AN EXPLORATORY STUDY OF DISPLACEMENT AND HOSPITAL RESTRUCTURING ON GENERAL DUTY REGISTERED NURSES AND HOW IT AFFECTED THEIR WORKLIFE

by

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BY

LINDA JEAN KENNEDY

A Thesis/Practicum submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements for the degree of

MASTER OF NURSING

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ABSTRACT

A qualitative approach was utilized to examine the impacts of displacement and hospital restructuring on General Duty Registered Nurses and how their worklife was affected. A convenience sample of 10 nurses who were both directly and indirectly affected by displacement were interviewed using a semi-structured interview guide.

Restructuring and displacement were found to have profound effects on all participants and their worklife. Displacement was seen as an expected consequence of restructuring and themes were found to be interrelated to both processes. Specific displacement themes were extrapolated from the analysis of interview transcripts. Nurses' worklife was most affected by displacement in the first year after the bumping had commenced, whereas restructuring effects were viewed as ongoing throughout the process.

The need for adequate preparation and support for the care-giver during change were found to be critical for a nurse's successful transition. Recommendations for nursing practice, administration, education and research have been made on the basis of the findings.

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CHAPTER 1: INTRODUCTION

Today, hospital administrators are being challenged to create more efficient, cost effective systems and to critically review the services they provide (Curtain, 1990; Averill, 1993; Nornhold, 1994; Trioli, Allgeier & Schwartz, 1995; Study Province Health Department, 1992). To ensure the future of the health care system, Health Care Reform (HCR) was introduced in the study province (Study Province Health Department, 1992). All aspects of health care, including hospital care, were being scrutinized to ensure a more cost effective system. The HCR officials hypothesized that the study province may have the highest paid hours per patient day when compared to the other Canadian provinces.

Since HCR was introduced in the study province, many disciplines have been affected but none more so than the nursing profession. The closing of hospital beds and changes made to staffing patterns have reduced the numbers of nurses required as workforce. To date, the brunt of the loss of employment in hospitals is being borne by the nursing staff (Joel, 1994; Rozak, 1994). To address the needs of employees affected by

HCR, an adjustment Committee was established (Provincial Health Care Labour Adjustment Committee, 1993).

Nursing, for the most part, had always been a discipline which guaranteed employment (Darling & Luciano, 1985; Frank, 1993; Hicks, 1982). However, the nursing profession has experienced profound changes, most notably in the areas of decreased employment opportunities and changing responsibilities and work roles (Rozak, 1994). Nurses are the largest classifications of direct patient care workers in hospitals (Olson, 1995; Schull, 1986; Wilson, 1995), and they are the ones most affected by the cost cutting measures (Rozak, 1994). Since the advent of HCR, many nurses are having difficulty either obtaining jobs or retaining the positions they have (Rozak, 1994). In May 1995, there were 2650 RNs and 103 nursing supervisors receiving Unemployment Insurance benefits across Canada; down considerably from the May 1993 statistics of 3744 and 222 respectively (Canadian Nurses Association, 1995). However, there is a continual trend of job loss for nurses since HCR was introduced. As well, there has been an increase in the

number of nursing supervisors, including head nurses, being laid off.

During the period of March 1993 to October 1993, a total of 541 study province health care workers received deletion notices and were assigned redeployment numbers (Study Province Nurses' Union, 1994). Redeployment numbers entitled laid off workers to apply for new and vacant unionized positions at any associated facility (Provincial Health Care Labour Adjustment Committee, 1993). A total of 443 nurses received redeployment numbers, of which 248 were Registered Nurses (RN), 183 were Licensed Practical Nurses (LPN), and 12 were Registered Psychiatric Nurses (Study Province Nurses' Union, 1994). Of the 541 redeployment numbers issued, 262 were at the study hospital, 277 were at 20 other provincial hospitals, and two were in community care. Approximately half of the nurses who were displaced had been employed at the study hospital.

Statement of The Problem

Almost all hospitals are restructuring or redesigning the way nursing care is delivered (Farley, 1994). Beds were closed in the study hospital, thus

reducing the numbers of nurses required. As well, a new staffing mix utilizing more nursing assistants to provide certain aspects of patient care was implemented, thereby reducing even further the numbers of nurses required for direct patient care (Study Province Nurses' Union, 1994).

To date, minimal research has been done to describe the impact of displacement and hospital restructuring on General Duty Registered Nurses (GDRN) and how their worklife has been affected. It had been speculated that HCR is only in the beginning stages, and additional cost saving attempts will be instituted in the future (Collins & Noble, 1992; Hurley, 1994; Manga, 1992; Mara, 1993; Zimmermann, 1994b). Hospitals are doing more with fewer resources (Bice, 1990; Collins & Noble, 1992; Roos, Brownell, & Currie, 1996; Zimmermann, 1994a). However, work previously performed by laid off employees cannot be assimilated by a restructured organization unless the work is redesigned, eliminated or performed by survivors (Alevras & Frigeri, 1987).

With the fast pace of change and the significant numbers of staff reductions, nurses are concerned that

the additional work duties and responsibilities added to their already full workload will adversely affect patient care (Farley, 1994). The changes implemented to improve the quality of patient care and streamline services have resulted in an environment of continuous disruption (Triolo et al., 1995). At a time when nurses are confronted with restructuring, displacement and job insecurity, research is imperative to learn more about the direct impacts on nurses and their worklife, and to develop strategies to assist them through the process.

Purpose of The Study

The purpose of this study is to explore the impacts of displacement and hospital restructuring on those nurses affected in the largest numbers, General Duty Registered Nurses (GDRNs), hereafter called 'nurses' and how it affects their worklife.

Specifically:

1. What effects/impact did displacement and organizational restructuring have on the displaced and non-displaced nurses?
2. What effects, if any, did displacement have on their worklife?

3. What effects, if any, did organizational restructuring have on their worklife?

Definition of Terms

Organizational Restructuring is a process where organizations thoroughly and critically review its structure and operating practices to control expenditures and maintain productivity (Van Sumeren, 1986). In this study, organizational restructuring refers to hospital restructuring. Terms synonymous with restructuring include rightsizing, downsizing, reorganization, and retrenchment.

Registered Nurse (RN) is an individual who has completed an educational requirement specified by the professional registering body (Labor Market Information Unit, 1994). In this study, the term ***General Duty Registered Nurse (GDRN)*** will be used because it is a specific classification of nurses who care directly for patients. GDRN is classified as 'Nurse II' under the Nurses' Union Collective Agreement.

Displacement refers to a unionized GDRN who is unable to remain in a current, permanent position due to an involuntary reduction in work force, such as receiving position deletion notice or being bumped.

Bumping is the right of an employee to displace a less senior employee if qualified to perform the work (Harnden & LeBlanc, 1991). At the study hospital, the bumping protocol stipulated a key factor in the bumping process was "the nurses' ability, performance and qualifications for any given position" (Study Hospital & Study Hospital Nurses' Union, 1992, p. 1).

Non-Displaced Nurse is a GDRN whose position has not been affected by reductions in work force. The non-displaced nurse will have remained in her/his permanent GDRN position or voluntarily accepted another position within the hospital. The term non-displaced nurse is synonymous with indirectly affected nurse.

Displaced Nurse is a GDRN who has been affected by involuntary reductions in work force. This can include position deletion or being bumped by a nurse with greater seniority. The displaced nurse is entitled to rights as outlined in the Study Hospital and Nurses' Union Bumping Protocol (1992). The term displaced nurse is synonymous with directly affected nurse.

Layoff Survivors are "those people who remain in organizational systems after involuntary employee reductions" (Noer, 1993a, p.13). This includes nurses,

either indirectly and directly affected by displacement, who remained employed at the study hospital.

Worklife refers to all aspects of the working environment of a nurse. "Quality of worklife is a complex and multivariate phenomenon that has many interrelated parameters" (O'Brien-Pallas, Baumann, & Villeneuve, 1994b, p.392).

Staff Mix is an alternative patient care delivery system which decreases the number of nurses required and increases the number of nursing assistants to provide certain aspects of patient care (Burda, 1993).

Chapter Summary

In this chapter, a background for the study has been presented. Much has been written on the process and approaches to hospital restructuring and subsequent displacement of staff. However, there is a scarcity of information related to the impact of restructuring and displacement on nurses and their worklife. Thus, research is needed to describe the impacts of displacement and restructuring on nurses and their worklife and to develop strategies to improve the process for the betterment of all involved, but

particularly to safeguard patient care. The research questions have been presented, and a definition of terms has been established for the study.

Chapter 2: LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

REVIEW OF THE LITERATURE

In this chapter, the literature which addresses the research topic will be presented. The scope of the literature review included: an overview of HCR; job loss and anticipatory job loss; hospital restructuring; and layoff survivors. While the review focuses on the related nursing literature, literature from management, labour relations, and psychology is integrated throughout. The chapter will conclude with a discussion of the conceptual frameworks selected for use in this study.

Health Care Reform

Organizational restructuring is occurring in a large number of sectors, but most notably in health care (Rozak, 1994). Canada has a reputation for the provision of high quality health care to its citizens. However, many believe health care is in a state of crisis, requiring reform (Deber & Thompson, 1992). Much of the literature found is American based. Thus, the American and Canadian perspectives on HCR were reviewed.

American and Canadian Perspective On HCR

Health care reform is being driven by financial constraints, and action to further control health care expenditure is expected (Avery, 1994; Manga, 1992). Canada spends more on health care than any other country with universal health care (Roch, 1992). The United States does not have universal health care. In 1992, approximately nine percent of the Canadian Gross Domestic Product was spent on health care (Mara, 1993; Roch, 1992; Weil & Stack, 1993), compared to 12.1% in the United States (Weil & Stack, 1993). According to Campbell (1994), Canada's standing is eighteenth out of 21 countries in medical cost control, and seventeenth in system performance. Health care costs have increased and costs must be cut if hospitals are going to survive (Campbell, 1994; Hequet, 1994).

Many American hospitals are experiencing decreased income due to decreased occupancy rates and an insurance system that pays per diagnosis, not length of stay (VanSumeren, 1986; Weil & Stack, 1993). Federally regulated diagnosis-related group reimbursement is the manner in which charges are determined (Jacobs & Pelfrey, 1995). In Canada, health care costs are not

paid for directly out of the user's pocket. Thus, consumers are not always aware of the costs for service (Canadian Hospitals Association, 1990).

Coinciding with the financial issues facing the American Health Care System is a nursing shortage in many parts of the United States. As a result, different approaches to patient care delivery that incorporate a decrease in nurse employment have been initiated (Burda, 1993). According to Scott (1993), this approach has dealt with the issue of nursing shortages, but there appears to be a trend to shift more direct patient care to lesser trained workers to lower costs.

In contrast to the American system, there is not a nursing shortage in Canada. An average of 5.5 full-time equivalent (FTE) employees per bed is found in the United States compared to 3.3 FTE employees in Canadian hospitals (Weil & Stack, 1993). Canadian hospitals deliver an increased volume of patient care for less costs per discharge when compared to the American system. However, they have longer lengths of stay and staffing patterns more oriented toward RNs. Research has demonstrated that hospital systems which employ a

higher RN ratio have more positive patient care outcomes (Avery, 1994).

Trends In Health Care Reform

Prior to HCR, the proportion of beds allocated for long-term care had increased from 22% to 33% with a decline in over 6,000 acute care beds (Canadian Hospitals Association, 1990). At that time, it was speculated that the acute care beds would decrease. Since HCR, many acute care beds have been closed with an increase in long term bed allocation (Roos et al., 1996).

Between 1971 and 1986, the numbers of hospital nurses employed increased dramatically from 21% to 33%, with a decrease in the numbers of nursing assistants from 26% to 15% (Canadian Hospital Associations, 1990). With the study province's HCR, a reverse trend is occurring. In 1993, the Canadian unemployment rate was approximately 10%, and unemployment in health care and medicine were below the national average (Statistics Canada, 1994). However, health care related unemployment has increased from 2.4% to 3.6% between 1990 and 1993.

Alternative health care delivery, which decreases

the number of RNs required and increases the number of nursing assistants (NA) to provide non-nursing activities (Burda, 1993; Pallarito, 1993; Scott, 1993), have been introduced to decrease hospital costs (Farley, 1994). According to Bhardwaj (1995), the trend in health care has been to replace highly skilled workers with less skilled workers. With the introduction of these staffing patterns, many nursing positions have been eliminated (Brider, 1993).

The roles and responsibilities of health care workers will change dramatically as new technologies surface within the health care system (Campbell, 1994; Canadian Hospital Associations, 1990). The use of technological assistance in the provision of patient care has increased (Canadian Hospital Associations, 1990). Nurses are concerned that machines will replace the need for their services, causing a further reduction in the numbers of nurses required for direct care giving.

There is a growing movement to consolidate services, expand outpatient and community services, and develop specialized treatment centres which serve a large population (Canadian Hospital Associations,

1990). The movement toward community care will further decrease the number of hospital nurses required; although it is postulated that there would be an increase in the numbers of RNs needed for these programs (Study Province Health Department, 1992). Many hospital policies have been changed to allow much of the pre-admission work to be done prior to the actual admission (Lowry, 1994).

Many nurses chose specialized areas of nursing, but are now finding them unavailable. Thus, nurses are being forced to re-examine their career directions. There is a dichotomy between whether nurses should specialize or not (Curtain, 1990). Diversification of skills and abilities may increase the likelihood of job retention. Unionized nurses may be recalled to positions only if they meet the minimum qualifications for a position (Study Hospital & Study Hospital Nurses' Union, 1992). As well, specialized nurses may be spared from displacement if prior education was required before position attainment.

The trend in HCR has been to close acute care beds and alter staffing patterns to contain costs. Nursing has been directly affected and will be further impacted

since this trend is predicted to continue (Collins & Noble, 1992; Hurley, 1994; Mara, 1993; Zimmermann, 1994a).

Hospital Restructuring

Hospital restructuring is a logical process requiring both interdisciplinary input and committed leadership (Smeltzer, Formella, & Beebe, 1993). Few hospitals have approached downsizing in an organized manner (Kazemek & Channon, 1988), although Rozboril (1987) found that an organized, systematic approach minimizes mistrust and disruptions in patient care. Cost reduction strategies are being driven by expediency (Kazemek & Channon, 1988; Manga, 1992; Rozak, 1994; Suderman & Dyck, 1994).

Approaches To Hospital Restructuring

Various models of organizational redesign have been formulated which profess successful restructuring (Arndt & Duchemin, 1993; Burns, 1993; Collins & Noble, 1992; Dull, 1986; Farley, 1994; Gelman & Marotta, 1986; Kazemek & Channon, 1988; Lowry, 1994; McGill & Kelly, 1983; Peterson & Fisher, 1991; Smeltzer, 1993; Smeltzer et al., 1993). Several restructuring approaches emphasize the importance of matching the decisions with

a long-term strategic plan (Arndt & Duchemin, 1993; Collins & Noble, 1992; Haywood, 1990). As well, matching the mission of the hospital to the deletion of a particular activity was deemed critical (Collins & Noble, 1992).

Many restructuring strategies need to include an emphasis on layoffs being a last resort (Begany, 1994; Borg & Jensen, 1985; Lee, 1992; Meehan & Price, 1988; Roberts, 1989; Rozboril, 1987; Zemke, 1990). Proactive restructuring activities has been proposed (Begany, 1994; Burns, 1993; Kazemek & Channon, 1988) which includes program incentives to encourage employees to voluntarily leave the workplace. As well, in preparation for layoffs, some administrators have instituted options such as freezing vacant positions (Meehan & Price, 1988).

The amalgamation of nursing units and departments has been reported in the literature (Collins & Noble, 1992, Roch, 1992). Mergers have long been associated with the business community, and are becoming a more common occurrence in hospitals (Begany, 1994; Chenoy, 1987; Dull, 1986; Gelman & Marotta, 1986; McGill & Kelly, 1983; Peterson & Fisher, 1991). Some

administrators are decreasing their hospitals' size in order to control costs (Lowry, 1994; Van Sumeren, 1986). Streamlining departments by deleting positions and closing beds is becoming a familiar picture in health care restructuring (Lowry, 1994).

Hospital restructuring using a Patient Focused Care (PFC) approach is beginning to receive attention (Hequet, 1994; Moffitt, Daly, Tracey, Galloway, & Tinstman, 1993; Noseworthy & Thompson, 1994; Watson, Shortridge, Jones, Rees, & Stephens, 1991). Activities specifically designed to improve existing patient care services are integral to this model (Hequet, 1994), and PFC puts the needs of patients first (Noseworthy & Thompson, 1994). According to Hequet (1994), jobs change significantly when hospitals restructure using this type of an approach.

Actual and Anticipatory Job Loss

Work affords a sense of structure, purpose and meaning to one's life (Amundsen & Borgen, 1992; Bridges, 1980, 1994a; Rozak, 1994). However, work, as we know it today, will not be here tomorrow (Bridges, 1994a). According to Bridges (1994b), "today's organization is rapidly being transformed from a

structure built out of jobs into a field of work needing to be done" (p. 64). The organization of tomorrow will re-shape itself as the situation demands. However, most companies are unprepared to manage a work force of temporary or part-time staff, consultants, and contract workers.

The trauma associated with job loss has been identified as significant, and has been equated with divorce or death (Haywood, 1990; Rozak, 1994). Job security can no longer be guaranteed (Bridges, 1994a, 1994b; Isabella, 1989), and one's sense of security must come from within rather than from the job (Noer, 1993a; Rozak, 1994). According to Bridges (1980), people have difficulty letting go of the old to reach the new reality of work, and many are caught in an "in-betweenness". If the change occurs too fast, employees may not be able to adapt (Haywood, 1990).

