severe it was. The night nurses brought in a little tiny two-seater vinyl, not very comfy, but a couch that I could curl up and sleep on. And they did that for me without even asking permission or worried about the rules or regulations. [They were] real people and had compassion. They treated us like real people and not just a number. [150]

Experiences like these made Linda decide that she would become a nurse.

The impetus that brought Linda to the profession epitomizes some of the motivators that inspire exceptional nursing care. My participants usually have life-shaping experiences that highlight their desire to make a difference. Lisa shared the following story,

> When I was a child, my cousin had a very bad [vehicle accident] and I was fascinated by the helicopter. I wanted to be one of those people that picked him up and took care of him. ... When he came home, he was better. I wanted to make a difference. I wanted to make a known difference in somebody's life. [9]

That story described how flight nurses airlifted Lisa's cousin and administered initial care on the helicopter before a facility treated her cousin. Familiarity with the healthcare environment and the profession helped made nursing a salient option. Susan's mother was a nurse but she said, "I've wanted to be a nurse since I was in my 20s because I wanted to help people and make a difference; it just seemed logical that I could do that by being a nurse [95]." While these participants had life-changing events that sustained their passion for nursing, some participants had simpler reasons. Julie initially worked as a medical assistant at primary care offices for eight years before going to nursing school and working at hospitals. She found her life purpose in helping patients "feel a little more comfortable through the night, help them get a little bit of sleep, and just make them feel a little bit more secure [268]."

Nurses have always mentioned that they join the profession so that they can help others (Duffield et al., 2004). Sharon, who grew up in a New England state and spoke in a straightforward fashion like most Northeasterners, emphasized that her caring aptitude kept her in the profession,

> I know I always wanted to work with kids. So, that's what led me to be in the pediatric field. I was always in between, teaching and nursing, and I feel as a nurse, you're a little bit of both. I like helping people. I like talking to people and

> having different experiences every day. I like that, and you're also teaching them. You're always teaching the parents about what's going on, explaining everything. So, that's one of the main reasons why I chose nursing. And why I've remained in the nursing field. [409]

My participants stayed in the profession because they saw the difference that they have made and will continue making in other people's lives, as Angela put it when I asked her what kept her in the profession, "My inner idealism that I am making a difference in the world [202]."

This final theme – *make a difference* – marks the purpose of my participants' master career narrative. That idealism can manifest in many forms because of the profession's *unlimited opportunities*. My participants' journey in becoming travel nurses has also helped them achieve personal and professional aspirations to *become tourists, learn how others do things,* and *make more money*. Having *family conversations and scientific minds* contextualize my participants' entry into the profession, as they make sense of their career decision and their motivation in staying in nursing.

Discussion

This study's purpose was to investigate how travel nurses construct their careers. My analysis suggests the career narratives of travel nurse can be characterized as a story of "personal curiosity" that manages the tension between intrinsic and extrinsic motivators.

My participants painted an overall career narrative driven by personal curiosity. Whether it was seeing a piece of medical equipment for the first time or wondering how

someone in pain could feel better, my participants' curiosity about their worlds and a genuine care for people shone through the interviews. Their early exposure to family members in the healthcare industry, personal encounters with healthcare professionals, and interest in the sciences collectively created strong impressions of healthcare professions – specifically nursing – as careers that help people (Price et al., 2013a). Those impressions resonated with their personal values and reinforced encouragement from family and friends to pursue nursing as a career, leading them to view nursing as a profession that not only aligns with their personal identities but also their aspired professional identities. As they progressed beyond the early years as registered nurses, their curiosity led them to recognize that alternative work arrangements can help them achieve outcomes that they desire. While the motivation for earning more money did not come as a surprise (de Ruyter, 2007; Hurst & Smith, 2010), my participants expressed excitement in becoming tourists and learning how other nurses perform tasks—signaling an inner curiosity about the world, nursing, and helping others. The narrative of "personal curiosity" explains their optimistic outlook regarding unlimited work and learning opportunities in the profession and a conviction that they can make a difference both now and into the future.

Travel nurses in general, and my participants in particular, typically switched to this work arrangement from staff positions. However, the primary drivers for becoming travel nurses and staying in nursing were mainly intrinsic in nature. Intrinsic motivators include learning about the world by becoming tourists, learning how to do new tasks, unlimited opportunities, and the chance to make a difference. This is not surprising as

Abessolo et al.'s (2017) study on boundaryless careers and protean careers revealed that workers with mobility preference would more likely reject extrinsic/material rewards such as job security and economic returns. Instead, they would be more likely to appreciate intrinsic work values such as intellectual stimulation and autonomy as well as social/relational work values such as altruism and one's contribution to society. The same study noted that individuals in protean careers also sought status work values such as prestige and influence. My participants also sought travel-nursing opportunities for the same work values (intellectual stimulation and autonomy) of learning how nurses at other facilities might perform tasks differently and how they exercised their scope of practice. This is consistent with other studies that have examined why individuals chose nursing as a career so that they could make a difference and care for others (Price et al., 2013a; Price, McGillis Hall, Angus, & Peter, 2013b; Price et al., 2018). The narrative of "personal curiosity" balances a tension between constructing a career that meets one's intrinsic and extrinsic (financial) needs.

While the majority of themes that I identified that move people into travel nursing are intrinsic in nature, extrinsic motivators such as financial remuneration also play a role. Participants did move from staff to travel nursing positions, in part, because travel nurses tend to be compensated at higher rates that staff nurses. Once in the travel nursing profession, my participants recognized that they earn more through travel-nursing contracts; a finding that mirrors the scholarly literature on travel nursing (de Ruyter, 2007; Hurst & Smith, 2010). By industry practice, facilities typically pay travel

nurses higher hourly wages than staff nurses of equivalent qualifications do because the former do not receive employee benefits.

Different perspectives emerge when some travel nurses feel that their higher gross income does translate into higher net income while other travel nurses feel that they do not earn a significantly higher net income that compensates their effort. Travel nurses have to balance the intrinsic reasons they selected their career with financial remuneration. While travel nurses are mostly intrinsically motivated to pursue their career, they still have to meet their financial obligations. For example, some travel nurses strategically chose contracts in states with lower taxes and cost of living as well as negotiating for additional housing stipend. These strategies work very well when facilities desperately need nurses and when travel nurses do not mind where they work. Other travel nurses vocalized concern that they did not earn as much as other travel nurses if they were paying mortgages and renting temporary lodging. For those travel nurses, the intrinsic reasons they selected their profession has to be balanced with the financial responsibilities associated with paying their mortgage and visiting their families.

Theoretical Development

Grounded in the analysis of this study, I propose a new theory to understand contemporary careers. My theory builds upon the theoretical underpinnings of CCT and advances career adaptability sensemaking theory (CAST) to spotlight contemporary professionals' proactivity, whose frequent job changes saliently manifest their intrinsic values and identities as work while developing their careers. As career mobility becomes

increasingly common among nurses after the Baby-Boomer generation (Duffield et al., 2004; Price et al., 2013a), CAST highlights those frequent job changes akin to the dances and songs in musicals because they purposefully extends the protagonist's plot and it gives the protagonist freedom in expressing the details meaningful to the protagonist.

The constructionist nature of CCT means that protagonists refine their narratives between work role transitions and based on their perceptions of their identities (Ibarra & Barbulescu, 2010; Savickas, 2006). Although a protagonist shapes different narratives for different audiences (Bayerl et al., 2018; Del Corso & Rehfuss, 2011), CCT does not include feedback that comes from the protagonist's audience. Prior audiences' responses to prior versions of career narratives help protagonists shape their narratives for future audiences because career construction is the sensemaking of social events and interactions (Bujold, 2004; Burns, Garcia, Smith, & Goodman, 2016).

Following CCT's lead in describing life events as narratives, I will characterize CCT using a film genre analogy. CCT, boundaryless career, and protean career provide a top-down view of careers that spotlights either the protagonist's adaptability or proactivity; they do not focus on frequent job changes, a crucial career phase in contemporary alternative work arrangements. From an epistemological perspective, CCT's consideration of a protagonist's life events analogizes the film genre documentary where the film captures key milestones or turning points in the protagonist's story but may only feature the scene on job changes in passing. Frequent job changes do not represent just a scene in travel nurses' narratives because sequential

contracts intricately develop their careers. Documentaries also present narratives to their audiences as nonparticipating observers. Thus, the documentary-style presentation of CCT provides a structured narrative of a protagonist's adaptability but lacks the nuanced details of the protagonist's proactivity.

A more accurate depiction of travel nurses' career narratives will look like musicals, where the plots transpire through dances and songs that engage their audience. They express more accurately the constructionist stories of contemporary workers whose frequent job changes instrumentally shape their identities and careers. Musicals also tell stories that speak directly to and involve the participation of their audiences: the performance appears as though the audience partakes in the development of the plot yet the protagonists perform based on the script they had practiced. Indeed, travel nurses enact their "practiced scripts" of performing nursing tasks at different facilities. As musical performers develop the plot and draw their audience in, they feel encouraged when their audience sings along; career sensemaking operates similarly as professionals feel encouraged when their audience affirms the construction and development of their narratives. Just as prior audiences' response to the songs also give the protagonists ideas on how they should deliver future renditions, professionals update their narratives for future audiences. Therefore, protagonists enact their adaptability and proactivity as well as revise their narratives for future audiences and toward the aspired version of themselves.

Future Research

I highlight three areas for future research: (1) generational differences on nursing career construction, (2) the influence of travel nursing in shaping nursing professional socialization, and (3) the development of travel nurses' social support networks. Each of these directions considers how travel nurses' careers may evolve differently than permanent nurses' careers because different work arrangements may create different resources and challenges.

First, future research should explore how generational differences may account for the influence of generational differences on the career construction of temporary workers. Generational differences allude to potential variation in the way that generational cohorts view work and why they choose nursing as their career (Christensen et al., 2018). For example, Baby-Boomer nurses are delaying full retirement by switching to alternative work arrangements (Ryan, Bergin, & Wells, 2017; Wargo-Sugleris, Robbins, Lane, & Phillips, 2017). At the same time, nursing programs around the world are matriculating some of the last high school graduates from the Millennial generation (that is, those born between 1980 and the early 2000s) and are preparing them for the possibility of entering a workforce that increasingly emphasizes temporary work. How does one's generation and the time one becomes a travel nurse in one's career (early versus late stage) influence how they construct their career narrative? Do Baby Boomers and Millennials construct their career narratives differently? Future research could examine how the structure and themes for career narratives may vary due to generational differences.

Second, future research should examine how the professional socialization experiences associated with nursing may include the development of nonclinical skills. Apart from licenses and certifications needed for their clinical specialty areas, nurses do not need additional certifications to become travel nurses. Yet travel nursing is to a great degree a specialty in itself because travel nurses must have the competence to function well in different workplace cultures and with different colleagues. Having to constantly relocate and adapt to new environments are stressors that permanent nurses may not have to experience. The nursing profession emphasizes professional socialization as early as in nursing school (Strouse, Nickerson, & McCloskey, 2018). However, socialization is usually specific to issues and people whom one will work with. Although nurses will acquire transferable skills that they can bring to other facilities, specific travel-nursing skills such as managing finances for living in different places and keeping track of the different income tax obligations incurred for working in different states will require a different kind of socialization than those that help nurses to assimilate into specific organizations or settings. An important research area is to understand how and from whom travel nurses learn nonclinical skills that they realize they need while on travel assignments.

Third, future research should examine how travel nurses manage their transitions to new facilities. Research suggests well-supported nurses tend to view their work environments favorably (Chisengantambu, Robinson, & Evans, 2017; Sveinsdóttir, Ragnarsdóttir, & Blöndal, 2016) and the level of social support they receive depends on people inside and outside of work (Gifkins et al., 2017). The transiency of travel

assignments makes relationship building more challenging for travel nurses and may hamper the breadth and depth of the support network that they may establish at temporary facilities. Alternatively, travel nurses may rely more heavily on fellow travel nurses at the same facility and former colleagues at other facilities. Future research should investigate how travel nurses manage the many transitions into new facilities. While we have an understanding of how a career narrative of "personal curiosity" helps travel nurses connect their various experiences across multiple facilities, we do not have a clear understanding of how they enter and exit job assignments in constructive ways and how that might confirm or disconfirm elements of their career narrative.

References

Abessolo, M., Hirschi, A., & Rossier, J. (2017). Work values underlying protean and boundaryless career orientations. *Career Development International, 22*, 241–259. doi:10.1108/cdi-10-2016-0167

Akkermans, J., & Kubasch, S. (2017). #Trending topics in careers: A review and future research agenda. *Career Development International, 22*, 586–627. doi:10.1108/cdi-08-2017-0143

Arthur, M. B. (1994). The boundaryless career: A new perspective for organizational inquiry. *Journal of Organizational Behavior, 15*, 295–306. doi:10.1002/job.4030150402

Arthur, M. B., & Rousseau, D. M. (Eds.). (2001). *The boundaryless career: A new employment principle for a new organizational era*. New York, NY: Oxford.

Baumann, A., Hunsberger, M., & Crea-Arsenio, M. (2013). Full-time work for nurses: Employers' perspectives. *Journal of Nursing Management, 21*, 359–367. doi:10.1111/j.1365-2834.2012.01391.x

Bayerl, P. S., Horton, K. E., & Jacobs, G. (2018). How do we describe our professional selves? Investigating collective identity configurations across professions. *Journal of Vocational Behavior, 107,* 168–181. doi:10.1016/j.jvb.2018.04.006

Brown, A. D., Stacey, P., & Nandhakumar, J. (2008). Making sense of sensemaking narratives. *Human Relations, 61*, 1035–1062. doi:10.1177/0018726708094858

Bujold, C. (2004). Constructing career through narrative. *Journal of Vocational Behavior, 64*, 470–484. doi:10.1016/j.jvb.2003.12.010

Burns, S. T., Garcia, G. L., Smith, D. M., & Goodman, S. R. (2016). Adding career biographies and career narratives to career interest inventories. *Journal of Employment Counseling, 53*, 98–111. doi:10.1002/joec.12032

Chisengantambu, C., Robinson, G. M., & Evans, N. (2017). Nurse managers and the sandwich support model. *Journal of Nursing Management, 26*, 192–199. doi:10.1111/jonm.12534

Christensen, S. S., Wilson, B. L., & Edelman, L. S. (2018). Can I relate? A review and guide for nurse managers in leading generations. *Journal of Nursing Management*. doi:10.1111/jonm.12601

Colduvell, K. (2017, August 19). *Why is everyone packing up and becoming a travel nurse?* Retrieved from https://nurse.org/articles/why-travel-nursing/

Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five tradition.* (3rd ed.). Thousand Oaks, CA: Sage.