There are many sources of detrimental consequences for mental health when job loss occurs (Ensminger & Celentano, 1988). Much has been written on the unemployed person and their health status (Ensminger & Celentano, 1988; Hagen, 1983; Hamilton, Broman, Hoffman & Penner, 1990; Hoffman, Carpentier-Atling, Thomas,

Hamilton & Broman, 1991; Kasl, Gore & Cobb, 1975; Rozak, 1994; Smith, 1990). Hagen (1983) found that actual and anticipated job loss are threatening and seriously unsettling. Ensminger and Celentano (1988) found that once re-employed, recovery in mental health occurred. However, Kasl et al. (1975) concluded that workers who returned to work after being unemployed had poorer mental health than those continually employed. Hamilton et al. (1990) found being laid off meant worse mental health as demonstrated by more somatic complaints, more depression, and higher anxiety. More subtle effects were identified in those anticipating layoff, and these effects were dependent on demographic characteristics. Women showed greater distress, married workers reported less distress, more highly educated respondents had less somatic complaints, and older workers reported less depression. Kasl et al. (1975) found anticipating job loss could be as stressful as the event itself. Subjects had an increased incidence of somatic complaints, hypertension, depression, and suicide during this time. The suicide rates for laid off workers is 30 times the American average (Bunning, 1990). Hoffman et al.

(1991) found those already laid off and those anticipating layoff reported increased tension with their spouses. However, this finding was more true for those already laid off. Many families cope with job loss by reframing their nurturing (Webb & Friedemann, 1991), and spouses and children are affected by a family member's unemployment (Dew, Penkower & Bromet, 1991).

The majority of literature on unemployment has focused on blue collar workers. The disadvantaged, the unskilled, and the undereducated are not the only ones at risk of job loss (Hagen, 1983). Unemployment can no longer be considered something that only happens to the other person (Rozak, 1994). Jacobson (1987) reviewed technical professionals' reactions to unemployment, and surmised meaning of job loss was related to their perceptions of being able to meet financial needs. Farley (1991) investigated mental health professionals' (n=38) reactions to layoff notifications, and found their reactions related to their attitudes toward administration; their affective responses and coping efforts; recovery; and the effects on the agency.

Nurses and Restructuring

Financial factors are affecting many hospitals' viability, and are forcing system restructuring (Avery, 1994). Officials in many Canadian provinces have either announced or implemented drastic measures to curtail health care costs (Manga, 1992). Many Canadian nurses have been affected by restructuring (Lynch, 1993; Olson, 1995; Rozak, 1994; Sears, 1992; Suderman & Dyck, 1994).

Nurses and Displacement

Nurses are more likely to be affected by restructuring activities, such as bed closures, than any other hospital job classification (Olson, 1995; Wilson, 1995). The frequency of nurses experiencing displacement has dramatically increased post-restructuring (Rozak, 1994; Sears, 1992). According to Zimmermann (1994a), 47 to 65% of nurses ignore the warning signs of pending layoff. Layoffs or at least a serious threat of layoffs are being experienced in 63% of the 19 states surveyed by the American Nurses' Association (Burda, 1993; Zimmermann, 1994a, 1994b). Minimal opportunities exist for new graduates, since RN vacancy rates are lower than they have been in recent

years (Anderson, 1993; Canadian Nurses Association, 1995; Gentry, 1993). Begany (1994) surveyed RN readers (n=300) and found almost a quarter of the participants reported that they have experienced layoffs in their departments. Many of the respondents saw nursing as a thriving profession, although they saw nurses assuming new roles and practicing in new settings.

The majority of literature on nursing displacement describes an American, non-unionized system (Barnes, Harmon & Kish, 1986; Borg & Jensen, 1985; Feldman & Daly-Gawenda, 1985; Lucas, 1994; Roberts, 1989; Tuttle, 1992). However, three Canadian studies were found which relate specifically to unionized nursing displacement (Lynch, 1993; Olson, 1995; Sears, 1992). As well, much of the literature on nursing displacement has focused on approaches used to handle displaced workers.

Lucas (1994) describes a rightsizing experience at one American hospital. The major emphasis on the plan was the implementation of a displaced worker pool (DWP). Employees identified as surplus in their departments were relocated to the DWP cost centre. This process was found to be beneficial since it gave

employees time to find new jobs. Hospital executives met with staff to obtain input on DWP policies, and most employees wanted seniority to be the primary factor in displacement. The hospital complied with this request, but those with significant performance issues were also displaced. This strategy was found to decrease substantially the number of employees actually laid off. Staff's anxiety levels have been found to decrease when positions are retained based on seniority (Lucas, 1994; Roberts, 1989; Tuttle, 1992). Roberts (1989) found many administrators would have preferred to use performance as a separation indicator. Seniority was chosen since their method of performance evaluation was not deemed satisfactory. However, to meet the situation in which seniority was not in the best interests of patient care or the cost-containment effort, an exceptions clause was incorporated into the plan.

Several authors recommend employee fairness be integral to the displacement plan (Roberts, 1989; Tuttle, 1992). Tuttle (1992) stresses using a "transfer fair" approach to deal with displaced workers. This approach enables employees to have

information, conduct immediate interviews, and feel they have been treated with respect and dignity. Showing institutional support and caring has been found to be important during displacement (Borg & Jensen, 1985; Tuttle, 1992). As well, programs designed to assist displaced nurses and their spouses cope with job loss were found to convey organizational concern for those individuals affected, and reassure those who remained that the facility cared about them (Tuttle, 1992). Job finding assistance programs (Gallivan, 1986b; Schlossberg & Leibowitz, 1980), employee assistance programs (Watts, 1988), and out-placement services (Howes, 1995; Michelin, 1995) have been reported as helpful during downsizing. However, Olson (1995) did not find nurses utilized the hospital's employee assistance program for support.

Feldman and Daly-Gawenda (1985) interviewed nurse executives (n=9) to ascertain how they managed layoffs. All facilities had layoff criteria and formal plans. One hospital was unionized, thus had a pre-existing policy. Seven hospitals used seniority with or without performance as their criteria for layoffs, while two elected to use performance only as criteria. Few

hospitals had policies specific for those left behind. Factors for survival were identified as communication, visibility and availability of administrators, and good interpersonal skills. Communication has been found to be critical during displacement (Feldman & Daly-Gawenda, 1985; Haywood, 1990; Lynch, 1993; Meehan & Price, 1988; Noer, 1993a, 1993b; Olson, 1995; Sears, 1992; Veninga, 1987).

Many authors advocate strategies to cope with job loss or economic uncertainty (Hughes, 1993; Kaczmarek, 1993; Lynch, 1993; Nornhold, 1994; Russ, 1994; Wester, 1994; Zimmermann, 1993, 1994a), and several authors encourage nurses to prepare for the possibility of layoff (Lynch, 1993; Zimmermann, 1994a). Many anecdotal accounts of nurses' personal experiences with job loss have been reported recently (Frank, 1993; Jones, 1993; Nichols, 1994; Rozak, 1994; Zimmermann, 1993, 1994b).

Unionism and Displacement

The Canadian Nurses' Association endorsed collective bargaining in 1943 (Edwards, 1988). Unionism for nurses occurred for the same reasons as in other groups - better economic and social quality

(Roberts, Cox, Baldwin & Baldwin, 1985). Job security was not a motivating factor in the early days of unionism. However, it is a critical issue today (Greene, 1993, Pallarito, 1993, Scott, 1993). Unionization for nurses has resulted in monetary gains and provided a collective voice for nurses (O'Brien-Pallas & Baumann, 1992). Restructuring promotes increased union activity since job security becomes an overriding issue (Gallivan, 1986a). It has been reported that some nurses are promoting unionization (Greene, 1993), demanding guarantees that they will not be replaced by less skilled workers, having no-layoff clauses placed in their contracts (Pallarito, 1993) and calling for seniority based reductions (Gallivan, 1986a).

Seniority systems define who is eligible for certain monetary and fringe benefits (Anderson, Gunderson & Ponak, 1989; Palmer & Palmer, 1991). Traditionally, collective agreements outline that layoffs be carried out in accordance with seniority which includes the right of an employee to bump a less senior employee if qualified to perform the work (Harnden & LeBlanc, 1991). However, according to

Bridges (1994a), unions need to evolve or face extinction "as the American workplace becomes more and more dejobbed" (p. 190). He believes unions of tomorrow will be educational institutions, offering ongoing education similar to professional associations, to enhance workers' employability.

According to Meehan and Price (1988), bumping privileges are a "human resource nightmare" (p. 28), since there is a problem of balancing competency with quality care. They found many nurses were not suitable for the positions they bumped into. The result was time-consuming and costly grievances. Staff retraining was an additional cost. Despite a bumping process and staff orientations, low staff morale and productivity occurred. They found confusion and dissention resulted when workers replaced less senior, yet productive employees. They recommended that if a bumping policy exists, a merit system of performance should be taken into consideration.

Bumping usually affects five times more employees than those originally displaced (Meehan & Price, 1988). One Alberta Hospital assessed the ramifications of a bumping process (Farrell, 1994). Nineteen positions

were originally deleted. However, after bumping, 99 employees were ultimately affected. Bumping was found to cost the hospital $233,000 and in the end, only five employees were laid off. The administrator advocated that there should be a modified form of severance rather than bumping, and more emphasis should be placed on experience as opposed to years of organizational work.

Olson (1995) found that 76% of the nurses surveyed (n=93) did not perceive the bumping process as fair. Nurses who were displaced had the right to displace other nurses as long as they had more seniority. She differentiated between a bumping process and a layoff. Less senior staff are affected by layoffs, whereas bumping affects a larger number of staff including those with varying amounts of seniority. According to Sears (1992), nurses were uncomfortable with bumping co-workers to maintain their employment status.

Nurses' Reactions to Restructuring

Nurses' reactions to hospital downsizing and job loss mirror people's reactions to any traumatic incident (Pawlicki, 1994; Rozak, 1994). Pawlicki (1994) presents an anecdotal account of a pre-and post-

downsizing period. During the pre-downsizing period, she found staff felt abandoned and abused, had difficulty empathizing with patients, quality of patient care decreased, and staff split into groupings of new and old, depending on their seniority. Feelings of disorientation and exhaustion, a likelihood for errors, and a decreased faith in the treatment plans were noted post-downsizing.

"As the environment in which hospitals operate continues to become more and more competitive, financially stressed, regulated, and generally less supportive, more and more hospitals will be faced with closure" (Harris, 1985, p. 99). The closing of hospitals has been found to be traumatic for those involved (Bender, 1986; Davis, 1988; Dencker, 1989; Harris, 1985; Massey, 1991). Massey (1991) examined the bereavement reaction of mental health nurses (n=22) to their hospital closure. Anxiety about community care, a refusal to accept the closure as being right, and a strong identification with the old hospital were articulated by the staff. Dencker (1989) identified the greatest problems for the nurses (n=221) during a hospital closure were the splitting up of their working

teams and having to establish new relationships.

The numbers of hospitals downsizing is increasing (Kazemek & Channon, 1988). Many are in the midst of restructuring or are contemplating restructuring (Gentry, 1993). Impending cutbacks generate feelings of uncertainty and insecurity (Rozak, 1994; Suderman & Dyck, 1994). If not appropriately managed, lowered productivity may result (Darling & Luciano, 1985). Suderman and Dyck (1994) chronicled the restructuring process at a Canadian hospital, and identified two sides to the process - technical and people. They concluded, "effective restructuring demands having, and properly using, knowledge of both" (p.26).

Restructuring causes stresses on individuals at all levels (Mara, 1993). Minimizing trauma to employees is the only way to achieve downsizing benefits (Lee, 1992). Olson (1995) measured the impact of downsizing on nurses (n=93) who remained employed at a Canadian hospital. Findings revealed the majority of participants were dissatisfied with their jobs (88%), not committed to nursing (84%), not committed to the organization (90%), and stressed during the process (87%). However, only 10% of the participants had

intent to leave. She related this low statistic to a depressed economy and the loss of seniority if nurses left the facility. She suggested withdrawal in other forms, such as increased sick time utilization, may replace their inability to physically leave the organization.

Meehan and Price (1988) investigated the levels of stress, satisfaction and motivation in nurses who were experiencing restructuring. Nurses affected (n=49) and not affected by the budgetary cuts (n=30) were interviewed. Displaced nurses were found to have higher stress and lower job satisfaction. The greatest levels of stress were found in the affected group who were aware that their positions were in jeopardy. Nurses who were bumped showed the lowest levels of stress. Uncertainty was found to be more difficult to deal with than the actual displacement. Managers focused their attention on displaced nurses. Many affected nurses were angry and would have preferred layoff to working outside their specialty. They recommended more support for nurses indirectly affected by displacement.

Lynch (1993) investigated nurses' reactions to

displacement after a unit closed. Many of the stressors identified pertained specifically to bumping. Personal stressors for staff included concern for patient care, a different patient focus, fear of not being accepted on the new unit, loss of contact with colleagues, having to comfort colleagues, loss of income, feelings of loss of control over the situation, an inability to retire early, physical ability to perform the new job, feeling like starting all over again, and a re-evaluation of personal and professional values. Stressors identified for staff within the Department of Nursing were rumours, denial of position requested, awaiting verification of position, rotations not available on new units, hearing the misfortunes of others, lack of communication and information, the collective agreement, a decrease in casual shifts available, and lack of administration visibility. The collective agreement was seen as a necessity and an inconvenience, concurrently. Stressors for staff from outside the Department of Nursing were identified as lack of long-term planning, lack of alternative cost-saving measures, blaming of nurses' wages for budget strain, and downsizing in industry which had affected

spouses. Further details regarding these stressors were not provided.

Sears (1992) explored the relationship between stress, hope and coping in three groups of medical nurses: those whose positions were eliminated due to unit closure (n=18), those whose positions on a unit that was being relocated to another hospital (n=14), and those whose positions were unaffected (n=25). The group being transferred to another facility was found to have the highest stress, highest burnout, lowest hope, and to use coping mechanisms less effectively. Relocating to another hospital and having no choice were found to be more stressful than receiving deletion notice. Of note, nurses who received deletion notices were given support. The same level of attention was not deemed necessary for the nurses being transferred since they had job security.

Supportive Activities During Restructuring

Some models of redesign approach restructuring as an opportunity for change and a learning experience (Farley, 1994). Reframing the negative event into a positive outcome is a coping strategy recommended for nurses who are unemployed (Rozak, 1994; Strength &

Ulmer, 1987). When a hospital closed, Dencker (1989) found 37 percent of the staff decided to further their education and 43 percent were interested in community care. However, many laid off nurses feel like they have been fired (Rozak, 1994). Understanding that layoffs do not represent poor performance helps with the coping (Rozak, 1994; Strength & Ulmer, 1987).

When an organization is planning to restructure, supportive activities are required for both staff and managers (Arndt & Duchemin, 1993; Donley, 1994; Haywood, 1990; Meehan & Price, 1988). Arndt and Duchemin (1993) suggest managers should be supported with educational sessions such as managing change, supporting staff and stress management. Lynch (1993) interviewed managers after a restructuring and bumping process. Three themes - the need for information, the need for quality control, and the need for support - were identified as paramount to their survival. Employees have been found to have a high need for information (Lynch, 1993; Noer, 1993a; Veninga, 1987).

Barnes et al. (1986) examined the effectiveness of a displacement orientation program (DOP) by comparing displaced nurses (n=10) and non-displaced nurses

(n=10). The program was designed to minimize staff reactions and maximize their adjustment. Displaced nurses were to receive an orientation program immediately on transfer to the new units, and an adjustment program at one month. Initially, nurses were extremely angry and could not be recruited for the study. Staff were found to need time, about two and one-half months, to diffuse their anger before they could be recruited. Two measurements were obtained using the Profile of Mood States (POMS) and the Group Environmental Scale (GES). The treatment group had lower scores on the POMS indicating a decrease in negative mood states, and higher scores on the GES indicating an increase in group membership behaviours. They concluded that the DOP was beneficial for displaced nurses. However, the two and a half month recruitment delay may have been a factor in the positive results.

According to Sears (1992), the least helpful things for nurses during displacement were uncertainty and rumours; administration and poor communication; and the bumping process. The most helpful things for nurses during displacement were support and sharing

feelings; communication and information; and management working with union. Lack of choice during displacement causes increased stress. She concluded nurses can cope when given choice, information and support. According to Meehan and Price (1988), nurses need to be placed in the right setting from the beginning. Employees are happier when they are matched to their interests, and there can be considerable savings from redeployment and inplacement despite the expense of retraining (Stuller, 1993).

Rozak (1994) developed a transition series for nurses who have lost their jobs due to hospital restructuring. Many anecdotal accounts of the experiences of laid off nurses were included in the hopes that unemployed nurses would be able to relate to the experiences of others. Health care worker retraining is starting to receive attention (Michelin, 1995).

Restructuring and Nurses' Worklife

Restructuring of health care delivery systems, with subsequent alterations in nursing roles, are creating dramatic changes in the work environment for nurses (Rozak, 1994; Tumulty, Jernigan & Kohut, 1994;

Triolo et al., 1995). "These changes, although designed to improve healthcare delivery, have resulted in a rigorous environment of continuous disruption" (Triolo et al., 1995, p.56). Staff need to be prepared for the changes in health care delivery (Donley, 1994; Triolo et al., 1995), and many staff advocate for role preparation in order to survive in the new environment (Hurley, 1994).

Tumulty et al. (1994) investigated the effects of organizational change and the work environment on nurses' job satisfaction (n=159), using an Index of Work Satisfaction questionnaire. Various factors were found to contribute to job satisfaction, and working relationships were identified as the most significant. Nurses working on units with stronger managers and peer support were found to have more job satisfaction.