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory into Practice, 39,* 124–130. doi:10.1207/s15430421tip3903_2

Dall'Ora, C., Ball, J., Recio-Saucedo, A., & Griffiths, P. (2016). Characteristics of shift work and their impact on employee performance and wellbeing: A literature review. *International Journal of Nursing Studies, 57*, 12–27. doi:10.1016/j.ijnurstu.2016.01.007

de Ruyter, A. (2007). Should I stay or should I go? Agency nursing work in the UK. *The International Journal of Human Resource Management, 18*, 1666–1683. doi:10.1080/09585190701570742

Del Corso, J., & Rehfuss, M. C. (2011). The role of narrative in career construction theory. *Journal of Vocational Behavior, 79*, 334–339. doi:10.1016/j.jvb.2011.04.003

Duffield, C., Pallas, L. O., & Aitken, L. M. (2004). Nurses who work outside nursing. *Journal of Advanced Nursing, 47*, 664–671. doi:10.1111/j.1365-2648.2004.03155.x

Faller, M. S., Gates, M. G., Georges, J. M., & Connelly, C. D. (2011). Work-related burnout, job satisfaction, intent to leave, and nurse-assessed quality of care among travel nurses. *JONA: The Journal of Nursing Administration, 41*, 71–77. doi:10.1097/nna.0b013e3182059492

Flanagan, T. (2016, June 8). *Why the surge in demand for travel nurses?* Retrieved from http://www.hcrnetwork.com/surge-demand-travel-nurses/

Gifkins, J., Loudoun, R., & Johnston, A. (2017). Coping strategies and social support needs of experienced and inexperienced nurses performing shiftwork. *Journal of Advanced Nursing, 73*, 3079–3089. doi:10.1111/jan.13374

Gubler, M., Arnold, J., & Coombs, C. (2014). Reassessing the protean career concept: Empirical findings, conceptual components, and measurement. *Journal of Organizational Behavior, 35*(S1), S23–S40. doi:10.1002/job.1908

Hall, D. T. (1976). *Careers in organizations*. Glenview, IL: Scott, Foresman.

Hall, D. T. (2004). The protean career: A quarter-century journey. *Journal of Vocational Behavior, 65*, 1–13. doi:10.1016/j.jvb.2003.10.006

Hall, D. T. (Tim), Yip, J., & Doiron, K. (2018). Protean careers at work: Self-direction and values orientation in psychological success. *Annual Review of Organizational Psychology and Organizational Behavior, 5*, 129–156. doi:10.1146/annurev-orgpsych-032117-104631

Harris, R., Sims, S., Parr, J., & Davies, N. (2015). Impact of 12h shift patterns in nursing: A scoping review. *International Journal of Nursing Studies, 52*, 605–634. doi:10.1016/j.ijnurstu.2014.10.014

Hesse-Biber, S. N., & Leavy, P (2011). *The practice of qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.

Hurst, K., & Smith, A. (2010). Temporary nursing staff - cost and quality issues. *Journal of Advanced Nursing, 67*, 287–296. doi:10.1111/j.1365-2648.2010.05471.x

Ibarra, H., & Barbulescu, R. (2010). Identity as narrative: Prevalence, effectiveness, and consequences of narrative identity work in macro work role transitions. *Academy of Management Review, 35*, 135–154. doi:10.5465/amr.35.1.zok135

Institute of Medicine. (2004). *Keeping patients safe: Transforming the work environment of nurses*. National Academies Press.

Jeong, Y.-C., & Leblebici, H. (2018). How professionalization and organizational diversity shape contemporary careers: Developing a typology and process model. *Human Relations*, 001872671876155. doi:10.1177/0018726718761552

Jorgenson, J. (2016). Performing the "two-body problem": An analysis of academic couples' career sensemaking as revealed through joint storytelling. *Journal of Family Communication, 16*, 403–418. doi:10.1080/15267431.2016.1215985

Katz, L. F., & Krueger, A. B. (2016). *The rise and nature of alternative work arrangements in the United States, 1995-2015*. (NBER Working Paper No. 22667). Cambridge, MA: National Bureau of Economic Research.

Kostal, J. W., & Wiernik, B. M. (2017). A meta-analytic investigation of demographic differences in protean, boundaryless, and proactive career orientations. *Career Development International, 22*, 520–545. doi:10.1108/cdi-08-2017-0139

Kristoffersen, M., & Friberg, F. (2016). Remaining in the nursing profession. *Nursing Ethics*, 096973301668454. doi:10.1177/0969733016684545

LaPointe, K. (2010). Narrating career, positioning identity: Career identity as a narrative practice. *Journal of Vocational Behavior, 77*, 1–9. doi:10.1016/j.jvb.2010.04.003

Leineweber, C., Chungkham, H. S., Lindqvist, R., Westerlund, H., Runesdotter, S., Smeds Alenius, L., & Tishelman, C. (2016). Nurses' practice environment and satisfaction with schedule flexibility is related to intention to leave due to dissatisfaction: A multi-country, multilevel study. *International Journal of Nursing Studies, 58*, 47–58. doi:10.1016/j.ijnurstu.2016.02.003

Maenhout, B., & Vanhoucke, M. (2013). An integrated nurse staffing and scheduling analysis for longer-term nursing staff allocation problems. *Omega, 41*, 485–499. doi:10.1016/j.omega.2012.01.002

Mainiero, L. A., & Sullivan, S. E. (2005). Kaleidoscope careers: An alternate explanation for the "opt-out" revolution. *Academy of Management Perspectives, 19*, 106–123. doi:10.5465/ame.2005.15841962

Maitlis, S., & Christianson, M. (2014). Sensemaking in organizations: Taking stock and moving forward. *The Academy of Management Annals, 8*, 57–125. doi:10.1080/19416520.2014.873177

Mas, A., & Pallais, A. (2016). *Valuing alternative work arrangements*. (NBER Working Paper No. 22708). Cambridge, MA: National Bureau of Economic Research.

Mazurenko, O., Liu, D., & Perna, C. (2015). Patient care outcomes and temporary nurses. *Nursing Management*, *46*(8), 32–38. doi:10.1097/01.numa.0000469351.33893.61

Maor, S., & Cojocaru, S. (2018). Family as a Powerful Factor that Influences Career Choice in Nursing. *Social Research Reports, 10*, 7–22.