Restructuring and Patient Care

Nurses are concerned that changes in care delivery may lead to lower quality patient care (Avery, 1994; Collins & Noble, 1992; Munro, 1995; Roos et al., 1996). Fewer patient deaths and complications, shorter lengths of stay, and increased patient satisfaction result when patients are cared for by a higher percentage of RNs

(Avery, 1994; Prescott, 1993). Maintaining quality of care has been found to be critical during restructuring (Avery, 1994; Banning, 1992; Lewis, Nitta, Biczi & Robinson, 1986; Meehan & Price, 1988). Worron (1996) reported death rates rose at American hospitals where reductions in workforce were implemented without long term planning. Japsen (1993), reporting on the same study, identified reducing staff by 7.75% or more were 400% more likely to see an increase in patient illness and mortality. However, this finding was not further discussed. E.C. Murphy, one of the study consultants, stated in a telephone interview with Worron (1996), "cutting nurses could have a profound effect on patient health" (p. A9). However, Roos et al. (1996) reported no adverse patient care effects occurred as a result of approximately 500 inpatient beds being closed in a large Canadian city. They found residents had the same or better access, no evidence that downsizing negatively affects quality of care, and the health status of residents remained relatively stable between 1990 and 1993. Although the reported findings were significant, more bed closures have been announced which may influence these preliminary results.

Additional bed closures were seen as viable based on their results (Winnipeg Free Press, 1996).

Lewis et al. (1986) investigated nursing care during downsizing utilizing a Patient Care Assessment Tool. The hospital implemented a new charting procedure at this time, which may have impacted on the results. Findings revealed that overall, quality of nursing care remained relatively unchanged, although certain indicators did change. High scores were found in areas of hygiene, communication, and responses to nursing care; and low scores were found in charting, care planning, patient education and discharge planning. They concluded that many internal and external factors contribute to an unstable environment during downsizing, and these factors may negatively influence patient care.

Layoff Survivors

Whether downsizing is done the right way or the wrong way, it significantly affects all involved (Brockner, 1992; Brockner, Greenberg, Brockner, Bortz, Davy & Carter, 1986; Brockner, Grover, Reed, DeWitt & O'Malley, 1987; Davy, Kinicki, & Scheck, 1991; Isabella, 1989; Lee, 1992; Marks & Mirvis, 1992; Noer,

1993a, 1993b; Rozak, 1994; Zemke, 1990). After a staff reduction process, the toughest job is ahead for management - dealing with survivors (Kazemek & Channon, 1988). According to Lee (1992), initial reactions of anger and pain change to fear and cynicism. Trust in the company deteriorates and the result is low morale, decreased efficiency, productivity erosion, and lack of long term profit improvements. Treating survivors as though they are fortunate to have a job creates further emotional trauma and resentment. Interaction on a frequent basis is a key factor in repairing the employer-employee relationship (Lee, 1992). Staff who remain employed should not be ignored (Brockner, 1992; Isabella, 1989; Meehan & Price, 1988; Noer, 1993a, 1993b; Sears, 1992).

Organizations must deal with layoff survivors, or there are dangers of losing good staff, increasing employee stress and maladaptive behaviour, and having withdrawn and apathetic employees (Isabella, 1989). Brockner (1992) stresses that when the organization takes the time to provide adequate reasons for the layoffs, survivors will judge the process as fair. Many factors were found to impact how survivors

perceived the layoff process (Brockner, 1992; Brockner et al., 1986; Brockner et al., 1987). As well, survivors are influenced by changes in their work setting, which often accompany layoffs. How the changes are viewed, as a threat or an opportunity, affected productivity and morale. Job insecurity increases after layoffs, and survivors' reactions depend on their career prospects relative to pre-downsizing opportunities (Brockner, 1992). Brockner et al. (1987) found that survivors reacted most negatively when they identified with layoff victims and perceived them to have been inadequately compensated.

Davy et al. (1991) developed and tested a model of survivor responses (n=88) to layoff. They found that perceived fairness and job security have direct effects on job satisfaction. If the fairness perception decreases, attitudes toward the organization becomes more negative, and there is increased likelihood of withdrawal from the organization. They concluded that witnessing layoffs have a significant effect on survivors. The approach to downsizing creates a domino effect that can echo through the company for a long time (Lee, 1992; Noer, 1993a).

Noer (1993a) identified an emergence of a layoff survivor blaming phenomenon in a post-downsizing study. He conceptualized blaming as a form of projection, to prevent survivors from dealing with guilt. Minimal literature was found specific to survivor blaming. Godfrey (1994), an administrator during a unit closure, found staff blamed her for the decisions made. Cameron, Freeman and Mishra (1991) reported some survivors may develop survivor envy. There may be disincentives in the workplace after downsizing such as increased workloads, and layoff survivors can be envious of displaced workers.

Layoff Survivor Sickness

The concept of a survivor syndrome is starting to receive attention (Triolo et al., 1995; Lynch, 1993; Marks & Mirvis, 1992; Noer, 1993). Marks and Mirvis describe survivor sickness in the context of a merger. They advocate investing the time in post-merger team building. Noer (1993a) described individuals who remain employed, after layoffs, do not get the attention they need. He describes them as suffering from Layoff Survivor Sickness.

Layoff Survivors Sickness and Nurses

Several recent studies have investigated nurses as survivors of restructuring (Olson, 1995; Triolo et al., 1995). In a unionized Canadian hospital, Olson (1995) measured the impact of downsizing on RNs (n=93). Nurses were found to be affected negatively by the process, and no differences were identified between nurses directly or indirectly affected by displacement. Nurses had decreased job satisfaction, decreased job security, low commitment to nursing and the organization, were dissatisfied with their jobs, and did not perceive the layoff process as fair. She concluded many nurses who had survived a downsizing process were exhibiting layoff survivor syndrome symptoms.

Triolo et al. (1995) surveyed staff nurses to obtain feedback related to organizational changes. Included in the survey were seven written response questions, and the responses totalled 110 single-spaced typed pages. Staff had experienced numerous changes in their worklife including altered reporting relationships, loss of colleagues, and a working environment in constant flux. Feelings of staff

members were grouped into the following themes: fear, insecurity and uncertainty; frustration, resentment, and anger; sadness, depression, and guilt; and unfairness, betrayal, and distrust. They concluded that half of the respondents appeared to be exhibiting layoff survivor sickness. They identified two factors as being the causes for the layoff survivor symptoms: perceived violation of trust and a change in the employment relationship. A leadership development program was developed to assist staff in dealing with the constant changes and the grieving process, provide knowledge related to health care, and help nurses network with other nurses within the facility.

SUMMARY OF LITERATURE REVIEW

The business world has dealt with restructuring issues for many years, especially during the past 10 years (Bunning, 1990; Cameron, Kim, & Whetten, 1987; Heenan, 1989). Much literature has been written on the process and approaches to restructuring (Heenan, 1989). However, there is a paucity of research which investigates the impacts of restructuring on survivors (Cameron et al., 1991). This is a critical issue since organizations need an environment of high morale and

productivity to survive (Noer, 1993a).

Minimal research has been done on the human impact of health care restructuring and displacement and its effects on nurses' worklife. The full reverberation of restructuring and displacement is unknown and may not become apparent until employees have lived within the new organization for a time (Isabella, 1989). In addition, hospitals are continually changing. It may take several years before the outcomes are obvious (Pallarito, 1994). Anticipation of the layoff can be as stressful as the actual layoff (Hamilton et al., 1990; Hoffman et al., 1991; Kasl et al., 1975; Noer, 1993a; Sears, 1992). Sears (1992) contends that displacement is an added stressor for nurses who already work in high stress positions. It is anticipated that further action to control costs will be initiated (Collins & Noble, 1992; Hurley, 1994; Mara, 1993; Zimmermann, 1994a). Nurses will continue to be affected by the accompanying HCR changes (Manga, 1992).

Conceptual Frameworks

Two frameworks were utilized in this study. The first theoretical framework, O'Brien-Pallas and Baumann's nursing worklife framework (1992), integrates with the second theoretical base, Noer's management model of layoff survivors (1993a).

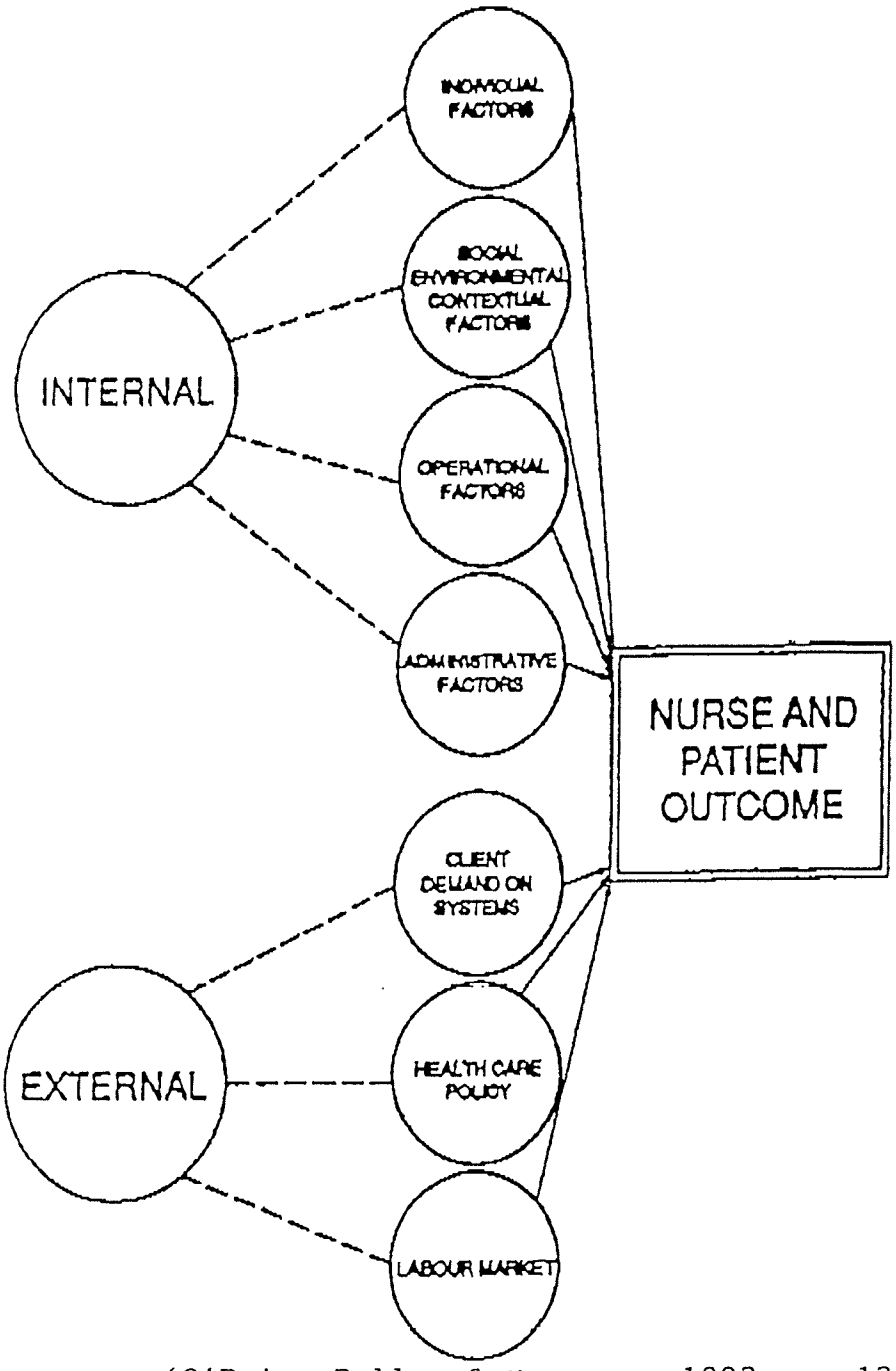
O'Brien-Pallas and Baumann's Unifying Framework

The unifying framework of nursing worklife proposed by O'Brien-Pallas and Baumann (1992) explores the relationship between the individual nurse's experience, the institutional context of work, and the features of the broader health care system (Figure 1). This theoretical framework is useful since it specifically addresses issues facing nurses in practice. A quality environment is one in which the goals of the individual nurse and patient are met, and where both outcomes are accomplished within the cost and quality framework of the receiving organization (O'Brien-Pallas, Baumann, & Villeneuve, 1994b). Nursing work is a system of interacting dimensions, with an increasing emphasis on productivity, efficiency, quality assurance, and cost effectiveness. These are important issues since health professionals'

roles and patient care are being challenged, and the health care system is rapid changing (Baumann & O'Brien-Pallas, 1993). Many variables, both internal and external to the nurse, affect worklife. There is a great deal of interaction between these factors which ultimately affect both the nurse and patient outcomes. Nursing worklife is complex.

The internal dimensions of the model include variables which focus on the nurse and her/his working environment (O'Brien-Pallas & Baumann, 1992). Four major factors - individual factors; social/ environmental contextual factors; operational factors; and administrative factors - comprise this dimension. The individual factors are an interplay between home life and worklife. Nurses are influenced by the work context, including their professional relationships. These factors are central to the socio/environmental contextual domain. Patient care delivery constitutes the operational factors. Care delivery activities, the degree of technology, and the availability of equipment will influence worklife. Administrative factors, which include benefits and policies, provide the structure for the smooth-running hospital operation.

FIGURE 1: MODEL FOR QUALITY OF NURSING WORKLIFE UNIT



(O'Brien-Pallas & Baumann, 1992, p. 13).

The external dimensions include factors external to the nurse and her/his working environment (O'Brien-Pallas & Baumann, 1992). Three major factors - client demand on system, health care policy, and the labour market - are central to this aspect of the model. Nurses are challenged to provide nursing care to meet the demands of health care users in an environment in which the numbers of active treatment beds have been reduced, and community health care is a major focus of care. Labour market conditions such as the numbers of positions available will influence worklife.

Noer's Layoff Survivor Model

The layoff survivor model described by Noer (1993a) provided the second conceptual framework for the study. This framework was useful because it described feelings, thoughts and experiences of individuals who lived through an organizational downsizing process. Noer (1993a) describes those employees, who remain working for the restructured organization after involuntary reductions in workforce, as layoff survivors. He contends that a profound shift in the employer-employee relationship occurs when downsizing is implemented, and this shift dramatically

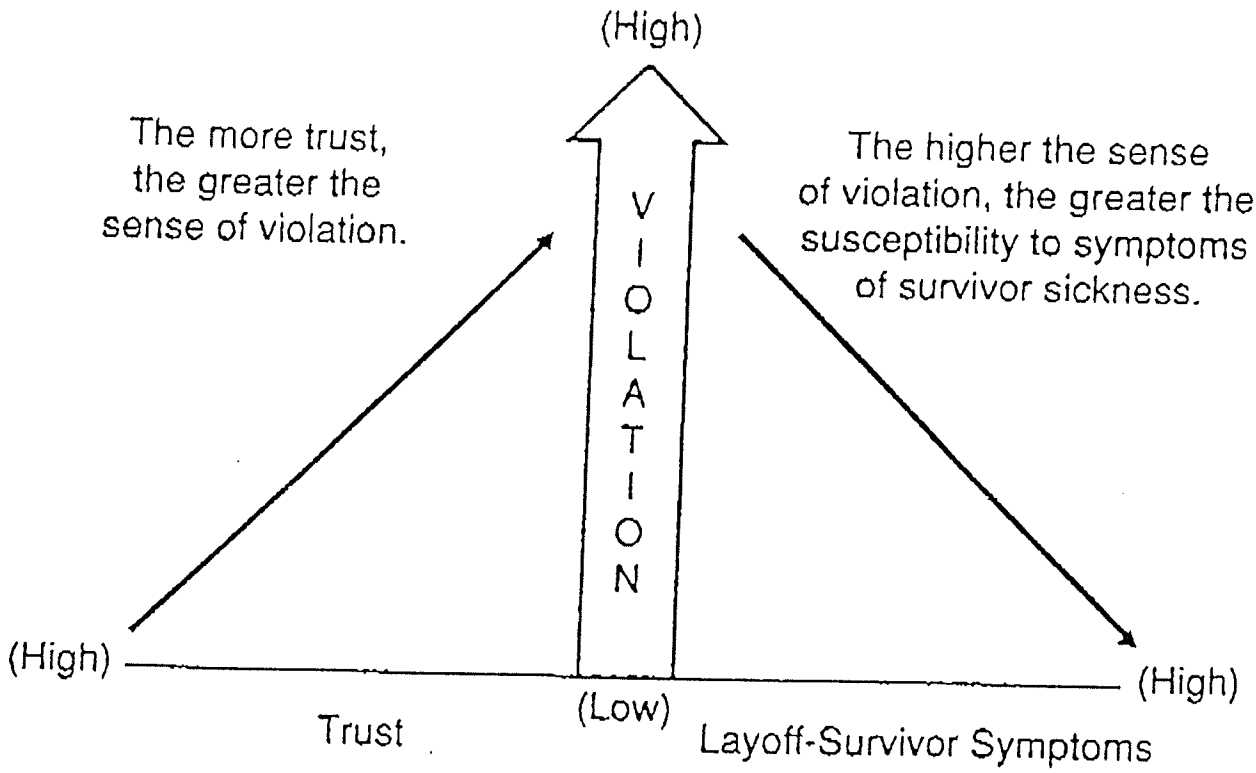
affects employees. Employees, who used to be regarded as assets, are now costs to be cut. Past organizational communication was nurturing toward employees, whereas post-downsizing communication is at times violent. Words such as terminated and deleted are more commonly used. Long-term career development has been replaced with short-term job fit and short-term profit orientation. Building up has been replaced with taking apart. As a result of these shifts, there is a deviation in the psychological contract that binds individuals and organizations. The result is an embittered workforce with reduced productivity.