Perera, H. N., & McIlveen, P. (2017). Profiles of career adaptivity and their relations with adaptability, adapting, and adaptation. *Journal of Vocational Behavior, 98*, 70–84. doi:10.1016/j.jvb.2016.10.001

Price, S. L., McGillis Hall, L., Angus, J. E., & Peter, E. (2013a). Choosing nursing as a career: A narrative analysis of millennial nurses' career choice of virtue. *Nursing Inquiry, 20*, 305–316. doi:10.1111/nin.12027

Price, S., McGillis Hall, L., Angus, J., & Peter, E. (2013b). The social context of career choice among millennial nurses: Implications for interprofessional practice. *Journal of Interprofessional Care, 27*, 509–514. doi:10.3109/13561820.2013.816660

Price, S. L., McGillis Hall, L., Murphy, G. T., & Pierce, B. (2018). Evolving career choice narratives of new graduate nurses. *Nurse Education in Practice, 28*, 86–91. doi:10.1016/j.nepr.2017.10.007

Price, S. L., & McGillis Hall, L. (2014). The history of nurse imagery and the implications for recruitment: A discussion paper. *Journal of Advanced Nursing, 70*, 1502–1509. doi:10.1111/jan.12289

Rispel, L. C., & Blaauw, D. (2015). The health system consequences of agency nursing and moonlighting in South Africa. *Global Health Action, 8*(1), 26683. doi:10.3402/gha.v8.26683

Rodrigues, R., Guest, D., Oliveira, T., & Alfes, K. (2015). Who benefits from independent careers? Employees, organizations, or both? *Journal of Vocational Behavior, 91*, 23–34. doi:10.1016/j.jvb.2015.09.005

Rodwell, J., & Fernando, J. (2016). Managing work across shifts: Not all shifts are equal. *Journal of Nursing Scholarship, 48,* 397–405. doi:10.1111/jnu.12220

Rudolph, C. W., Lavigne, K. N., Katz, I. M., & Zacher, H. (2017). Linking dimensions of career adaptability to adaptation results: A meta-analysis. *Journal of Vocational Behavior, 102*, 151–173. doi:10.1016/j.jvb.2017.06.003

Ryan, C., Bergin, M., & Wells, J. (2017). Valuable yet vulnerable—A review of the challenges encountered by older nurses in the workplace. *International Journal of Nursing Studies, 72*, 42–52. doi:10.1016/j.ijnurstu.2017.04.006

Savickas, M. (2006). Career construction theory. In J. H. Greenhaus & G. A. Callanan (Eds.), *Encyclopedia of career development* (pp. 85–88). Thousand Oaks, CA: Sage. doi:10.4135/9781412952675.n34

Spreitzer, G. M., Cameron, L., & Garrett, L. (2017). Alternative work arrangements: Two images of the new world of work. *Annual Review of Organizational Psychology and Organizational Behavior, 4*, 473–499. doi:10.1146/annurev-orgpsych-032516-113332

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques* (2nd ed.). Newbury Park, CA: Sage.

Strouse, S. M., Nickerson, C. J., & McCloskey, E. M. (2018). We don't miter the sheets on the bed: Understanding the preceptor role in the enculturation of nursing students. *Nurse Education in Practice, 32*, 21–27. doi:10.1016/j.nepr.2018.06.014

Sullivan, S. E., & Arthur, M. B. (2006). The evolution of the boundaryless career concept: Examining physical and psychological mobility. *Journal of Vocational Behavior, 69*, 19–29. doi:10.1016/j.jvb.2005.09.001

Sveinsdóttir, H., Ragnarsdóttir, E. D., & Blöndal, K. (2016). Praise matters: The influence of nurse unit managers' praise on nurses' practice, work environment and job satisfaction: A questionnaire study. *Journal of Advanced Nursing, 72*, 558–568. doi:10.1111/jan.12849

Tams, S., & Arthur, M. B. (2010). New directions for boundaryless careers: Agency and interdependence in a changing world. *Journal of Organizational Behavior, 31*, 629–646. doi:10.1002/job.712

Thomas, D. R. (2016). Feedback from research participants: Are member checks useful in qualitative research? *Qualitative Research in Psychology, 14*, 23–41. doi:10.1080/14780887.2016.1219435

Tomlinson, J., Baird, M., Berg, P., & Cooper, R. (2018). Flexible careers across the life course: Advancing theory, research and practice. *Human Relations, 71*, 4–22. doi:10.1177/0018726717733313

Wargo-Sugleris, M., Robbins, W., Lane, C. J., & Phillips, L. R. (2017). Job satisfaction, work environment and successful ageing: Determinants of delaying retirement among acute care nurses. *Journal of Advanced Nursing, 74*, 900–913. doi:10.1111/jan.13504

Wehrle, K., Kira, M., & Klehe, U.-C. (2018). Putting career construction into context: Career adaptability among refugees. *Journal of Vocational Behavior.* doi:10.1016/j.jvb.2018.08.007

Weick, K. E. (1995). *Sensemaking in organizations*. Thousand Oaks, CA: Sage.

Weick, K. E., Sutcliffe, K. M., & Obstfeld, D. (2005). Organizing and the process of sensemaking. *Organization Science, 16*, 409–421. doi:10.1287/orsc.1050.0133

Wu, L. T., Low, M. M. J., Tan, K. K., Lopez, V., & Liaw, S. Y. (2015). Why not nursing? A systematic review of factors influencing career choice among

healthcare students. *International Nursing Review, 62*, 547–562. doi:10.1111/inr.12220

Xie, B., Xia, M., Xin, X., & Zhou, W. (2016). Linking calling to work engagement and subjective career success: The perspective of career construction theory. *Journal of Vocational Behavior, 94*, 70–78. doi:10.1016/j.jvb.2016.02.011

Xue, Y., Chappel, A. R., Freund, D. A., Aiken, L. H., & Noyes, K. (2015). Cost outcomes of supplemental nurse staffing in a large medical center. *Journal of Nursing Care Quality, 30,* 130–137. doi:10.1097/ncq.0000000000000100

Yost, P. R., Yoder, M. P., Chung, H. H., & Voetmann, K. R. (2015). Narratives at work: Story arcs, themes, voice, and lessons that shape organizational life. *Consulting Psychology Journal: Practice and Research, 67*, 163–188. doi:10.1037/cpb0000043

CHAPTER V

CONCLUSIONS

Changing patterns in work arrangements complicate the supervisory role that managers perform in bureaucratic institutions such as those in the healthcare sector, whose organizations operate amidst multiple and sometimes conflicting regulatory and human resource practices. While new forms of work arrangements benefit organizations by helping them meet staffing needs, they can also make managers and human resource practitioners uncertain about employees' organizational commitment (Rubery, Earnshaw, Marchington, Cooke, & Vincent, 2002). Alternative work arrangements do not necessarily work against the needs and goals of nurses; rather, they can offer nurses with employment flexibility to create their desired work-life balance (Baumann, Hunsberger, & Crea-Arsenio, 2013; de Ruyter, 2007; Rispel & Blaauw, 2015). The result is that emerging work arrangements present a complex set of advantages and disadvantages for both health organizations and nurses. As a result, researchers must invest greater resources to understand how the phenomenon of changing work patterns affect employees (Agypt & Rubin, 2012; Peel & Boxall, 2005), as the rise in alternative work arrangements reshapes employment relations that benefit both individual and organizational needs (Foster & Mills, 2013; Myers, Gailliard, & Putnam, 2013).