The old employment contract, a psychological contract between employers and employees, implied employees who perform and fit the organizational culture can count on their jobs being there (Noer, 1993a). However, long term employment can no longer be expected. There is a new psychological contract, which fits with the new reality of the work place. Loyalty to an organization is replaced with loyalty to one's work.

The workforce left behind after downsizing has been seriously affected by the changes (Noer, 1993a).

Layoffs, which are expected to foster a lean and mean organization, result more often in an angry and depressed organization. He describes these employees as suffering from layoff survivor sickness, which "is a generic term that describes a set of attitudes, feelings and perceptions that occur in employees who remain in organizational systems following involuntary employee reductions" (Noer, 1993a, p. 13). Layoff survivor sickness is epidemic and virulent to both the human spirit and the organization. Instead of creating an efficient and productive organization, reductions in staff more often lead to a risk aversive and less productive workforce. The basic bind of lean and mean leads to sad and angry (Figure 2), and the key variable in the development of layoff survivor sickness is the survivors' sense of personal violation. The greater the employees' perception of personal violation, the greater their susceptibility to develop layoff survivor sickness. The perception of violation is related to their feelings of trust about the organization taking care of them - the old employment contract.

Figure 2: The Basic Bind



(Noer, 1993a, p.7).

The feelings of those who remained employed in the organization and those who underwent involuntary employee reduction were mirror images of each other. Survivor symptoms include the following: depression, stress and fatigue; job insecurity; distrust and

betrayal; decreased risk taking and motivation; wanting it to be over; lack of reciprocal commitment; dissatisfaction with planning and communication; lack of strategic direction; a sense of permanent change; continued optimism and commitment; anger over the layoff process; lack of management credibility; and short-term profit orientation. Layoff survivor symptoms persist over time and do not disappear without assistance (Noer, 1993a). Survivors struggle with their feelings in ways that are not personally healthy or organizationally productive (Noer, 1993b).

Summary

The two conceptual frameworks facilitate the understanding of the study's purpose. The unifying framework, proposed by O'Brien-Pallas and Baumann (1992), is useful since it specifically addresses issues confronting nurses at the bedside. Noer's (1993a) model of layoff survivor sickness provided another dimension to the issues confronted by nurse survivors in a restructured work environment. This framework was useful since it describes thoughts, feelings and experiences of those who live through a downsizing process.

Chapter Summary

In this chapter, a review of the literature regarding restructuring, including displacement, and nurses have been presented. Based on this review, it is apparent that a void exists in the knowledge related to impacts of restructuring and displacement on GDRNs and how their worklife has been affected. Previous research has focused on restructuring from the perspective of successful approaches utilized. However, the post-layoff environment has received relatively little attention (Noer, 1993a). Hospital restructuring, with resulting displacement for nurses, will have an effect on themselves and their worklife. O'Brien-Pallas and Baumann's unifying framework of nursing worklife (1992) and Noer's layoff survivor model (1993a) are sensitive to the study purpose which is to explore the impact of restructuring and displacement on nurses and how it affects their worklife.

Chapter 3: RESEARCH METHODS

In this chapter, the research approach, study setting and sample, data collection including the interview guide utilized, and data analysis procedures will be presented. Reliability and validity issues will be described, and the chapter will conclude with a discussion of ethical considerations.

Research Approach

Qualitative approaches in science are explicit methods of inquiry oriented toward understanding human thoughts, behaviours, negotiations, and institutions (Brink & Wood, 1989). The intent of these approaches is to gain a deep, rich understanding of the subject's experiences (Baker, Wuest & Stern, 1992; Habermann-Little, 1991), and are directed toward discovering new insights and meanings (Brink & Wood, 1989).

According to Brink and Wood (1989), qualitative approaches should be utilized when the present state of knowledge about the topic is minimal. Limited literature was found regarding the impact of restructuring and displacement on nurses and how it affected their worklife. Therefore, it was appropriate to use a qualitative approach, specifically

phenomenology, for this particular study.

Phenomenology

Phenomenology is the science of human experience and approaches the understanding from the individual perspective (Drew, 1989; Knaack, 1984; Morse, 1989; Pallikkathayil & Morgan, 1991). The method is an inductive, descriptive approach to investigate and describe phenomena in the way they are experienced and lived (Oiler, 1982; Omery, 1983). This method is particularly useful for research as only humans know what they have experienced by looking back on it (Oiler, 1982).

Assumptions Underpinning the Study

The following assumptions underpin this study:

1) All human behaviour is understood in terms of the subject's orientation in the world (Oiler, 1982).

2) Qualitative methodologies offer researchers valuable approaches to the understanding of human experience (Baker et al., 1992).

3) The research approach selected for this study is holistic in that it seeks to study the lived experience of the person, rather than isolating variables and then trying to put them back together

(Benner, 1985).

4) The researcher and participants respond to each other during the research process (Paterson, 1994).

5) The researcher's experience will contribute to the study's findings (Drew, 1989).

6) Nurses will disclose their feelings and thoughts about their lived experience with hospital restructuring and displacement.

7) Hospital restructuring and displacement affect nurses in varying degrees.

8) Nurses' worklife is affected by restructuring and displacement in varying degrees.

Description of the Study Sample and Setting

Nurse Participants

General Duty Registered Nurses (GDRN) employed at the study hospital were recruited for this study. A sample of convenience (n=10) was used. Nonprobalility sampling is appropriate when a researcher is examining understandings and meanings. Sample adequacy is evaluated by the quality, completeness, and amount of information contributed by informants (Chinn, 1986). According to Sandelowski (1995), adequacy of sample size is one that permits the deep analysis that is a

hallmark of qualitative inquiry, and that results in a new and richly textured understanding of experience.

Nurses who have been indirectly or directly affected by displacement were interviewed by the investigator. It was anticipated that at least half of the participants would be directly affected by displacement.

Inclusion Criteria

Inclusion criteria for participants in the study were:

1. All participants were currently employed in a permanent GDRN position within the study setting.
2. GDRNs who had been affected directly or indirectly by displacement were included in the study.
3. All directly affected participants were displaced from their positions by either the bumping process or position deletion.
4. All directly affected GDRNs were entitled to rights as outlined in the Study Hospital and Nurses' Union Bumping Protocol (1992). Positions obtained would either have been vacant positions or positions held by RNs with less accrued seniority hours.
5. Participants, indirectly affected by the bumping

process, were not displaced during the bumping process. They remained in either their permanent position or transferred voluntarily to another position.

6. All participants were GDRNs, classified under the Nurses' Collective Agreement as Nurse II.

Demographic Information

To further describe the study sample, demographic information about subjects is obtained (Pallikkathayil & Morgan, 1991). A demographic information form was developed by the investigator (Appendix B).

Questions Relating To The Bumping Process

Nurses, who had been directly affected by displacement, were asked questions regarding the bumping process (Appendix C). These questions related specifically to the displacement process including the exercising of seniority rights to maintain employment.

Study Setting

The study hospital is a 632 bed acute care, Catholic tertiary, university affiliated health care facility in Western Canada. A long tradition of providing humanistic and spiritual care had been established. "The hospital is committed to promoting a work environment of mutual respect, trust and

confidence among all members of the staff" as stated in the Study Hospital's Mission Statement (1994). The management philosophy reflected the belief that health care workers were partners in patient care. The concept of caring is integral to the hospital's mission and values.

The study hospital was mandated by the provincial government to reduce its budget with the assistance of an American consulting firm (Study Hospital Nurses' Union, 1993). Task force teams, comprised of employees from various hospital departments, were responsible for examining specific facets of the organization. Their focus was to make recommendations for reducing costs. This approach has been used in other hospital restructuring processes (Suderman & Dyck, 1994). The study hospital environment was already in a state of uncertainty when the contract between the government and the consulting firm was signed. The restructuring project soon became a "political football" (Litvack, 1994). Anger surfaced, and was associated with the use of an American consulting service (Study Hospital Nurses' Union, 1993). Prior to the implementation of the consultants work, 127 inpatient beds were closed at

the study hospital (Litvack, 1994). The hospital pediatric units were closed and, all inpatient pediatric services were centralized in another facility. Almost 50 percent of the health care workers laid off in the study province were employed at the study hospital (Study Province Nurses' Union, 1994).

Joint Hospital And Union Bumping Protocol

The nurses' union local and the study hospital managers developed a strategy for handling the reductions in work force (Appendix I). This process became known as the "Bumping Protocol" (Study Hospital & Nurses' Union, 1992). A nurse was not allowed to remain in her/his position if there was a nurse with more seniority who met the minimum qualifications for a position, who wanted to bump into it. Higher academic credentials and/or competency assessment were not considered. Nurses with greater seniority were assured a position, for the time being, within the study hospital.

In 1993, a total of 230 nursing positions were deleted at the study hospital. According to one of the Bumping Office representatives, approximately 500 RNs were affected by deletions and subsequent bumping.

When bumping to a particular unit was intense, the study hospital and union jointly closed bumping to that area due to issues of patient safety. Approximately 100 nurses did not exercise their bumping rights for reasons of an inability to go through the process, insufficient numbers of seniority hours to bump, or being in an LPN position. Role deletion for LPNs occurred. All LPNs were given the opportunity to return to school. As positions became vacant, RNs on layoff were recalled to positions based on their seniority and qualifications. All LPNs, who obtained their RN status, were placed on the layoff list. They regained their seniority hours after working one shift as an RN. As of October, 1995, approximately 40 nurses remained on the lay off list, according to the study hospital's staffing coordinator. When the study was conducted, additional bed closures were announced.

Data Collection

Sample Recruitment

Once ethical approval and hospital access were obtained, potential participants were recruited through an advertisement in the study hospital's newsletter (Appendix C). The author anticipated that a large

number of nurses would read the advertisement since copies of the newsletter were distributed to all nursing units. Within three weeks of the advertisement being published, eight potential participants had contacted the investigator to obtain additional study information. All but one potential participant met the inclusion criteria for the study. Prior to the commencement of the study, a procedure for recruiting additional potential participants, if needed, had been arranged with the study hospital. Since the number of potential participants was less than the previously anticipated number of 10, an information letter was distributed to all appropriate hospital units (Appendix F). The investigator requested head nurses to post the letter or place it in their communication book. Head nurses were not informed of staff's decisions to participate in this study or not. Participants' identities were not disclosed. The information letter was formatted to fit on one sheet of paper. The investigator's home telephone number was listed in the information letter should any potential participant elect to further pursue interest in the study. The letter included information about the investigator, the

study purpose, the requirements of the participant, anonymity of the participants, the interview process, and the voluntariness of participation. As well, potential participants were informed that the interview would be kept confidential and their names would not appear on any of the data. Data obtained from the interviews was scrutinized to assure anonymity of their participation, and the participants' identities were protected. It was stressed that participation was voluntary, and they could withdraw from the study at any time without any ramifications. Three additional potential participants were recruited via this method.

Interview

Data collection occurred in two phases: a pre-interview telephone call and an individual interview.

Pre-Interview Telephone Call

The advertisement attracting potential study recruits and the information letter listed the investigator's home telephone number. Potential study participants telephoned the investigator to obtain further information about the study. After potential participants were fully informed of the study and its requirements, the investigator determined their

eligibility for the study using a screening questionnaire (Appendix D). The questions on this form related to the inclusion criteria established for this study. Once it was determined that the potential participants met the study inclusion criteria, had no further questions, and gave verbal consent to participate in the study, a time and location was mutually agreed upon for the individual interview.

A total of 14 potential participants contacted the investigator. All but four of the potential participants met the inclusion criteria for the study. Four potential participants were excluded from participating because they were not employed in permanent GDRN positions. Arrangements were made with the potential participants to be interviewed in their homes at a time of their convenience. One participant requested to be interviewed in the investigator's home since it was more convenient for her.

Individual Interviews

Individual semi-structured interviews were conducted using an interview guide developed by the investigator (Appendix A). An interview that is not structured gives the researcher the opportunity to use

interpersonal skills to assist the subject with disclosing the lived experience (Pallikkathayil & Morgan, 1991). The semi-structured interviews were organized around areas of particular interest, yet still allowed flexibility in scope and depth of the interviews (Morse, 1989). Interview questions were kept broad and open-ended, and were designed in such a way as to avoid influencing the respondents' answers (Baker et al., 1992). Minimal prompts were used during the interviews. The interview approach was based on Benner's work (1985). This entailed having the participant describe the event, share as much information as possible, relate the importance of the event and include everything they wanted to say about the event.

It was anticipated that the 10 interviews would take approximately four months to complete. The study commenced in November, 1995 and the interviews were completed by the middle of February, 1996. The author anticipated that each interview would take approximately one to one and a half hours to complete. The interviews were audiotaped. The questionnaires relating to demographic information and the bumping

process were completed at the beginning of the interview after the participants asked any additional questions, the information letter had been reviewed, participants verbally agreed to participate, and the consent form had been signed (appendix H). A code number was assigned to each subject to maintain anonymity.

The interview guide was critically reviewed by one expert in hospital downsizing and nursing displacement, as well as the thesis committee. The interview guide was then pilot tested. Pretesting the questionnaire was done to ensure that the interview questions are suitable and relevant to the participants (Chinn, 1986).

Pilot Study of Interview Guide

A pilot study of the interview guide was completed in late October, 1995. Two RNs, one nurse who had experienced position displacement and one nurse not directly affected by position displacement, participated in the pilot. The nurses in the pilot study met the study's inclusion criteria. A sample of convenience was used. The nurses were known to the investigator. One participant, directly affected by

displacement, had five years of hospital seniority while the second participant, who had not experienced displacement, had 12 years seniority. The purpose of the pilot was explained to the participants. They signed a consent form prior to entry into the pilot study (Appendix G).

The interview guide was modified after the first interview. Modifications to the questions included refinement of terminology congruent with the participant's understanding. As well, one of the questions was reformulated into two distinct questions. As a result, one question was removed from the guide because of redundancy. The second participant found the questions to be appropriate to her experiences and made sense to her. Minimal prompting was required to elicit the requested information. The revised interview guide was found, by the investigator, to be relevant and suitable to both the participants and the study purpose.

Journal

Pallikkathayil and Morgan (1991) suggest the researcher should keep an ongoing record of the interviews, including thoughts, feelings and reactions.

The investigator, after each interview, kept a journal of her personal thoughts and feelings. It was completed after each interview. Information relating to the interview such as factors that may influence the data analysis were included in the journal entries.

Data Analysis

The purpose of analysis in interpretive research, according to Benner (1985), is to discover commonalities in meanings, situations, practices and bodily experiences. Interpretation of data with faithfulness is the goal of data analysis (Knaack, 1984). The process of data analysis required substantial time to develop coding decisions, to actually code the transcripts and to complete the analysis process (Pallikkathayil & Morgan, 1991).

Various approaches for analyzing qualitative research has been described (Jasper, 1994). However, the approach described by Colaizzi was utilized for this study (Colaizzi, 1978; Knaack, 1984). The steps were as follows:

1. The transcripts were read to obtain a sense of the whole.

2. Significant statements that pertained to the

phenomenon under investigation were extracted from all the transcripts.

3. Themes emerging from the data were identified. Contradictory themes were included in this component of the analysis.

4. The results were then integrated into an exhausted description of the phenomenon and statements were formulated to identify fundamental structure.

To further validate or clarify issues, the investigator returns to the participants to ascertain whether or not the analysis described their experiences (Colaizzi, 1978; Knaack, 1984). The investigator arranged to contact participants by telephone, at their home, if post-interview clarification of information was required. The investigator contacted one participant to clarify her thoughts related to comments about wanting to leave nursing.

After each interview, the audiotapes of each individual interview were transcribed verbatim onto a computer program. This was saved on a diskette and stored in a locked filing cabinet. A hard copy of each interview was printed. The investigator listened to the audiotape several times after each transcription to

ensure the interviews were transcribed exactly. This was followed by analysis of the text. Each line of the transcript was read and re-read. Thoughts and feelings of each participant were marked, using a highlighter pen, on the printed transcripts, and the investigator wrote comments in the margins. The investigator also used Benner's approach to analyzing text data. According to Benner (1985), the investigator "enters into a dialogue with the text" (p. 9). For example, all participants were angry initially over the restructuring plans. The author considered the question, "Why did the participants feel this way?". As the author questioned the data, the themes started to emerge. Each interview was analyzed prior to subsequent interviews. The themes which emerged from the analysis of text were found to be repetitive after the first five interviews. No additional themes were discovered in the last five interviews. However, the analysis of these interviews validated the themes previously identified by the investigator. The thesis chair, an expert in qualitative research, reviewed two transcripts.

Issues Related To Reliability and Validity

Strategies to control bias were integrated into the study (Benner, 1985). It has been recognized that researchers have a reactive effect on the subjects of a study (Drew, 1989; Paterson, 1994) and the interviewer is affected by the subjects (Drew, 1989; Paterson, 1994). One never approaches a situation without a pre-understanding (Chinn, 1986). Research is carried out because the phenomenon in question matters in some way to the researcher (Drew, 1989).

Reactivity is the response of the researcher and the subjects to each other during the research process (Paterson, 1994). Reactivity in qualitative research is not a limitation of the research process, but rather an inherent element of the research which must be recorded (Paterson, 1994). Bracketing is the activity of clarifying the investigator's assumptions and preunderstandings about the phenomenon (Munhall, 1994) It enhances the trustworthiness of the phenomenological method (Pallikkathayil & Morgan, 1991) bringing perspective into view (Oiler, 1982). The subject is approached and asked broad, open-ended questions in regards to the subject's experience (Pallikkathayil &

Morgan, 1991). This was done to prevent the investigator from influencing the participants' responses. The investigator is not free of bias. However, it is possible to control it (Oiler, 1982). The researcher keeps track of thoughts, feelings and reactions about the interviews by keeping an ongoing record (Pallikkathayil & Morgan, 1991). The investigator kept a journal after each individual interview.

Drew (1989) believes that the interviewer's own experience can be considered data and examined within the context of the study for the part it played in the study's results. "It is especially relevant and appropriate, however, for a phenomenological researcher to look at his or her own experience of a study, particularly the reasons for choosing the phenomenon, and the way he or she experiences the persons interviewed" (Drew, 1989, p. 431). The investigator for this study is a survivor of hospital restructuring and displacement, having experienced bumping, lay off, and subsequent recall. As such, the investigator experienced many of the challenges and disappointments that the subjects in this study have encountered. The

investigator kept a journal of her thoughts and feelings after each interview, especially how she felt about the interview and the participant's stories.

Ethical Considerations

An information letter was given to all subjects interested in participating in the study (Appendix F) as well as distributed to all appropriate nursing units. Potential participants were informed that the interview would be kept confidential and their names would not appear of any of the data. It was explained to participants that data obtained during the interviews would only be available to the investigator and the thesis committee. It was also explained that their names would not appear on any of the documentation. Participants and all information pertaining to participants would be assigned a code number. The code and matching name would be kept in a locked cabinet, of which access was restricted to the investigator. Data obtained from the interviews would be scrutinized to assure anonymity of their participation. Participants' identities would be protected at all times. All information that could identify participants were omitted from all reports.

Only aggregated participant data appeared in this report. Nurses signed a consent form to participate in the study (Appendix H). The voluntary nature of the study was explained. Participants were informed that they could withdraw from the study at any time without any ramifications to their employment.

Participants were informed that there would not be any monetary compensation for their participation. There did not appear to be any risk factors to the subjects in this study. However, participants were being asked to describe a time period in their lives that for some, were considered a crisis. As such, feelings and emotions could surface during the interviews that may cause some degree of discomfort or distress among the subjects. The investigator was sensitive to the issues and would terminate the interview when appropriate or ask the participants if they would like to terminate the interview. Counselling services such as the Study Hospital's Employee Assistance Program and outside agencies would be suggested by the investigator should the need arise.

Chapter Summary

An exploratory descriptive design was selected for

use in this study. An interview guide was developed by the investigator to examine the impacts of restructuring and displacement on GDRNs and how their worklife was affected. The guide was reviewed by an expert on nurses and downsizing and the thesis committee, and pilot tested. The procedures for data collection and analysis were explained in detail. Issues related to reliability and validity were described. This chapter concluded with a discussion of ethical considerations for this study.

CHAPTER 4: FINDINGS

In this chapter, a description of the sample and the findings of this study will be presented. Participants' demographic characteristics will be discussed, and their thoughts and feelings will be introduced via the themes that emerged from data analysis. Themes specific to the impact of restructuring and displacement on GDRNs and how their worklife was affected will be addressed separately.

Participants' Demographic Characteristics

All the participants in this study were women, seven of them were married. The ages ranged from 24 to 38 years, the mean was 30 years. Their years of experience at the study hospital (Table 1) and in nursing (Table 2) ranged from three to seventeen years with a mean of 7.5 and 8.7 years respectively. Seven participants had worked at the study hospital since their graduation from nursing, and three participants had worked previously in other facilities. Prior to restructuring, the majority of nurses worked part-time, while two participants worked full-time. Post-restructuring equivalent full-time (EFT) positions were comparable to their original EFTs (Table 3).

Table 1
Nurse Participants' Experience In Study Hospital

Years of Hospital Experience	Nurse Participants
<5	3
5.0 - 7.0	4
7.1 - 9.0	0
9.1 - 11.0	1
11.1 - 13.0	0
> 13.1	2

Table 2
Nurse Participants' Experience In Nursing

Years of Nursing Experience	Nurse Participants
<5.0	2
5.0 - 7.0	3
7.1 - 9.0	1
9.1 - 11.0	2
11.1 - 13.0	0
> 13.1	2

Table 3
EFT Pre-and Post-Restructuring

EFT	Nurse Participants (Pre-Restructuring)	Nurse Participants (Post-Restructuring)
< .5	2	2
.5 - .9	6	7
1.0	2	1

Eight of the participants had a diploma in Nursing and two participants had a degree in Nursing. Three participants had taken several university courses, and two were working toward their degrees. The majority of nurses worked in permanent positions within the Department of Critical Care (Table 4).

Table 4
Departments Employed

Nursing Department	Nurse Participants
Critical Care Nursing	4
Medical Nursing	3
Maternal Child Nursing	2
Geriatric Nursing	1

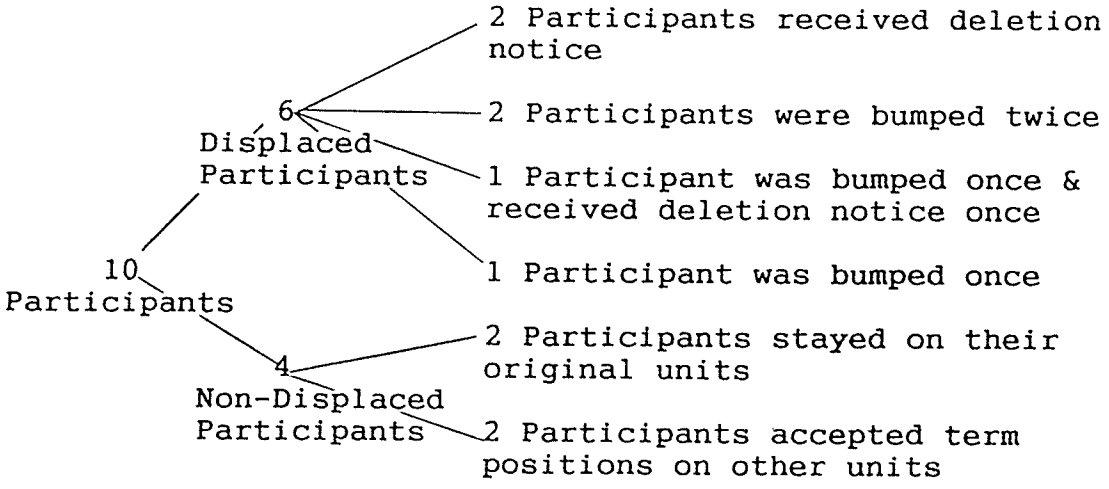
Six of the participants were directly affected by displacement, and four participants (Table 5) were not displaced from their positions (Figure 3). Nurses who were displaced either bumped into positions or were offered vacant codes within the system. Three subjects elected to bump to different areas of practice. For nurses directly affected by displacement the time between notification and the initial meeting with the bumping office ranged from two to 21 days, with a mean of nine days. The time between notification and the actual displacement ranged from three days to three

months, with a mean of 26 days. Nurses who initially received deletion, due to bed closures, were given three months notice which is included in the data.

Table 5
Number of Times Displaced

Nurse Participants	Number of Times Displaced
4	0
3	1
3	2

Figure 3:
Indirectly and Directly Affected Participants



Findings of the Study

The length of each interview ranged from 25 minutes to two hours, with a mean of 70 minutes.

Interviews with displaced participants were usually longer since they recounted their own displacement stories.

Restructuring was equated with displacement. All but one participant responded to the first question, "What are your thoughts and feelings about what it was like to live through hospital restructuring?" with displacement stories. They discussed either their seniority or staff displacements. Displacement was seen as an expected consequence of restructuring, and many themes were found to be interrelated to both processes. Thus, impacts of both restructuring and displacement will be discussed concurrently. However, separate displacement themes were extrapolated from the analysis of text, and will be discussed following the combined impacts of displacement and restructuring. Worklife effects will follow.

Restructuring and Displacement Impacts on GDRNs

All participants described the restructuring and displacement processes as stressful, and one of the most difficult experiences they had ever encountered. The impacts of restructuring and displacement on GDRNs were categorized under the following themes:

- the grieving process
- the meaning of their work
- worklife integral to personal life
- making sense of it all
- the change process

The Grieving Process

Grieving was noted in all of the interviews. Participants grieved the loss of jobs, the break-up of their working teams, the old way, and the loss of their nursing ideals. Displacements resulted from position deletions secondary to bed closures, and the bumping process which followed. Nurses grieved either the job loss itself or specific facets of the position that had changed secondary to restructuring. Many displaced participants described difficulty in leaving their departments and the people they worked with. One displaced participant described how difficult work was for her, post-restructuring:

> It's like I'm putting in time. It makes it tough to get up in the morning and want to go to work, whereas before, I looked forward to going to work.

Prior to restructuring, work afforded a sense of security in the planning of their lives. For many of the participants, living became for the day. They were unable to make plans due to the uncertainty associated

with restructuring and possible displacement.

All participants grieved the break-up of their teams. Almost all the nurses expressed sadness over the LPN deletions. One participant felt "a whole paper could be written on that [topic]". Many found it "appalling" that LPNs were replaced with nursing assistants, who do not earn much less money. The added union issues were found to further invalidate this decision. One participant believed that LPNs had "priced themselves out of a job".

Participants discussed how difficult it was to witness the break-up of their teams. One non-displaced nurse discussed how difficult it was for her to see a co-worker leave. She described a void in the department after she left, a void that had never been filled. Participants found the departure of staff to have an effect on the unit's morale. One nurse, who remained working on her original ward, described the unit as "gone" yet, physically, it still existed.

Many of the participants described their work as being intertwined with their co-workers. There was a "connected-ness" between them which enabled nurses to know when a co-worker needed help. They could depend

on their co-workers, "they were there for you". When the teams changed, this special relationship was lost. For many, this "connected-ness" was never re-established due to uncertainty and staff turnover.

Initially, many of the participants were saddened by restructuring. However, for most of the participants, their sadness turned to anger. Anger was directed at the "system", the hospital, their union, and their co-workers. However, no particular group was the focus of all their anger, although much anger was directed at "the system". Half of the participants were angry at their union. Several nurses described decreased feelings of generosity for their co-workers; they were looking after themselves.

Meaning of Their Work

Prior to restructuring, participants held the nursing profession in high regard. However, for the majority of participants, this changed. They were taught how to be a "good" nurse under one paradigm, and restructuring had introduced a change in their profession that they expressed difficulty in accepting as they no longer could enjoy their work.

After graduation, one participant found that she

had already morally abandoned her nursing ideals, and restructuring made her compromise care by taking even further short cuts. Another subject found "restructuring had forced nurses to get away from what nursing was all about". Two nurses wondered about what the impact on newly graduated nurses would be, when no jobs even for experienced ones were available.

Work allowed many of the participants to be a part of and committed to an organization. Being a nurse at the study hospital was seen as very important. This was exemplified by all the participants' expressions of profound loyalty to the hospital prior to restructuring and displacement. For almost all of the participants, this loyalty diminished. According to one participant:

> I've got my friends. I'm not here to make any more friends so therefore it became just going to work ... I don't feel very much loyalty to the facility that I work for. They employ me. They give me a pay cheque.

Many participants felt the facility and their union did not care about them so why should they care about those organizations. Many subjects took mental inventory of the things they had done for the facility such as coming to work early, missing breaks, not claiming for overtime, staying late, and performing at

more than 100 percent. In the final analysis, these sacrifices were perceived as not contributory to their status. Five of the participants expressed a re-prioritizing of their professional and work values. According to one participant:

> A few years back, I would have been more willing to put my family second. Never phoned in sick on a night shift. When it came down to my job and my devotion, it only became a seniority issue and not how well I did my work.

Many of the nurses believed their relationship with the hospital had changed. A "we-they" phenomenon emerged. The nurses felt they were on their own, and those at or in higher positions were not supporting them. It appeared to the author that this thinking became a survival mechanism in not getting their hopes up since it would prevent them from being hurt again when further deletions were made. One nurse stated:

> My feeling has always been if management respects me and look after my interests, I will produce for them ... That's how it used to be.

Most of the subjects discussed how their faith in the union and the organization had decreased, and many were less trustful of the "systems". According to one

participant:

> Should they have another bumping process in the hospital, I am not going to be as trustful of their system. I'm going to look out for my individual interests and not rely on either the union nor the management to look after them for me.

Worklife Integral to Personal Life

Work was seen as an enjoyment and a fulfilment in their lives prior to restructuring. Work was a part of who they were; of their identity. One displaced nurse discussed the emptiness she felt; she said she was "left with nothing". Another nurse described work as "my life and I just did it".

All participants described the impacts of restructuring and displacement as affecting their personal life. Worklife and personal life were found to be integral to each other. This was also reciprocal; stresses in their personal life impacted their worklife. The difference between the home life and worklife related to support. Families and friends were seen as a stability and support, whereas work was seen as unstable and lacking supports. Unit changes, displacement of staff, and loss of support systems were viewed as additional stressors during restructuring,

and these affected their personal lives. According to one participant:

> It not only affected my life. It affected my family's life. It affected my friends. It affected my co-workers. And I was a pretty unhappy person for quite a length of time.

Participants described numerous personal stresses that were occurring simultaneously to restructuring. Combined worklife and personal stresses were synergistic to each other. Two participants, in particular, had experienced profound personal stressors. For one participant, in particular, the home life stresses were getting unmanageable.

Many participants discussed personal impacts as a result of displacement. A job change impacted on baby sitting arrangements. This was found to be especially difficult for several participants since it all happened so fast. Several indirectly affected participants discussed this issue in relation to displaced co-workers.

One participant discussed the fact that for her displacement was a positive experience, because it was fitting with her personal life. It was an opportunity to change from a full-time to a part-time position.

Prior to restructuring, participants had flexibility, and they could change jobs to meet their families' needs . However, at the time of the study, there was limited movement within the system. According to one participant:

> We had a lot of freedom which was really good as far as family life ... Suddenly, I ran into a brick wall. It's been really frustrating because [I] had to take shifts that did not suit my family life.

Making Sense of It All

Participants attempted to make sense out of what had happened. All nurses defended the hospital's decision to restructure. One subject realized that the hospital was under financial constraints and had to do some restructuring. However, for many nurses there was a sense that the planners did not understand what was happening at the bedside. Several participants viewed themselves as "drowning", "treading water", or "hanging by a rope". One nurse wanted the planners to follow her around for a shift. She felt that the planners could not "understand it unless they do it, unless they live it".

Although nurses justified the hospital's decision to restructure, the approaches used were not defended.

The majority of participants spoke of nursing ideas that were not considered. One participant, discussed the fact that nurses' cost saving ideas "may not save millions of dollars, but neither did [the consultants]".

All the subjects felt that nursing division had been affected the most by restructuring and displacements. Nine nurses questioned the accountability of other disciplines in the restructuring process. According to one subject, "nurses seemed to take the brunt of cuts. Their ideas are not listened to and [another discipline] is wasting money right and left". All participants expressed their perception as having no control over the process and that their concerns were not being addressed. Nine respondents discussed the use of the Union's Heavy Workload forms. There was a strong sense that completing these forms would not change outcomes, but it was their way to document problems.

Participants viewed themselves as victims, needing to find out who was at fault. All respondents assigned blame for restructuring and forced job change, although the majority were ambivalent over who to blame.

According to one:

> Everybody is starting to blame one another and not look at who is really responsible. I'm angry at management, not management, the system. I don't know.

The Change Process

The change process was found to be very difficult for participants. They were between old and emerging paradigms of nursing, and many had experienced forced job change. All participants found the uncertainty difficult to deal with. Even nurses with greater than 10 years seniority were concerned about their employment future. Restructuring activities commenced three years prior to this study. However, cost-saving strategies were being administered throughout the time frame, and further restructuring had been announced.

Many of the participants felt communication between nurses and administration had been poor. One nurse was angry that the other hospital unions seemed to know more about what was happening than she did. Many subjects found the rumours difficult to handle. One participant had heard that half of the staff on her unit would be bumped. All participants enjoyed their work prior to restructuring and displacement. They did

not want to change.

Most participants described meeting the introduction of staff mix and accompanying role changes with ambivalence. Respondents with the least amount of seniority and nursing experience appeared to adjust more easily to the transition, although it was difficult for them too. This was summarized by one respondent:

> It's been really hard for nurses to let go ... prior to staff mix, [nurses] were washing their patients. They could assess them from head to toe ... Nurses are still having a hard time with their change in roles.

Specific Displacement Impacts on GDRNs

Most participants were able to graphically recall their experiences of living through the displacement process. Many of the themes identified related specifically to the bumping protocol. The impact of displacement on GDRNs were categorized under the following themes:

- personalization of the process
- unfairness
- the bumping process
- survivor-victim connection
- embracing the challenge

Personalization of The Process

Although it had been stressed that bumping was not

a personal issue, all participants personalized the process. One participant stated:

> A lot of people thought when you got bumped, it was a personal thing because this nurse bumped you. But there was nothing personal about it.

Another participant stated that "it is difficult not to personalize the process because nurses are people, not robots". None of the respondents discussed bumping in terms of their position but rather in terms of being directed at them personally or their co-workers. Most displaced nurses felt their contributions did not matter. One participant stated that, "it just mattered what date you entered the hospital". This feeling of not mattering was articulated by all but one of the displaced participants. One nurse was pleased with the outcome of her displacement, since she wanted to work part-time. However, the majority of displaced participants felt devalued and betrayed.

Unfairness:

All but one participant expressed unfairness over the bumping process. This unfairness was related to longevity versus competency, and the individual nurse

versus the membership at large.