My dissertation investigated three pertinent areas regarding the study of alternative work arrangements in the nursing profession: (1) nurse managers' perspectives regarding the structure of temporary nursing and how to communicate with

temporary nurses, (2) travel nurses' perspectives of the relational challenges they encountered when working with permanent nurses and how they manage them, and (3) travel nurses' construction of their career narratives. This final chapter provides a summary of the three empirical studies and highlights several implications for future research. I propose three areas for future research: (1) an extended inquiry on other ways that alternative work arrangements alter the way nurse managers work, (2) an exploration of the intersection between professional and national cultures on how nurses manage relational challenges, and (3) more in-depth investigations using interactional data that would permit triangulating research findings regarding the relationships among nurse managers, permanent nurses, and temporary nurses.

Study #1— Changing Times: Nurse Managers on Working with Nurses in Alternative Work Arrangements

This study investigated nurse managers' perceptions of their nurses who worked in alternative work arrangements. The first research question asked, "*How do nurse managers categorize and perceive alternative work arrangements?*" and the second research question asked, "*How do nurse managers communicate with nurses in alternative work arrangements and nurses not in alternative work arrangements?*" I conducted semi-structured interviews with 26 nurse managers to answer these questions.

This study focused on learning how nurse managers categorized and perceived alternative work arrangements' impact and the ways that nurse managers communicated with the nurses in their unit. My participants did not describe temporary nurses as part of their team, hinting at a clear permanent-temporary distinction where the core of a team is

consisting of permanent nurses and that temporary nurses complement the permanent nurses. My participants instinctively considered temporary nurses as non-staff nurses. Their focus on teams primarily shows that patient care delivery is their top priority. They also considered the personality fit of temporary nurses with their permanent nurses when hiring. While this consideration suggests that nurse managers care about the interactions among nurses, it also underscores their focus on patient care and that permanent nurses understand the standard that nurse managers expect from their nurses.

Building on the above analysis as an operative framework, I answered the first research question by outlining nurse managers' descriptions of their nurses' work arrangements. I developed a typology of five work arrangements as perceived by nurse managers: (1) staff-floaters, (2) per diem nurses, (3) agency nurses, (4) float nurses, and (5) staff nurses. These categories and descriptors mirror findings and discussions in current scholarship (e.g., Adam, Kaplow, Dominy, & Stroud, 2015; Hemann & Davidson, 2012; Shinners, Alejandro, Frigillana, Desmond, & LaVigne, 2016). The categories of per diem nurses, agency nurses, and float nurses share two common descriptors namely *Money* (temporary nurses typically earn more money than permanent nurses) and *Flexibility* (facilities may experience unexpected staffing needs and some nurses may choose when and where they work to fit work into their schedules).

I answered the second research question by offering three themes that captured communication patterns between nurse managers and nurses: (1) *You cannot overcommunicate,* (2) *Mentoring,* and (3) *When things go wrong*. The first theme explained that nurse managers used the same communication channels to disseminate

consistent task-related messages to both temporary nurses and permanent nurses to perform tasks. My participants did not consider the use of multiple communication channels and restating the same message multiple times as overcommunication because they wanted their nurses to have access and use the information. The other themes identified communication episodes where nurse managers would communicate differently with permanent and travel nurses. Nurse managers were more likely to reserve limited resources such as precepting and mentoring for their permanent nurses because temporary nurses were generally expected to adapt quickly and work competently with little supervision. Such resources also served as socialization into organizational norms, which temporary nurses may not find particularly beneficial especially for those on short-term contracts. Finally, nurse managers revealed that noncompliant nurses face different remedial actions depending on their work arrangements. I summarized themes two and three by creating the NM-RN Feedback Channels and the NM-RN Communication Model. The model of NM-RN Feedback Channels summarizes the bidirectional feedback channel between nurse managers and their permanent nurses and shows that nurse managers do not have a direct mentoring responsibility toward temporary nurses. The NM-RN Communication Model provides a summary of my analysis for Research Question 1 and Research Question 2 by showing my participants' workplace relationships with their nurses, moderated by time and mediated by comfort level and trust, affect how they communicate positive and negative topics with their nurses.

Study #2—Temporary Work and Relational Challenges within the Nursing Profession

This study explored how travel nurses perceived their relational experiences with other nurses. A purposeful sample of 25 registered nurses with travel nursing experience in the United States participated in this study. I collected data using one-on-one semi-structured interviews and analyzed the data using thematic analysis. The research question that guided this study was: "*How do travel nurses manage nurse-to-nurse relationships with permanent nurses?*

I found that my participants experienced two forms of relational challenges: (1) demonstrating professional competence, and (2) fitting in with pre-existing unit culture and relationships. The first relational challenge delineates the permanent-temporary distinction where permanent nurses perceived travel nurses as out-group members with untested competencies. This perception meant that permanent nurses may test the competencies of travel nurses before accepting them as an in-group or team member. In response to this relational challenge, my participants used the strategy of the *Competent Coworker* to mitigate some of the skepticism that permanent nurses may have regarding travel nurses' clinical competence. My participants demonstrated this strategy by proactively volunteering to help other nurses. They felt that it was important to show their clinical competence in order to deliver quality patient care even in hostile and unsupportive environments.

The second relational challenge that travel nurses highlighted was the challenge of fitting into the pre-existing unit culture and relationships that can vary across facilities. My participants recognized that permanent nurses sometimes were

unmotivated to develop relationships with travel nurses because of the short duration of travel assignments and that permanent nurses had other obligations. Another reason for this relational challenge was the reality that travel nurses typically earn higher remuneration that permanent nurses, which permanent nurses may use to justify why their units assign less desirable or more patients to travel nurses. Participants found it appropriate to respond to the second relational challenge by using the strategy of the *Gracious Guest.* This strategy required travel nurses not to criticize facilities' practices (unless those practices threaten patient safety where travel nurses then feel obligated to intervene) and to give permanent nurses the control in deciding how they want to develop the relationships with travel nurses (to respect permanent nurses' interactional preferences). The analysis highlighted three major implications: (1) professional socialization may mitigate potentially negative effects when temporary workers negotiate the task dimension of their relationships, (2) contributions to unit innovation and learning by travel nurses were discouraged, and (3) creating travel-permanent nurse relationships involved managing dialectical tensions.

Study #3—Travel Nurses' Construction of Career Narratives: A Qualitative Study on Career Sensemaking

This study considered travel nurses' career construction narratives to understand how my participants made sense of their career choice and path. Career sensemaking is essentially a communicative behavior that connects one's past, present, and future. I framed this study using career construction theory as well as the notion of proactivity

founded in the boundaryless career and protean career concepts. This study was guided by the following research question, "*How do travel nurses make sense of their careers?*

My analysis offered three main insights. First, travel nurses did not choose their profession purely on earning potential. Second, my participants and other nurses understood that travel nursing could increase their earning potential in certain circumstances. Third, my participants used travel nursing to learn how other facilities work differently, which enhanced their competencies and future employment prospect in the profession.

My analysis suggest that *family conversations and scientific minds* contextualized my participants' entry into the profession, as they make sense of their career decision and their motivation to stay in nursing. My participants' journey to become travel nurses helped them achieve personal and professional aspirations to *become tourists*, *learn how others do things*, and *make more money*. The idealism to *make a difference* marked the purpose of my participants' master career narrative, which could manifest in many forms because of the profession's *unlimited opportunities*. Overall, my participants' inner curiosity about the world and their desire to help others provided a consistent backdrop throughout their early thoughts about pursuing nursing as a career to their future plans to become travel nurses.

The fact that many of my participants mentioned that money motivated their decision to become travel nurses was not a surprise, because other scholars have also made this observation (de Ruyter, 2007; Hurst & Smith, 2010). However, participants' excitement in becoming tourists and their enthusiasm in learning how other nurses

perform tasks complemented this financial motivation and demonstrated their inner curiosity about the world, the delivery of patient care, and helping others. My participants' narrative of "personal curiosity" undergirded their optimistic outlook of a profession with unlimited career paths and learning opportunities as well as their conviction that their work does make a difference.

I concluded this study by proposing career adaptability sensemaking theory (CAST) as a new theory that emphasizes contemporary professionals' proactivity in managing frequent job changes. CAST builds upon the theoretical foundations of career construction theory to stress the proactivity of contemporary professionals whose frequent job changes give form to their values and identities.

Implications of this Dissertation

The rise in alternative work arrangements focuses on novel ways of organizing work and determining the evolving effects on employee-employer relationships (Foster & Mills, 2013). In this section, I would like to compare and contrast the results generated by the three studies in terms of the experience of nurse managers and travel nurses.

Nurse managers viewed temporary nurses as nurses who do not belong to their teams but were brought in to their units to fill staffing gaps. This meant nurse managers tended to view temporary nurses as an interim solution to the ideal staffing arrangement of having a staff (or team) of permanent nurses. While they described the nurses under their supervision as "teams" and not just "staff," they viewed temporary nurses as secondary members of their team. To be sure, they expect some degree of collaboration

among permanent and temporary nurses, which includes social support and the sharing of emotional and physical resources (Bae et al., 2017) as they recognize relational and task coordination are important factors in the delivery of patient care (Gittell, 2016; Wagner, Bezuidenhout, & Roos, 2015). Nevertheless, they tend to invest more time and resources into the development or permanent nurses.

Similarly, my travel-nurse participants also valued the delivery of quality patient care. They emphasized teamwork that was aimed at fitting in versus challenging existing work practices as they were mindful to avoid appearing as disrespectful to the normative practices of their temporary facilities. Both nurse managers and travel nurses understood the importance of teamwork and task collaboration but travel nurses also know that their delivery of quality patient care is limited to the extent to which they function acceptably professionally and interpersonally by permanent nurses. The combination of nurse managers not investing in temporary nurses and travel nurses being hindered in sharing their full knowledge suggests that the resources that travel nurses bring to a new work situation may not be fully capitalized on.

While both nurse managers and travel nurses identified differences between temporary and permanent nurses that influenced what communication channels were used to perform task and relational responsibilities, the data for both nurse managers and nurses suggest that the formality of the communication processes creates a set of standardized expectations for communicating about tasks. These formal interactions revolve around standardized activities such as handoffs and patient record documentation. The relative ease communicating regarding tasks is most likely due to

the extensive professional socialization that begins in nursing school that has successfully inculcated in nurses a common set of values, work ethic, and a standardized way of performing tasks. Nurse managers' use of consistent communication with both travel and permanent nurses equalize information asymmetry and minimize miscommunication. Their highly-structured work and the shared profession ethics and jargon may fit them as a team almost seamlessly like finding the right gears for a machine.

Such elements of successful socialization not only standardize nursing work and reduce task communication challenges, they also make nurses interchangeable and replaceable as the work is clearly structured feeding the perception of nurse managers regarding the need to invest in the development of travel nurses. This depersonalizing nursing work as labor undergirds part of the rise in alternative work arrangements in the nursing profession as healthcare delivery becomes increasingly an economic activity that concurrently reshapes the nature of employee-employer relationships in that industry (Foster & Mills, 2013).

The concern that evolves from the above discussion is that nursing work can become more about task performance that is mechanized than it is traditionally about people helping people. This observation juxtaposes my nurse managers' view of the interim help of temporary nurses as generic and interchangeable labor while travel nurses create a narrative structure that connects their individual life experiences in a way that emphasizes the value of their labor as helping others and that their clinical competence is always undergoing development (Bujold, 2004; Del Corso & Rehfuss,

2011; Ibarra & Barbulescu, 2010; LaPointe, 2010; Price, McGillis Hall, Angus, & Peter, 2013).

Future Research

I propose three areas for future research: (1) an examination of the network of relationships within a unit that employs temporary nurses, (2) an exploration of the intersection between professional and international cultures on how relational challenges are managed, and (3) developing studies that focus on collecting interactional data.

First, future research should examine how communication networks in health units include and orient around temporary nurses. The communication networks and relationships that nurse managers, permanent nurses, temporary nurses, physicians, and other staff must manage has become increasingly more complex with the increasing proliferation of alternative work arrangements. My current studies focused on the relationships among nurse managers, permanent nurses, and temporary nurses. Future research needs to examine how other staff such as physicians interface with temporary nurses and how different groups such as physicians and nurse managers talk about temporary nurses and make sense of their role in the health unit. Moreover, much of scholarly work on nurse managers has chiefly studied how nurse managers can improve their communication style but not how structural dynamics created by conditions such as work shifts can influence their relationships with temporary nurses (Kunie, Kawakami, Shimazu, Yonekura, & Miyamoto, 2017; Marx, 2014; see also Agypt & Rubin, 2012). The paucity of such research studies highlights a need for more attention on individuals'

work experiences in the blended workforce: namely, alternative work arrangements' effect on nurses' workplace interactions among coworkers and their supervisors.

Second, future research should examine the intersection of nursing culture and national culture and their influence on how travel nurses perform their work and how they construct their career narratives. Scholars have reported that nurses in the United States generally prefer the avoidance conflict management style (Cavanagh, 1991; Johansen, 2014; Mahon & Nicotera, 2011; Vandecasteele et al., 2017) while nurses based in Arab countries favor the integrative style (Labrague, Al Hamdan, & McEnroe-Petitte, 2018). It appears that nurses may prefer the avoidance style because of universal stereotypes of this profession and its perceived position in the hierarchy of healthcare professions, but it is also plausible that nurses in the United States may view and manage nurse-to-nurse relationships differently than their international colleagues. Examining how nursing and national cultures interact is important given the global nursing shortage problem and the international migration of nurses.

Third, future research should examine the interaction between temporary nurses and their interaction with other members of the team. As this study demonstrates, the ubiquitous team-based approach in delivering patient care raises occurrences for nurse-to-nurse communication, which also raises potential instances of relational challenges (Lee & Doran, 2017). This study employed interviews to generate insight into the dynamics of nurse manager, permanent nurse, and temporary nurse relationships. It provided a general understanding of the kinds of issues and forms of communication that are associated with managing these relationships. It did not, however, focus on the

concrete interactions that characterize nurse manager, permanent nurse, and temporary nurse conversations. Complementing the interview data with data collection that focuses on the concrete conversations that make up these relationships, ethnography (Van Maanen, 1998) or participant observation (Spradley, 1980) would be useful. Collecting such data may allow researchers to better triangulate their research findings.

A Final Thought

Alternative work arrangements "affect how work is done, how people feel about their work, what their orientation toward work is, and the role of work in their lives" (Spreitzer, Cameron, & Garrett, 2017, p. 486), so much so that novel ways of organizing continuously change the nature of work and careers (Barley, Bechky, & Milliken, 2017; Heaphy et al., 2018). Scholars concerned about the delivery of patient care must understand how these developments influence how nurse managers manage their units and how nurses utilize work arrangements to construct their ideal careers.