Longevity versus Competency

The majority of participants described the people who had exercised their seniority rights to maintain employment in terms of their competency and ability to perform the work. Matching seniority with competency was seen as paramount, although two participants felt nurses could be trained to do the work since new graduates had previously been hired into the positions.

Displaced participants stressed the importance of being bumped by a nurse who fit with their ideals of what kind of nurse should be in their job. This finding was also articulated by many non-displaced participants. One participant sympathized with the receiving units who had to take a nurse with few if any desirable attributes. Most participants believed that being bumped by a nurse with more seniority and expertise in the area was fair since they would have been given the job, if they had applied for it originally. This thinking became less distinct when the person bumping had no experience in the area. This was not perceived as fair. Although three nurses bumped to areas outside of their specialty, they had

past or related experience, thus the bump was justified. For many, merit was as important as seniority. This was summarized by one respondent:

> If someone has been working in the hospital and they have the seniority; they put in 100 percent or more ...; they meet the [job] qualifications; and are competent; then I don't think I would feel so bad.

Some participants felt resentment over the fact that they were being displaced when there were some nurses working who were not qualified for the positions they were working in. One participant found "bumping forces people to have to accept this person and have to work with them". Seven participants commented on the fact that LPNs, who returned to school, regained all their seniority hours once they worked as an RN, yet they had no RN experience. One participant was extremely upset about this since she felt "in the next go around, [she] will be out the door and an RN with less experience than [her] will be still around". Two displaced nurses described LPNs who obtained their RN diplomas as being in a transitional period, adjusting to the new role, and they did not feel they were functioning at an RN level. Although most of the interviewed nurses identified bumping as unfair, no one

provided an alternative solution.

The Individual Nurse Versus The Membership At Large

Much concern and anger was expressed by the participants that this was an unfair process for the individual nurse because of the collective approach to reductions in workforce and bumping. According to her:

> It was a collective agreement. But when it is happening to you, it's happening to you. It may be happening to 50 other people in the room but it was affecting my life.

One participant, after demonstrating how she met the qualifications for a particular position, was bumped several months later by someone with no experience in the area at all. She found this especially unfair because not all nurses were treated equally. Another participant found that management had no control over bumping. They "couldn't deal with the individual" because "it was a collective agreement".

The Displacement Process

The displacement process was perceived as stressful. Four phases of the process emerged: displacement notification, time between notification and discussion of options, meeting with bumping office representatives, and the actual displacement.

Displacement Notification

All but one of the displaced nurses expressed shock when they were notified of their displacement, although many had been anticipating the event. Reactions varied from initial disbelief to anger to sadness. One participant received her displacement notice later than she felt she should have; she felt cheated out of time. Another nurse who received deletion notice, found the three months notice gave her time to think about where she wanted to work. The majority of participants who were bumped did not have the time to prepare for the job change. Most participants had less than three weeks between their notification and the actual bump. This was found to be stressful. Three participants discussed the fact that not hearing anything was a signal that they had been spared from bumping, and then they were "hit". Two participants discussed psychologically separating from the unit after receiving notification.

All displaced participants felt that their immediate supervisor should be the person to notify them of their displacements. In actuality, only one nurse was not notified of being bumped by her head

nurse. This nurse was particularly angry over her notification, and described it as "unprofessional". Most nurses felt their head nurses supported them, and were sensitive to the information they were relaying. Several participants received their notifications while they were at work. This was difficult because they still had to complete their shifts, although one nurse had been anticipating the event, so it was "not that big a deal". All the other nurses, who were bumped, received a phone call from their head nurses. They believed this was a "better" method of notification. Receiving the news of the displacement as soon as possible was also deemed important because of the rumours. One participant questioned how people knew about her bump, and was distressed about the lack of confidentiality.

Time Between Notification and Option Selection

Participants described the time frame between their notification and the meeting with the bumping office to be an extremely difficult wait because even a few days was felt as too long. Participants expressed the feeling that their lives were on hold, and participants with the least amount of seniority usually

waited longer since interviews were being arranged on a seniority basis. Many nurses felt apprehensive once the meeting was set, and many did not know what to expect. They had heard rumours about what took place in the bumping office.

Meeting With the Bumping Office Representatives

Many of the participants did not know what to expect when they entered the bumping office. One participant was shocked to find a union representative at the meeting; she felt ill-prepared for the meeting. Another participant likened the walk down the hallway to the bumping office as going to the "gallows to be hung". She felt isolated and not supported, although she felt more support by management. The representative for the hospital was a nursing supervisor, who knew many of the participants because of her role within the facility. One participant had hoped for closure when the meeting was over. She was angry that, after this meeting, she still did not know what she would be doing.

Several participants described "keeping it clean" when they were in the bumping office, and not wanting to burn their bridges. Many displaced nurses described

the bumping office in negative terms. Much of their anger was associated with the concurrent interviews that were occurring. Individual nurses were being interviewed in order of seniority, and prior to a nurse making a decision regarding her future employment, the next nurse in succession was being met with. This caused, at times, a delay in verification of position acceptance since they were waiting for other nurses to decide ahead of them.

Two participants described positive experiences when meeting in the bumping office. Factors found to be essential to their positive reactions were time related considerations and the options available. One nurse discussed being given more time than she actually needed to make her decision. Having time to make a well thought-out decision about where to bump was found to be important. Initially when the bumping commenced, displaced nurses were being given up to two weeks to make their decision. However, as the displacement deadline was being neared, nurses were accorded less time. One participant was angry over being pressured to make a decision too fast, and not being given "two weeks like other people". Another participant found

that she made her decision "out of anger" since she was upset about being bumped a second time. Options in areas of interest for participants were viewed positively. Nurses with the least seniority had limited selections to choose from, and many were dissatisfied with their choices. One respondent found bumping "forces people to take jobs they didn't want". Several participants discussed how some nurses thinking about bumping to a particular unit were reviewing rotations on the units prior to making their decision. Many of the participants found this stressful, and questioned why the bumping office did not have this information.

Actual Displacement

Anticipation of starting work in the new position was an added stressor. The majority of directly affected participants described a feeling of apprehension about the unit they were moving to, although two were less distressed since they were going to work in previously employed areas. The rest of the displaced participants described themselves as being "petrified" or "scared".

Some nurses felt uncomfortable about starting to

work on a unit where they had displaced someone else. Many were concerned about how they would be perceived by the receiving unit staff. Nurses were somewhat less stressed when they were able to accept a vacant position rather than exercise their bumping rights. Although they had not personally displaced a peer, a nurse had been employed in the position prior to deletions. Almost all displaced participants expressed guilt, whether they bumped a filled position or were offered a vacant position. According to one participant:

> I knew the person. And that was her job ... I felt bad because even though it was a [vacant] code, it was a good friend who had been laid off ... And I landed in her job. Being a friend, you feel they're out the door and you're in their position. You feel guilty.

Participants who bumped to new areas found it extremely difficult. They had been experts in their previous position, and now they were novices. One nurse described herself as being a "new grad" despite her 11 years of nursing experience. Having acquaintances or prior co-workers working on the receiving units were found to decrease their anxiety. One respondent felt that she "would probably feel more

apprehensive if [she] didn't know anyone". One nurse was ambivalent about bumping back into the unit from which she had been bumped. She initially described the bump to her old unit as "not as bad because [she] stayed on the same unit so [she] knew everybody". However, she later acknowledged, "it would have been easier to have bumped somewhere else because it was awkward" working with the nurse who had bumped her.

One indirectly affected participant discussed what it was like being a receiving unit nurse. She found that some nurses were "reluctant" to help the new nurses out. This particular nurse wanted to give them a chance. However, she found that she had to "consciously remind [herself] that it was not their fault". "Bumper-blaming" was articulated by all non-displaced participants. "Bumpers" were perceived as less expert, thus more work was placed on the senior staff, initially. Not all receiving unit nurses were negative toward the bumpers. Many of the non-displaced nurses embraced the new staff, and they believed that the new nurses had a lot to offer the unit. Although they were not experts in the new area, they were invaluable in other ways to the new environment.

Several indirectly affected participants discussed trying to help the new people out but it was difficult since there were two or three new staff per shift on some units. When bumping to a certain unit was intense, the hospital and union collectively closed bumping to a particular unit due to patient safety considerations.

Some nurses later left the ward onto which they had bumped. This caused additional stress for the receiving unit nurses since they had to start all over again orienting new nurses. Half of the participants discussed the financial implications of bumping. Unit orientations and their replacements while they were being orientated were seen as being in direct opposition to the hospital's cost saving plans.

Survivor-Victim Connection

All participants who were bumped described a connection with the person bumping them. Initially, all displaced participants expressed anger at the person, but for the majority of respondents this feeling changed, especially if they worked with the person or got to know them personally. One nurse described the person who bumped her as a wonderful

person, although she acknowledged that initially she thought this person was the "fungus that was going to kill [her]". One subject bracketed her feelings and thoughts about the bumper so she could work with her. However, she found it awkward, but she "would never show her that [she] felt that way". Nurses who elected to bump acknowledged that this must have been reciprocal for the people they displaced.

The majority of participants viewed themselves as victims of the "system", but they had lived through it. They were disillusioned, angry, and less trustful of their employer and their union. Bumping was perceived as a painful experience for those bumping in, those observing the displacements, and those being displaced. Although there was initial anger at the bumper, this was eventually replaced by a sense of being a reciprocal victim.

Embracing The Challenge

Participants who were displaced found new opportunities for themselves in areas they could feel excited about. One participant thought the changes might help to diversify her career. Participants, although apprehensive about the move, embraced the new

challenges. Another nurse welcomed it as a learning experience to gain more knowledge. Two respondents discussed being optimistic about the future. However, one participant felt less motivated when she was bumped a second time.

HOW WORKLIFE WAS AFFECTED

All participants acknowledged that restructuring and displacement had affected their worklife. Nurses were most affected by displacement in the first year, whereas restructuring effects were perceived as more impactive throughout the time frame. All participants recognized that displacement would affect their worklife again when future deletions occurred. Thus, worklife effects will be discussed together. The effects of restructuring and displacement on nurses' worklife were categorized under the following themes:

- worklife effects related to staff mix
- concern over quality patient care
- decreased team work
- a need for ongoing education
- decreased mobility
- decreased job satisfaction

Worklife Effects Related to Staff Mix

All participants felt that their nursing care had been affected because of staff mix. They described their care as being very "basic", "bare bones", "task

focused", or "just something to get you by for the shift". All nurses described nursing as having changed significantly, and many viewed staff mix as stressful. They found that their day was dependent on their assigned orderly. If their buddy orderlies were able to work with minimal direction, nurses found that they would have a "good day". Many nursing assistants failed to meet with the nurses' standards and were ill-prepared for the work. Nurses' workload was found to further increase because nurses were "chasing" some orderlies to ensure the work was done. Two participants vocalized that orderlies had difficulty accepting delegation from women.

Staff mix was seen as perpetuating the task focused approach to care. In theory, staff mix would allow nurses to spend more time with their patients. However, in practice, participants' workloads increased, and they were spending less time with patients. Throughout the interviews, there was a strong appreciation for nurses performing nurses' work. Several respondents described confusion around or concerning what the orderly should be doing and what the nurse should be doing. As a result, there was

negativism associated with the staff mix relationship. One nurse found that some orderlies expected her to take on 50% of their workload, and she was angry since an orderly cannot do 50% of her work. She felt orderlies did not understand what nurses do. Issues related to incommensurability between nurses and orderlies were noted in almost all the interviews.

Concern Over Quality Patient Care

All participants expressed concern over a decrease in the quality of patient care, especially since important aspects of care were being left out because of time constraints and the need to attend to urgent tasks. Three nurses described patient care situations that had potential implications for patient safety. These situations were blamed on staff mix, and a lack of adequate time to do proper assessments. Several nurses perceived patients were being discharged sooner, without adequate planning. Psychological care was being omitted, for the most part, from care because of time constraints. Physical needs were being met since they were deemed a "must" in patient care. They felt they did not have the time to give the total care they regarded as necessary. One participant summarized her

thoughts:

> I'm giving the basics ... You are just running in and doing what's priority and leave what could be, unfortunately, left to the next shift.

Many participants discussed how nursing had changed from a patient-focused to a task-focused approach to patient care. According to one nurse:

> It's sad but you can't help being task focused. [You] focus on the tasks because these things have to be done ... And the caring side, came along with it as you did these tasks. Now you are limited on that amount of time and you can't give as much.

According to another participant:

> There isn't the time anymore. You run in, you change the dressing. We are all trying to provide that extra Florence Nightingale touch, but there isn't time.

Decreased Team Work

The nurses felt the team approach to patient care had decreased, and the team had been negatively affected by displacement, restructuring and the introduction of staff mix. The majority of participants felt that although they worked well with the new staff, they had never re-established the same relationships. As well, half of the nurses described a loss of autonomy in their worklife which impacted the

team. According to one respondent:

> I find it really hard now. I'm on a unit where the head nurse deals with the doctor ... And if the doctor is questioning us, we have to direct them to the Head Nurse. I feel inadequate and not part of a team.

Many of the respondents commented on the fact that the staff was constantly changing since many nurses were taking term positions. According to one participant, "there is such a big turnover [of staff], you don't get to know people as well as you did".

Need for Ongoing Education

All nurses felt they had a lot to learn in their worklife, especially if they moved departments or unit function had changed due to restructuring. Learning related to the new environment they were working in, the new patient populations they were caring for, and the specific aspects of their job that had changed.

Many believed their ongoing educational needs were not being met. Several were dissatisfied with their unit orientations when they began to work in the new area. Six participants expressed the need for further education.

Decreased Mobility

All respondents discussed the lack of movement

within the hospital system due to the bumping protocol. Laid off nurses were being recalled to positions. As a result, there were fewer opportunities available for them. Many nurses expressed anger since nurses with greater seniority were not having the option of applying for these positions. Many participants discussed being "stuck" in their jobs. Four nurses discussed wanting to be bumped. It appeared that some nurses were envious of displaced nurses since they had the option of changing positions.

Decreased Job Satisfaction

The majority of nurses described negativism associated with the restructured working environment. Almost all of the participants found their co-workers to be bitter and resentful over what had happened. Half of the participants discussed an increased utilization of sick time by staff, which could relate to chronic stress or decreased job satisfaction. Almost all of the nurses discussed how their satisfaction with nursing as a career had diminished. Several nurses wished they had selected a different career path. One participant who remained working on her original unit discussed her dissatisfaction with

nursing:

> I don't enjoy my work any more. I used to. I come home crying. I could not give adequate care ... And I've never come home so many times saying I don't know if I can survive, if I can handle staying there. I come home and I don't want to go back the next day because I know what I have to look forward to.

Another nurse stated:

> It's become a job more than a career. I go there. I work my shift. I do my job. When I lose the ability to give patient care in a conscientious manner, I hope that I would quit.

None of the participants discussed recovery or healing at the unit level although the beginning of healing was noted in one interview. One nurse recounted an incident that happened recently:

> We were sitting around, charting and laughing. It occurred to me that [this] was the first time in months that we had actually joked like we did in the old days. It was such a foreign sound.

Despite the majority of nurses having expressed decreased job satisfaction, only two of the participants discussed leaving nursing, and one participant discussed a detailed plan.

Chapter Summary

The thoughts and feelings of the nurses living through the restructuring and displacement processes were at times similar, yet distinct at other times. Restructuring and displacement were found to be very difficult events. Impacts specific to restructuring and displacement were categorized under the following themes: the grieving process, meaning of their work, worklife integral to personal life, making sense of it all, and the change process. Displacement specific themes were identified as personalization of the process, unfairness, the displacement process, survivor-victim connection, and embracing the challenge. Throughout the interviews, it was quite evident to the author that working at the study hospital had been very important to the participants prior to restructuring. However, the majority of participants were disillusioned with their jobs and nursing, although all were still highly committed to patient care. Restructuring and displacement had affected their worklife. Nurses noted that the first year after bumping provided more effects on their worklife. By the second year, this was less of a

concern. Now their attention focussed on the personal and professional opportunities available for them. There were profound effects on their sense of loyalty and trust in the workplace. Worklife effects were categorized under the following themes: worklife effects related to staff mix, concern over quality patient care, decreased team work, need for ongoing education, decreased mobility, and decreased job satisfaction.

CHAPTER 5: DISCUSSION, RECOMMENDATIONS AND CONCLUSIONS

In this chapter, the findings of the study will be presented in relation to the conceptual frameworks utilized and the literature reviewed. Limitations to the study will be examined and the conclusions of this study will be presented. Recommendations for nursing practice, education, administration and research will be offered.

The qualitative nature of this study enabled nurses to recapitulate their thoughts and feelings regarding the impacts of restructuring and displacement on themselves and their worklife. Although nursing literature was found regarding restructuring and displacement, none of the previous research examined these processes within the context of the nurse and her/his worklife.

Restructuring and Displacement Impacts on GDRNs

Restructuring and displacement have been described as stressful and emotional experiences (Brockner, 1992; Brockner et al., 1986; Brockner et al., 1987; Hequet, 1994; Lynch, 1993; Noer, 1993a; Rozak, 1994; Rozboril, 1987; Sears, 1992; Triolo et al., 1995) which certainly was evident in this study. Restructuring and the

displacement process were found to be extremely difficult for participants, whether they were displaced or not. Nurses equated restructuring with nurses' job loss. Although minimal research was found specific to this finding, Miller (1980) asked the question, "Is staffing realignment just another word for layoffs?" (p. 113).