My dissertation investigated the relational effects of alternative work arrangements in the management of nurses and the delivery of nursing tasks. I learned that nurse managers and travel nurses view patient care as a team-based enterprise but they also differed in how they enact that vision. Nurse managers worked hard at building core teams of permanent nurses supplemented by travel nurses (and other forms of temporary nurses), while travel nurses viewed their contribution as part of their personal curiosity in learning how other nurses perform tasks. Travel nurses and nurse managers also perceived travel assignments quite differently in terms of professional development where nurse managers viewed travel nurses as interim help while travel nurses viewed

travel assignments as learning opportunities to gain exposure and improve their competencies. These different expectations can create tensions as nurse managers may consider travel nurses as products of the nursing socialization process while travel nurses view themselves as "work-in-progress" protagonists in their constructed career narratives who create their unique socialization experience through travel assignments. The present work adds to the growing literature on the changing nature of careers and workplace relationships about the lived experiences of nurse managers and their supervision of permanent and travel nurses as well as the lived experiences of travel nurses in the United States.

References

Adams, J., Kaplow, R., Dominy, J., & Stroud, B. (2015). Beyond a Band-Aid® approach: An internal agency solution to nurse staffing. *Nursing Economics, 33*, 51–58.

Agypt, B., & Rubin, B. A. (2012). Time in the new economy: The impact of the interaction of individual and structural temporalities on job satisfaction. *Journal of Management Studies, 49*, 403–428. doi:10.1111/j.1467-6486.2011.01021.x

Bae, S.-H., Farasat, A., Nikolaev, A., Seo, J. Y., Foltz-Ramos, K., Fabry, D., & Castner, J. (2017). Nursing teams: Behind the charts. *Journal of Nursing Management, 25*, 354–365. doi:10.1111/jonm.12473

Barley, S., Bechky, B., & Milliken, F. (2017). From the editors: The changing nature of work: Careers, identities, and work lives in the 21st century. *Academy of Management Discoveries, 3*, 111–115. doi:10.5465/amd.2017.0034

Baumann, A., Hunsberger, M., & Crea-Arsenio, M. (2013). Full-time work for nurses: Employers' perspectives. *Journal of Nursing Management, 21*, 359–367. doi:10.1111/j.1365-2834.2012.01391.x

Berg Jansson, A., & Engström, Å. (2017). Working together: Critical care nurses experiences of temporary staffing within Swedish health care: A qualitative study. *Intensive and Critical Care Nursing, 41*, 3–10. doi:10.1016/j.iccn.2016.08.010

Bujold, C. (2004). Constructing career through narrative. *Journal of Vocational Behavior, 64*, 470–484. doi:10.1016/j.jvb.2003.12.010

Burke, R. J., Dolan, S. L., & Fiksenbaum, L. (2014). Part-time versus full-time work: An empirical evidence-based case of nurses in Spain. *Evidence-Based HRM: A Global Forum for Empirical Scholarship, 2*, 176–191. doi:10.1108/ebhrm-02-2013-0001

Cavanagh, S. J. (1991). The conflict management style of staff nurses and nurse managers. *Journal of Advanced Nursing, 16*, 1254–1260. doi:10.1111/j.1365-2648.1991.tb01536.x

Cicellin, M., Pezzillo Iacono, M., Berni, A., & Esposito, V. (2015). Dealing with resistance in temporary agency nurses. *Journal of Health Organization and Management, 29*, 298–316. doi:10.1108/jhom-02-2013-0044

Cohen-Charash, Y., & Larson, E. C. (2017). An emotion divided. *Current Directions in Psychological Science, 26*, 174–183. doi:10.1177/0963721416683667

de Ruyter, A. (2007). Should I stay or should I go? Agency nursing work in the UK. *The International Journal of Human Resource Management, 18*, 1666–1683. doi:10.1080/09585190701570742

Del Corso, J., & Rehfuss, M. C. (2011). The role of narrative in career construction theory. *Journal of Vocational Behavior, 79*, 334–339. doi:10.1016/j.jvb.2011.04.003

Evans, A. M., Traynor, M., & Glass, N. (2014). An exploration of jealousy in nursing: A Kleinian analysis. *Nursing Inquiry, 21*, 171–178. doi:10.1111/nin.12036

Faller, M. S., Gates, M. G., Georges, J. M., & Connelly, C. D. (2011). Work-related burnout, job satisfaction, intent to leave, and nurse-assessed quality of care among travel nurses. *JONA: The Journal of Nursing Administration, 41*, 71–77. doi:10.1097/nna.0b013e3182059492

Ferrara-Love, R. (1998). Are you being sabotaged by your coworkers? *Journal of PeriAnesthesia Nursing, 13*, 301–303. doi:10.1016/s1089-9472(98)80034-8

Foster, J., & Mills, A. J. (2013). Construction work: Evolving discourses of the "worker" in management textbooks, 1920s to the first decade of the 21st. *Journal of Workplace Rights, 17*, 443–466. doi:10.2190/wr.17.3-4.l

Fritz, J. H. (2014). Researching workplace relationships. *Journal of Social and Personal Relationships, 31*, 460–466. doi:10.1177/0265407514522888

Gittell, J. H. (2016). Rethinking autonomy: Relationships as a source of resilience in a changing healthcare system. *Health Services Research, 51*, 1701–1705. doi:10.1111/1475-6773.12578

Heaphy, E. D., Byron, K., Ballinger, G. A., Gittell, J. H., Leana, C. R., & Sluss, D. M. (2018). The changing nature of work relationships. *Academy of Management Review, 43*, 1–12. doi:10.5465/amr.2018.0222

Hemann, M., & Davidson, G. (2012). Perspective of a float pool model in ambulatory care. *MedSurg Nursing, 21*, 164–170.

Hofmann, D. A., Lei, Z., & Grant, A. M. (2009). Seeking help in the shadow of doubt: The sensemaking processes underlying how nurses decide whom to ask for advice. *Journal of Applied Psychology, 94*, 1261–1274. doi:10.1037/a0016557

Hurst, K., & Smith, A. (2010). Temporary nursing staff - cost and quality issues. *Journal of Advanced Nursing, 67*, 287–296. doi:10.1111/j.1365-2648.2010.05471.x

Ibarra, H., & Barbulescu, R. (2010). Identity as narrative: Prevalence, effectiveness, and consequences of narrative identity work in macro work role transitions. *Academy of Management Review, 35*, 135–154. doi:10.5465/amr.35.1.zok135

Johansen, M. L. (2014). Conflicting priorities: Emergency nurses perceived disconnect between patient satisfaction and the delivery of quality patient care. *Journal of Emergency Nursing, 40*, 13–19. doi:10.1016/j.jen.2012.04.013

Kunie, K., Kawakami, N., Shimazu, A., Yonekura, Y., & Miyamoto, Y. (2017). The relationship between work engagement and psychological distress of hospital nurses and the perceived communication behaviors of their nurse managers: A cross-sectional survey. *International Journal of Nursing Studies, 71*, 115–124. doi:10.1016/j.ijnurstu.2017.03.011

Labrague, L. J., Al Hamdan, Z., & McEnroe-Petitte, D. M. (2018). An integrative review on conflict management styles among nursing professionals: Implications for nursing management. *Journal of Nursing Management*. doi:10.1111/jonm.12626

LaPointe, K. (2010). Narrating career, positioning identity: Career identity as a narrative practice. *Journal of Vocational Behavior, 77*, 1–9. doi:10.1016/j.jvb.2010.04.003

Lee, C. T.-S., & Doran, D. M. (2017). The role of interpersonal relations in healthcare team communication and patient safety. *Canadian Journal of Nursing Research, 49*, 75–93. doi:10.1177/0844562117699349

Litwin, A. H., & Hallstein, L. O. B. (2007). Shadows and silences: How women's positioning and unspoken friendship rules in organizational settings cultivate difficulties among some women at work. *Women's Studies in Communication, 30,* 111–142. doi:10.1080/07491409.2007.10162507

Mahon, M. M., & Nicotera, A. M. (2011). Nursing and conflict communication. *Nursing Administration Quarterly, 35*, 152–163. doi:10.1097/naq.0b013e31820f47d5

Mancl, A. C., & Penington, B. (2011). Tall poppies in the workplace: Communication strategies used by envious others in response to successful women. *Qualitative Research Reports in Communication, 12*, 79–86. doi:10.1080/17459435.2011.601701

Marx, M. (2014). Examining the structural challenges to communication as experienced by nurse managers in two US hospital settings. *Journal of Nursing Management, 22,* 964–973. doi:10.1111/jonm.12091

Mazurenko, O., Liu, D., & Perna, C. (2015). Patient care outcomes and temporary nurses. *Nursing Management, 46*(8), 32–38. doi:10.1097/01.numa.0000469351.33893.61

Myers, C. (in press). Coactive vicarious learning: Towards a relational theory of vicarious learning in organizations. *Academy of Management Review*. doi:10.5465/amr.2016.0202

Myers, K. K., Gailliard, B. M., & Putnam, L. L. (2013). Reconsidering the concept of workplace flexibility: Is adaptability a better solution? *Annals of the*

International Communication Association, 36, 195–230. doi:10.1080/23808985.2013.11679132

Peel, S., & Boxall, P. (2005). When is contracting preferable to employment? An exploration of management and worker perspectives. *Journal of Management Studies, 42*, 1675–1697. doi:10.1111/j.1467-6486.2005.00562.x

Price, S. L., McGillis Hall, L., Angus, J. E., & Peter, E. (2013). Choosing nursing as a career: A narrative analysis of millennial nurses' career choice of virtue. *Nursing Inquiry, 20*, 305–316. doi:10.1111/nin.12027

Rispel, L. C., & Blaauw, D. (2015). The health system consequences of agency nursing and moonlighting in South Africa. *Global Health Action, 8*(1), 26683. doi:10.3402/gha.v8.26683

Rubery, J., Earnshaw, J., Marchington, M., Cooke, F. L., & Vincent, S. (2002). Changing organizational forms and the employment relationship. *Journal of Management Studies, 39*, 645–672. doi:10.1111/1467-6486.00306

Shinners, J., Alejandro, J. A. N., Frigillana, V., Desmond, J., & LaVigne, R. (2016). Quality improvement: Creating a float pool specialty within a new graduate residency. *MedSurg Nursing, 25*(2), 79–84.

Spradley, J. P. (1980). *Participant observation.* Belmont, CA: Waveland Press.

Spreitzer, G. M., Cameron, L., & Garrett, L. (2017). Alternative work arrangements: Two images of the new world of work. A*nnual Review of Organizational Psychology and Organizational Behavior, 4*, 473–499. doi:10.1146/annurev-orgpsych-032516-113332

Tuttas, C. A. (2015). Job integration factors as predictors of travel nurse job performance. *Journal of Nursing Care Quality, 30,* 44–52. doi:10.1097/ncq.0000000000000070

Van Maanen, J. (1998). *Tales of the field: On writing ethnography*. Chicago, IL: University of Chicago Press.

Vandecasteele, T., Van Hecke, A., Duprez, V., Beeckman, D., Debyser, B., Grypdonck, M., & Verhaeghe, S. (2017). The influence of team members on nurses' perceptions of transgressive behaviour in care relationships: A qualitative study. *Journal of Advanced Nursing, 73,* 2373–2384. doi:10.1111/jan.13315

Wagner, J.-D., Bezuidenhout, M. C., & Roos, J. H. (2015). Communication satisfaction of professional nurses working in public hospitals. *Journal of Nursing Management, 23,* 974–982. doi:10.1111/jonm.12243

APPENDIX A

Interview Protocol for Nurse Managers (Study #1)

1. How long have you been a registered nurse?
2. What are your perceptions of temporary nurses? How are they different from permanent nurses? How are they similar?
3. What is your experience with temporary nurses? How has your experience with temporary nurses shaped your perception of them?
4. What characteristics do highly productive temporary nurses display? How have temporary nurses contributed to your unit/organization?
5. How do you communicate with temporary nurses? In what situations do you communicate differently with temporary nurses than with permanent nurses and vice versa?
6. What topics and issues do you discuss with temporary nurses? What topics and issues do you discuss with permanent nurses?
7. How do temporary nurses and permanent nurses communicate differently with one another?
8. What issues do temporary nurses raise to you? What issues do permanent nurses raise to you?
9. What do temporary nurses say about permanent nurses? What do permanent nurse say about temporary nurses?

APPENDIX B

Interview Protocol for Nurses (Studies #2 and 3)

1. How long have you been a registered nurse? Are you a permanent or temporary nurse?
2. How long have you been a permanent and/or temporary nurse?
3. Have you ever worked in other work arrangements before? If yes, what are the similarities and differences between permanent and temporary positions? If no, why not?
4. How are permanent and temporary nurses similar? How are they different? How is the work they perform similar or different?
5. What are your perceptions of the permanent nurses in your unit/organization? What are your perceptions of the temporary nurses in your unit/organization?
6. What characteristics do highly productive temporary nurses display? How have temporary nurses contributed to your unit/organization?
7. How do you communicate with temporary nurses? In what situations do you communicate differently with temporary nurses than with permanent nurses and vice versa?
8. What topics and issues do you discuss with temporary nurses? What topics and issues do you discuss with permanent nurses?
9. How do temporary nurses and permanent nurses communicate differently with one another?

10. What memorable messages inspired you to become a nurse? (prompt: Who influenced you to pursue nursing?)
11. Thinking back about the moments in life that influenced you in becoming a nurse, did you have more of those memories or messages from pre-college years or during college?
12. I know it has been awhile, but what memories or messages from clinicals still stick in your mind?
13. What were your thoughts about nursing prior to pursuing your nursing degree?
14. How did your thoughts about nursing evolve while pursuing your nursing degree?
15. Why do nursing students persevere in their nursing programs, despite unpleasant clinical experiences?
16. To what extent do you think that recent positive memories might remind nursing students about those memorable messages that brought them into their programs?
17. What keeps you in the nursing profession, despite unpleasant memories and experiences?
18. In a sense, we are all in the middle of our story.
    a. What crossroads are you at right now in your life and career? Let's say you were to think about your life as an autobiography: What would this chapter be called?
    b. What will happen next? In the coming chapters, what are some ways that the plot might play out?