The majority of nurses were sad, disillusioned, and angry at the "system". They felt the organization did not care about them, and this was particularly difficult since participants had been highly committed and loyal to the hospital prior to restructuring. Utilizing Noer's model of layoff survivors (1993a), the majority of participants in this study were at high risk to develop or had already developed layoff survivor sickness. There was a strong sense of personal violation and decreased trust. Noer (1993a) contends that the feelings of those who remain in the organization and those who leave are mirror images of each other. All participants in this study had work since they were entitled to union rights. Although six of the nurses were displaced, they never left the facility. Noer did not discuss displacement in

relation to a bumping process, where those affected stayed within the organization. However, the thoughts and feelings of the displaced and non-displaced nurses in this study were similar to Noer's findings, although their stories differed.

Noer (1993a) found layoff survivors exhibited certain symptoms, and many of the thoughts and feelings of the participants in this study were congruent with his findings, although some differences emerged. Nurses exhibited many of the following survivor symptoms: depression, stress, and fatigue; job insecurity; distrust and betrayal; decreased risk taking and motivation; wanting it to be over; anger over the layoff process; dissatisfaction with planning and communication; lack of strategic direction; short-term profit orientation; and a sense of permanent change. Survivors were also found to demonstrate continued optimism and commitment, lack of reciprocal commitment, and lack of management credibility. These findings were not completely congruent for the survivors in this study. Only two participants expressed optimism for the future, and many described the future as bleak. All displaced participants

embraced the challenges of their new jobs, although one nurse was less motivated when she was bumped a second time. Only two participants expressed ongoing commitment to the organization, and many were less committed to the organization. The majority of nurses perceived the organization did not care about them. In Noer's study (1993a), managers expressed ongoing commitment to the organization whereas managers were not included in this study.

Respondents blamed others, which is consistent with Noer's (1993a) model. No one group was the focus of that anger, although the "system" and the union were the primary targets. None discussed a lack of management credibility although many questioned decisions that had been made. It was interesting to find that there were few expressions of survivor guilt as found in Noer's study. He suggested that guilt is a difficult human emotion to express, especially in a group setting. In contrast to his study, the majority of participants discussed feelings of guilt in the privacy of the individual interview where anonymity had been assured. It appeared that the majority of nurses in this study were exhibiting symptoms of a syndrome

Noer (1993a) has identified as layoff survivor sickness.

The majority of research on hospital restructuring examined specific aspects of a nurse's worklife that may have been affected by the process such as quality of patient care and job satisfaction (Lewis et al., 1986; Tumulty et al., 1994). The participants' lived experiences will be explored, with reference to the literature on this topic.

The Grieving Process

Prior studies have found nurses are quite stressed by restructuring and subsequent job loss (Lynch, 1993; Olson, 1995; Rozak, 1994; Sears, 1992; Triolo et al., 1995), and several have discussed grieving as being significant for nurses (Rozak, 1994; Triolo et al., 1995). All participants experienced grieving in relation to numerous losses they had experienced as a result of restructuring. Consistent with Greenhalgh and Rosenblatt (1984), what an individual perceives as potential loss of continuity in a job situation can range from permanent job loss to loss of some subjectively important feature of the job. Nurses responded intensely to the process since they had been

particularly committed to their work, the organization, and working with people. Participants grieved the loss of their nursing ideals, and the perception of many losses concomitant with the loss of jobs enhanced its significance. This study supported Olson (1995) who found nurses to be less committed to their profession after downsizing.

All participants grieved the break-up of their working teams. This finding was consistent with previous studies regarding the disruption of working teams (Bonner, 1992; Dencker, 1989; Tumulty et al., 1994). No literature was found regarding the break-up of working teams in the context of a bumping process, although Lynch (1993) found that loss of contact with colleagues was a stressor for nurses after bumping. Bumping created a fear of loss of cohesiveness since people had worked closely together. All respondents felt badly for their co-workers who were deleted or bumped. This was consistent with prior studies which have found survivors mourn laid off co-workers, and can suffer from survivor guilt (Brockner, 1992; Brockner et al., 1986; Brockner et al., 1987; Marks & Mirvis, 1992; Noer, 1993).

Meaning of Their Work

Rozak (1995) found nurses identified intensely with job loss since being a nurse was a strong part of their identity which was visible in this study. Nursing was found to be extremely important to all the participants, as it was so much a part of their identity. Amundsen and Borgen (1992) and Rozak (1994) suggest work is a basic human need. It affords a sense of structure, purpose, and meaning to one's life. Prior to restructuring, nurses felt they were a part of a team. However, they now felt that their sense of belonging and community had diminished. The meaning of work decreased for eight respondents which is consistent with previous research on job loss and change (Amundsen, 1993; Amundsen, Westwood, Borgen, & Pollard, 1989; Rozak, 1994; Watson et al., 1991).

The majority of nurses expressed a sense of decreased commitment to the hospital, their union, and/or their profession. No research was found on commitment to unions post-bumping and further study is indicated. This study supported work done by Davy et al. (1991), Noer (1993a), and Olson (1995) who found many employees to have lower commitment to the

organization post-downsizing. Consistent with Noer (1993a), loyalty to the organization was replaced with loyalty to one's work, and nurses remained highly committed to patient care. Davy et al. (1991) and Olson (1995) found organizational commitment to be correlated with job satisfaction. Olson (1995) further found none of the nurses were highly committed. Although participants in Noer's study (1993a) had continued commitment to the organization, very few employees held optimistic future organizational views.

The majority of participants were also found to be less committed to the nursing profession which is consistent with Olson (1995). She suggested that this finding, coupled with a decline in popularity of nursing, may indicate a trend for a severe nursing shortage in the future. This study also supported Sear's (1992) findings that downsizing and displacement are added stressors for nurses who already work in stressful jobs. Dealing with the crises of changing values and relationships were found to be additional stressors for participants.

Personal Life Integral To Worklife

All participants described the restructuring

process as affecting them personally. Their personal life and worklife were found to be intertwined, with an impact on one affecting the other. Although no literature was found regarding restructuring and displacement and this particular theme, Borg and Jensen (1985) identified programs designed specifically for displaced nurses and their spouses were beneficial for all involved.

Hamilton et al. (1990) found women showed greater distress than men, but married subjects showed less stress when they experienced actual or anticipated job loss. It could not be ascertained if the nurses' stress levels in this study were greater than male nurses since all participants were women. Both married and single nurses showed stress in relation to actual or anticipatory job change. However, many participants who were married discussed numerous stressors in their personal lives which further impacted their work related stress. This study confirmed Lynch's finding (1993) that married nurses experienced more stress at times. She attributed this to nurses' partners who had lost their jobs.

The quality of experience in work and parental

roles has been identified as predictors of role overload in women (Barnett & Baruch, 1985). All participants in this study expressed having stress in their personal lives since they had multiple roles. Work related stresses were found to increase their personal stress levels which was congruent with Sear's (1992). Nurses re-evaluated both their personal and professional values after restructuring which has been identified in prior work (Lynch, 1993).

Making Sense of It All

Minimal literature was found regarding this theme. This could be attributed to the fact that most studies have utilized survey designs which do not address this specific issue. Although one qualitative study was found regarding the effects of downsizing and bumping on nurses (Lynch, 1993), making sense of the situation was not identified as a theme. Nurses attempted to find blame for their situation, although participants were confused over who was at fault. A generic "system" and the union were the focus for much of the blame, whereas in Noer's study (1993a) a generic "management" or the next level up in the hierarchy were the focus of blame. Survivor blaming has been

minimally discussed in the literature. Noer (1993) found that all groups blamed others. He saw layoff-survivor blaming to be possibly a form of projection so that the individual can avoid confronting individual survivor guilt. In this study, blaming was a way for nurses to try to make sense out of what had happened by placing it within the context.

Many nurses in this study demanded accountability of the other departments in regards to cost-saving strategies. Noer (1993) found normal layoff survivor symptoms intensified when layoffs were disproportionate between managers and workers. Brockner (1992) identified survivors' fairness judgments depended upon the higher levels of management being cost-conscious which was evident in this study. All participants found that the Nursing Division had been affected the most by the restructuring process. Olson (1995), Rozak (1995), and Wilson (1995) suggest nurses are more likely to be affected by restructuring since nurses comprise the largest classification of direct care-givers in hospitals.

Davy et al., (1991) identified global process control (GPC), or the degree to which staff can express

their views or have a voice in decision-making, as a predictor in perceived fairness of layoffs. Participants in this study perceived nursing ideas were not listened to which is consistent with Olson (1995) who found most nurses had low GPC and decreased organizational commitment.

Bridges (1980) contends that when people are in between the old and new realities of change, it is important not to lose ways of making sense out of the "lostness" and the confusion. He asserts that if we do, we are like "Alice at the bottom of the rabbit hole" (p. 130). All participants attempted to make sense out of what had happened, and many participants were left with unanswered questions. Hirschhorn (1983) ascertained many staff attempt to make sense of their situation relative to the rumours by filling in their gaps of knowledge.

The Change Process

Nurses recognised the change process was very stressful for themselves and their co-workers. All participants experienced varied levels of stress which is consistent with Olson's findings (1995). However, Meehan and Price (1988) found that displaced nurses

experienced higher levels of stress which was not found in this study. In contrast, all participants in this study who were either displaced and not displaced expressed insecurity, stress and uncertainty about the future due to continual change. Despite a unionized system where seniority is one of the most important factors in job retention, nurses with greater seniority did not feel more secure in their jobs. Since bed closures were followed by deletion notices, nurses with long term seniority had been displaced. This finding is similar to Olson (1995) who found that despite the back-up of a union contract and high seniority, many nurses felt job insecurity. Participants experienced anxiety related to job insecurity which is consistent with studies done by Alevas and Frigeri (1987), Noer (1993) and Sears (1992). In contrast, Sears (1992) found nurses who had job security but no choice as to where they would work were more stressed than nurses who received deletion notice. She identified lack of choice to be a perceived loss of control over their destinies. The majority of participants in this study expressed no control over the process, and Mara (1993) contends powerlessness is inherent to job insecurity

because it exacerbates the threat.

The uncertainty related to anticipatory job loss was as stressful as the event itself for many displaced participants which is similar to other studies done by Kasl et al. (1975), Hagen (1983), and Hamilton et al. (1990). Having subsequent employment, either through bumping or accepting vacant positions, did not make the process any less difficult. In fact, for some nurses, the process of bumping was as difficult, if not more so. This finding is supported by Kasl et al. (1975) who found individuals who returned to work after job loss had poorer mental health than those continually employed. Although layoffs and bumping differ, a parallel could be drawn between the two. Although Lynch (1993) identified many stressors affected nurses during downsizing and bumping, minimal research has been done on forced job change as a result of a bumping process.

Additional factors such as rumours and lack of information augmented nurses' uncertainty regarding change. Dealing with rumours has been identified as critical since they exacerbate anxiety, anger, and confusion which is consistent with previous work done

by Hirschhorn (1983), Roberts (1989), and Mara (1993). Despite the fact that subjects found rumours unsettling, they were a source of information which was found to be congruent with prior research done by Dencker (1989), Farley (1991), and Lynch (1993). Dencker (1989), Farley (1991), Noer (1993a), Triolo et al. (1995), and Veninga (1987) recognized insecurity increases the need for information. All participants felt they were not current with the restructuring plans which was similar to Lynch (1993) and Olson (1995). Communication has been well documented as a necessity during restructuring (Lynch, 1993; McGill & Kelly, 1983; Noer, 1993a; Sears, 1992; Triolo et al., 1995; Veninga, 1987).

Participants in this study expressed difficulty with the change process. They did not want to change although one nurse expressed an appreciation for change. They liked what they had been doing, and did not see the need for certain changes being implemented. The introduction of staff mix and the increased nurse-patient ratios, in conjunction with increased unit acuity levels, were met with much ambivalence. Nurses were expressing difficulty "letting go" of the old

ways. Bridges (1980) would describe the participants as being in the neutral zone of the transition process, between the old and the new realities. Since the hospital had not achieved stability and more changes are anticipated, it was difficult for participants to accept the new reality because they did not know what the new reality would be. Although two appeared to be reaching the acceptance stage of change, they vacillated between an excitement and an apprehension for the future. Letting go of the old and launching forth in a new situation is a difficult because the "in-betweenness" is so confusing (Bridges, 1980). Many participants described themselves as "treading water", "hanging on a rope", and "drowning". These descriptions would certainly fit with Bridge's (1980) definition of being in transition.

Specific Displacement Impacts on GDRNs

The loss of one's job is a major stressful life event in an adult's life (Bridges, 1980; Ensminger & Celentano, 1988; Hamilton et al., 1990; Lee, 1992). However, there is a paucity of research on forced job change secondary to a bumping process. Although prior studies were found on bumping (Lynch, 1993; Meehan &

Price, 1988; Olson, 1995; Sear, 1992), none of the research identified the "non-mattering", guilt, and disillusionment that nurses continue to feel long after the bumping was finished.

Personalization of The Process

Minimal literature was found regarding this particular theme. Participants personalized the bumping process. They felt their contributions did not matter to the hospital and their union. They felt de-valued and betrayed. Although no literature could be found specific to mattering within the context of a bumping process, the importance of mattering has been documented in the employment counselling literature (Amundsen, 1993; Schlossberg, Lynch, & Chickering, 1989). According to Amundsen (1993), mattering is paramount during times of rapid change and economic dislocation. He describes job loss as a truly "non-mattering" experience accentuated by feelings of despair, disillusionment, and anger which were articulated by the majority of nurses in this study.

Unfairness

Davy et al. (1991), Brockner et al. (1987), Brockner (1992), and Olson (1995) found various factors

affect employees' perceptions of layoff fairness. The majority of participants in this study articulated unfairness related to the displacement process.

Longevity versus Competency

Although the majority of participants in the study believed seniority was an important factor in job retention, competency and ability were also deemed significant. Most respondents had less than seven years hospital seniority which may have impacted this finding, although two with more than 15 years seniority felt seniority and competency were both critical especially for patient safety considerations. In contrast, other studies have found seniority-based layoffs to be more likely viewed as fair (Brockner, 1992; Brockner et al., 1987; Lucas, 1994; Roberts, 1989; Tuttle, 1992).

The bumping protocol stipulated that a nurse with greater seniority who met the minimum qualifications for a position could bump into that particular position if it was held by a nurse with less seniority. However, unlike Olson's study (1995), some restrictions were placed on the process. For example, when bumping to a particular unit was intense, limits to the numbers

of nurses bumping to that area were initiated by both union and management representatives. Moreover, nurses could only bump into a specific code held by the least senior nurse on that ward. Criteria for bumping excluded factors such as seeking better rotations, whereas in Olson's study, few restrictions were placed on bumping, and decisions for bumping could be based on factors such as desirable shift schedules. In both of these studies, nurses with varying amounts of accrued seniority were displaced.

Respondents believed that a nurse with more seniority who had the qualifications for a position should have the job over someone with less seniority. This finding is consistent with previous studies done on layoffs, where the least senior staff are released from their jobs (Brockner, 1992; Brockner et al., 1987). However, many of the participants' thinking became less clear when the person bumping into a position had no particular experience in the area, yet they had greater seniority. The majority of them did not find this aspect of the protocol fair. Merit has been identified as a legitimate consideration when layoffs are necessary (Darling & Luciano, 1985; Meehan

& Price, 1988). Meehan and Price (1988) found that during a bumping process, there was a problem with balancing quality care with competence. Many subjects stated that some nurses who had bumped were not qualified for the job, and "good" nurses were displaced. LPN issues were found to increase their perceptions of unfairness. Consistent with Meehan and Price (1988), dissention and confusion resulted when productive nurses are bumped.

Individual Nurse versus The Membership At Large

Many of the participants found it difficult to deal with the collective approach to bumping since patient safety and nurses' abilities were perceived as just as important, although the group approach to layoffs was seen as necessary. No literature specific to this finding was found. However, Brockner et al. (1987) and Noer (1993a) found severance equity to be a critical factor in perceptions of layoff fairness. According to Brockner et al. (1987), survivors respond most negatively when they identify with those laid off, and they perceive them as being unjustly compensated. The majority of the participants in this study viewed the LPN deletions unjustly.

Nurses described discomfort with the actual bumping process which is consistent with Sears (1992). They were uncomfortable with the collective approach to displacement which is congruent with Lynch (1993) who found that the collective agreement was a stressor for staff. Many participants believed the bumping protocol was necessary for job retention, although they were ambivalent.

The Displacement Process

Dreiss (1988), Lee (1992), and Noer (1993a) found that resentment and bitterness lingered long after a layoff because of how the situations were managed which was evident in this study. According to Darling and Luciano (1985), handling of layoffs often lead to horror stories. This was certainly the case for many displaced nurses. While telling the investigator their stories, many nurses described extremely difficult situations which were directly related to the handling of displacements. However, due to the fact that their identities could be jeopardized, their stories will never be told. It was quite evident to the investigator that all aspects of the process affected them intensely. Many participants were found to still

harbour the bitterness and anger associated with the approaches used in displacements. They felt violated and betrayed.

Displacement Notification

All participants wanted their head nurse to inform them about their displacement. All except one nurse were notified of their bump by their head nurse. The participant, who was not notified by her immediate supervisor, was angry about the method of notification. All nurses who were deleted were notified by letter. This study confirms Borg and Jensen (1985) findings that displaced nurses appreciated receiving their notification personally by their head nurse, and the explanation of how the reduction would affect them. The majority believed a phone call from their head nurse was a better method of notification. They had the privacy of their homes to deal with the news. This study substantiated Kazemek and Channon (1988) findings that layoff notices should be given in such a way as to be sensitive to those affected.

Time Between Notification and Option Selection

Several participants, who received position deletion, found that having three months notice of

their displacement gave them time to adequately prepare for job change, and to think about where they wanted to work. In contrast, many participants who were bumped had much less time to prepare for the displacement. For nurses with the least amount of seniority, their decision-making time was usually much shorter since their bump occurred toward the end of the process. This finding is consistent with prior studies which found time to be a critical factor for a nurse's adjustment (Barnes et al., 1986; Lucas, 1994). Most participants found the wait before they met with the bumping office representatives to be stressful. This is consistent with work done by Borg and Jensen (1985) and Tuttle (1992) who found when displaced nurses were met with immediately upon notification, they were less stressed. Tuttle (1992) also found that when employees were given all information and had immediate meetings, they felt like they had been treated with dignity.

Meeting With the Bumping Office Representatives

Many participants had negative experiences which specifically related to the bumping protocol. Minimal literature was found regarding this finding, although Shaw, Fields, Thacker, and Fisher (1993) found both

emotional and informational support from supervisors, managers and union officials during change were perceived as helpful by staff. Many nurses in this study found it stressful to have to justify how they met the qualifications for a position, and then wait to hear if their choices were accepted. This study supported Lynch (1993) who identified that position denial and waiting for verification of position acceptance were additional stressors for nurses.

The Actual Displacement

Minimal literature was found related to the actual displacements and bumping. Having choices in areas the participants wanted to work were viewed positively by all displaced nurses, although respondents were apprehensive about starting on the new units especially if they had displaced a peer. Accepting a vacant position rather than bumping was deemed less intrusive to the unit cohesiveness, although many participants expressed guilt. Consistent with Lynch (1993), nurses were fearful of not being accepted on the new unit. Sears (1992) identified the bumping process as one of the worst things for nurses to deal with during downsizing which was evident for respondents in this

study. Participants identified that the process had affected them intensely. They described themselves as having emotional scars three years after the displacements had commenced which is congruent with Noer (1993a) who found time did not heal the wounds of a downsizing process.

Survivor-Victim Connection

All directly affected participants discussed a relationship with the person who bumped them and the person they displaced. Although many described the person in a positive manner, some participants would bracket their negative feelings, especially if they had to work with the person who had bumped them. Although no literature was found specific to this theme, Lynch (1993) identified having to comfort co-workers was a personal stressor during downsizing and bumping.

Initially, the author was surprised to find nurses who accepted vacant codes expressed guilt. However, the position, at one time belonged to a co-worker or friend, thus guilt in that context can be understood. Their expressions of guilt were mirror images of many of the nurses who bumped. Survivor guilt has been documented in the literature, although individuals in

these studies did not experience a bumping process (Brockner, 1992; Lee, 1992; Marks & Mirvis, 1992; Noer, 1993a). Survivor guilt has been minimally discussed in previous nursing studies. Lynch (1993) identified a stressor for staff within the Department of Nursing was the hearing of misfortunes of persons who were bumped. Staff expressed discomfort with having to bump someone out of their position, and their stress increased when they heard about the misfortunes of the people they had bumped. This finding could be interpreted as being related to guilt. Triolo et al. (1995) found guilt over staying employed difficult to identify, since it is usually not discussed. In contrast to her findings, almost all participants discussed survivor guilt. This may have been related to the differences in research approaches used or the ethos and culture of the hospital. Seeing co-workers displaced was a difficult experience for all, even those who had been displaced themselves. This is consistent with previous studies on layoff survivors and witnessing co-workers' displacements (Brockner, 1992; Brockner et al., 1986; Brockner et al., 1987; Lee, 1992; Noer, 1993a).

"Bumpers" were seen as less expert in the new

area. As a result, more stress and work were placed on the senior staff within the first year after bumping had ensued. As well, nurses were accepting term positions throughout the hospital. This was found to be an added stress for senior nurses since they were in charge more and had to orientate new staff. No literature regarding this finding was found although past experience with nursing shortages has identified high staff turnover is a stress for nurses (Schull, 1986).

Embracing The New Challenge

All displaced participants were apprehensive about the new work. However, they all embraced the new opportunities although one nurse who had been bumped twice was less excited and motivated about the future. Bridges (1994) would explain this finding as nearing the final stage in transition; the new beginning. No literature was found that related specifically to this finding, although the reframing of stressful events into positive outcomes have been reported (Rozak, 1994; Strength & Ulmer, 1987). Roberts (1989) found that staff reductions plans afforded many opportunities for both the institution and nursing staff to grow.

Several participants discussed ways they were enhancing their marketability as a nurse which is consistent with Nornhold (1994) who advocates nurses should acquire new skills in order to strengthen their marketability. These activities were seen by respondents in this study as survival skills for the future.

How Worklife Was Affected

The participants' worklife, as a result of restructuring and displacement, will be explored with reference to O'Brien-Pallas and Baumann (1992) unifying framework of nursing worklife and the literature reviewed. O'Brien-Pallas and Baumann's (1992) unifying framework of nursing worklife would support the premise that restructuring and displacement are external dimensions of a nurse's worklife that will affect the quality of her/his worklife. As well, internal dimensions such as the implementation of staff mix and changes to working relationships will further impact the quality of a nurse's worklife. Increasingly, there is more emphasis being placed on productivity, quality assurance, efficiency, and cost effectiveness in a nurse's worklife (O'Brien-Pallas et al., 1994a). As a result of restructuring, introduction of alternative

care delivery models, and less in-hospital patient care, nurses' worklife will be affected dramatically. Nurses described their worklife as being notably affected by both restructuring and displacement, although restructuring had a greater impact when the study was conducted.

According to Tumulty et al. (1994), restructuring of health care delivery and the redesign of nursing function are creating dramatic changes in the nurses' work environment which was evident in this study. The environment in which nurses work has received little attention (O'Brien-Pallas & Baumann, 1992; Tumulty et al., 1994). Previous studies have investigated aspects of a nurses' worklife that may have been affected by restructuring (Tumulty et al. 1994; Lewis et al., 1986). Worklife effects related to displacement were more notable within the first year following the bumping process. Although displacement was perceived to have less of an impact on their worklife at the time of the study, all respondents acknowledged it would be affecting their worklife when future deletions occurred.

Worklife Effects Related to Staff Mix

All participants discussed worklife effects related specifically to staff mix, which was a component of the hospital's restructuring plans. Staff mix was designed to allow nurses to spend more time with patients. However, nurses perceived that they were spending less time with patients and their workloads had increased. In contrast, previous studies have found nurses spend more time with patients after restructuring (Moffitt et al., 1993; Smeltzer et al., 1993). This difference may be dependent on the restructuring approaches used, and further study is needed.

Many of the participants in this study expressed some confusion over the nursing and orderly boundaries in regards to patient care. No research was found regarding this theme. However, Wilson (1995) described a trend towards "blurring" the margins between health care workers. She describes this issue in relation to overlapping of various types of health care workers' roles and responsibilities. She questioned what effect this will have on patient care when reductions in the numbers of beds have resulted in higher levels of

acuity in hospitals.

Concern Over Quality Patient Care

All participants in this study expressed concern over a decrease in the quality of patient care. They remained highly committed to patients which was consistent with Lynch (1993). Bumping was identified as a factor that might jeopardize patient care since units were losing staff with expertise and gaining staff who did not have the desired experience (Lynch, 1993). This finding was articulated by several nurses in this study. Impending layoffs set in motion behaviours that can impact staff members and the quality of services provided to clients (Dreiss, 1983). Nurses, especially those bumping to different areas of specialization, were found to have less expertise and knowledge. However, this impact was relatively non-existent within the first year of the bumping process. When the bumping commenced, concern was expressed that patients were not being cared for in the manner they had been pre-bumping. Several nurses commented on the fact that nurses were taking term positions to get off units they did not want to work on. This further affected the acquisition of expertise.

Many participants found they did not have the time to give the care they deemed important. Priority activities were implemented and those deemed less critical in terms of "need to do" activities were left out completely or left to the next shift. Lewis et al. (1986) found patient care can be negatively influenced during restructuring. This study confirmed their findings since the "must be done" activities were prioritized, and the less critical yet highly important activities were being omitted from their routine care. All participants found that nursing care had changed, and many nurses described their care as task focused instead of patient focused which had not been previously identified.

Decreased Team Work

Participants found that the team was, for the most part, non-existent at the time of the study. Nurses were still grieving the loss of the team, three years after the initial breakup. Team building strategies have been found to be needed post-restructuring (Marks & Mirvis, 1992; Rozboril, 1987). Marks and Mirvis (1992) suggest that team building helps people to let go of the past and excite them about the future.

Watson et al. (1991) found that the extent to which the workplace allows for interaction deteriorated post-restructuring which was evident in this study.

Need For Ongoing Education

All participants in this study expressed that their jobs had changed noticeably. Even nurses who remained in their original units found that their worklife had changed enough to require ongoing education. Hequet (1994) found that 60 to 70% of jobs change when hospitals restructure to a patient focused care model. The need for ongoing education was identified by almost all of the participants in this study. However, the educational needs were not further explored beyond the identification of the need for continuing education. Donley (1994) and Triolo et al., (1995) advocated staff must be prepared for the changes in care delivery. Smeltzer (1993) found changing roles, no matter how small, require education and follow up. For the most part, nurses were motivated to learn new things and embrace new challenges. This finding has been minimally discussed in the literature. Watson et al. (1991) found that staffs' perception of personal growth opportunity improved when patient

focused care was introduced. Educational needs may be related to the type of restructuring activities implemented, and an educational needs assessment is worthy of consideration.

Decreased Mobility

Few nursing references were found regarding this theme of loss of flexibility and decreased mobility in the job market. Almost all the participants were angry over the granting of positions based on preferential consideration for nurses who had been laid off. Some participants felt "stuck" in their positions which is consistent with Olson (1995) who found some nurses felt trapped in their jobs since there were limited job opportunities in their current hospital, as well as in other hospitals. Leaving their current employer for a position in a new hospital would cause them to lose their seniority, and they would have to start all over again accruing seniority. Several participants discussed displacement as a way for nurses to either obtain jobs elsewhere or change their employment status to part-time. As well, several nurses discussed the fact that either they or their co-workers were hoping to be bumped. No literature was found specific to this

finding, although Cameron et al. (1991) identified disincentives in the work place post-restructuring, and survivors could end up being envious of those displaced. Nurses expressed the fact that extra shifts were not available due to the procedure of offering all replacement shifts to nurses on the lay-off list which is consistent with Lynch (1993) who found there were less casual shifts available after restructuring.

Decreased Job Satisfaction

The majority of participants expressed decreased job satisfaction although only two participants expressed the desire to leave nursing in the future. Davy et al. (1991) found employees, who are unhappy with their jobs, withdraw psychologically from the organization long before they ever withdrew physically. Davy et al. (1991) and Olson (1995) found organizational commitment was positively correlated to job satisfaction. However, Olson (1995) found no correlation was established between organizational commitment and intent to leave, which is contrary to Davy et al. (1991). Olson (1995) found only 10% of the nurses surveyed intended to leave. She suggests that nurses were less likely to withdraw from the

organization given the current economic climate. To compensate, she suggested nurses may use other forms of withdrawal such as increased sick time utilization. The majority of participants discussed the substantial increase of sick time benefits by their co-workers. The author wonders if the reasons for increased utilization of sick time benefits could possibly be related to ongoing stress and/or decreased job satisfaction including psychological organizational withdrawal. In contrast, Moffitt et al. (1993) found nurses' job satisfaction increased after implementation of a patient focused care model. Different approaches used in restructuring may affect nurses' job satisfaction differently, and this is worthy of future study.

Several nurses discussed how they had lost autonomy in their work, which is consistent with Watson et al. (1991) who found that nurses' autonomy diminished after restructuring. However, Tumulty et al. (1994) did not find autonomy was a major contributor to nurses' job satisfaction. Job satisfaction was related to the importance of work relationships. They concluded a cohesive peer group

possibly compensated for other difficulties at work, and redesign of work should focus around groups.

Limitations of the Study

A sample of convenience was used in this study. The study participants (n=10) were not representative of all the Departments within the Nursing Division at the study hospital. The majority of participants were from the Departments of Critical Care (4) and Medical Nursing (3). This may impact on the fittingness of the results. The possibility that other areas where displacement and restructuring were occurring such as in the Department of Psychiatry or Surgery may have experienced different issues during the processes.

Although the advertisement informing potential participants of the study was distributed to all appropriate nursing units, float nurses did not volunteer for the study. The information letter which was distributed to all units was not sent to the area where float nurses were assigned work. As such, their lack of participation may have impacted the findings. Nurses in casual and term positions who do not have permanent positions within the hospital were excluded from this study. Four nurses in these particular types

of work contacted the investigator. They were disappointed that they could not participate. One respondent was quite distressed because of the difficulties new graduates are experiencing in job attainment. This particular person found it extremely difficult to "live for the day" and "casual" one's life away. Their lack of participation may have affected the study results. A balance of nurses participating from all areas of the hospital may have yielded more complete data.

The time the interviewer spent with each participant ranged from 30 minutes to two hours with a mean of one hour. All participants except for one were extremely candid with the investigator. During one interviews, the investigator sensed that a participant was being reserved.

During the four month time frame that the study was conducted, there were numerous restructuring activities being discussed. This may have caused stress for potential participants, and may have impacted on their decision not to participate in this study. Two potential participants cancelled interviews because they were "too busy". However, one potential

participant later contacted the investigator to be included in the study.

The restructuring and displacement processes commenced approximately three years prior to this study. Although continued restructuring activities were occurring in some departments, some of the potential participants may have started the healing process or reached acceptance in relation to the restructuring outcomes. This may have influenced their decision not to participate. Although some of the participants were angry over the restructuring and displacement processes, there may have been nurses who were too angry to participate. Thus, this may have influenced their participation.

Significance of the Study

Documentation of nurses' experiences with hospital restructuring and displacement and their ultimate effects on nursing worklife is paramount and would provide assistance in not only nursing administration but also in clinical practice and patient care.

Conclusions

Restructuring and displacement were found to have notable effects on all the participants and their

worklife. Nurses described being adversely affected by the processes. They needed to be given time and an opportunity to heal. The perception that there was no caring for the care-givers was strikingly noticeable in this study. Restructuring was a new experience for those involved in the planning and those being the recipients of the restructuring outcomes. This study underscored how important it is to plan for nurses to undergo such a change. Integral to the restructuring plans are the pre-planning and post-restructuring follow-up required regarding directly and indirectly affected nurses.

Restructuring was introduced to engender a more efficient, cost-effective system. Health Care Reform will be a part of nurses' worklife for years to come. It appears to be an established ongoing process. Adequate preparation during change is critical to a nurse's successful transition. It is paramount to determine the best approaches to assist nurses in the change. It is the hope of the author that despite the changing work environment, nurses will continue to be highly committed to patient care, and meet the challenges that a restructured work environment brings.

Nurses need to continue to develop survival skills to manage their own careers. By becoming active initiators, nurses will lead and not be led.

Recommendations

Education:

1. The majority of participants felt ill-prepared for the newly restructured working environment. Thus, it is recommended nurses receive ongoing education regarding changes to the health care system and restructuring, and how these activities will affect nurses' worklife. An needs assessment for nurses would be helpful to identify specific areas of education required.

2. Head nurse support was found to be especially important for nurses during both displacement and restructuring. As such, education specifically for head nurses to ensure they have the knowledge to fully support their staff during these times warrants further consideration.

3. The majority of participants expressed concerns in relation to staff mix. A thorough review of the staff mix, which was one component of the restructuring process, may reveal areas which need further

development. Integral to this review would be the inclusion of the role of both the nurse and Nursing Assistant II (NA II). Ongoing continuing education classes for NA IIs would be beneficial for themselves and the RNs.

Administration:

1. Communication, regarding future plans and direct impacts on nurses, were found to be important for the participants. Communication forums on a regular basis are recommended to inform nurses of the restructuring status on a continual basis. This forum could also be utilized for sharing of feelings and thoughts about restructuring and subsequent displacement issues. Other forums for communication should also be explored.
2. Personalized displacement notification was found to be important to the displaced participants. Thus, it is recommended that immediate supervisors be the ones to notify nurses of displacement.
3. The head nurse role was identified to be a key role by the participants. Thus, a head nurse support system would be worthy of consideration.
4. Many of the participants found they did not get the support they needed during displacement and

hospital restructuring. Including an employment counsellor for staff being displaced would be of benefit to nurses so they can receive expert career counselling regarding their future plans in nursing. As well, non-displaced staff may benefit from career counselling since future restructuring is anticipated. The author also suggests that the bumping office representatives may find this information helpful as they support staff through a difficult process.

5. All participants believed the team had been adversely affected by restructuring and displacement. Strategies to promote team building would be of benefit to nurses and the multidisciplinary team.

Practice:

1. Participants expressed feelings of time pressures in performing professional care, related to the introduction of staff mix. Aspects of care such as psychological support, discharge planning and patient education were being omitted, for the most part, because of the high amounts of physical care. Nursing care must be prioritized differently in order to meet the needs of patients in a restructured work environment with staff mix. Education specific to the

new working environment would be of benefit to nurses.

2. Participants felt that they were not supported on the wards. The Head Nurse role could be pivotal in providing support and ongoing follow up for staff. This is worth further consideration.

Research:

1. All participants were concerned over quality of patient care. Impacts of restructuring and displacement on patient care warrants further investigation.

2. Many directly affected participants expressed the feelings that the organization did not care about them. Ongoing follow up sessions to convey that they matter to the administrators would be of benefit, and warrants further research.

3. Little research has been done in regards to utilizing different approaches to restructuring, such as case management. Further research is recommended.

4. The study hospital has been actively involved in restructuring activities and further restructuring is anticipated. Thus, the hospital has never achieved equilibrium. It is recommended that future research regarding impacts of restructuring and displacement be

undertaken when stability returns.

5. The head nurse role was seen as important to the participants in this study. Further research regarding the role of the immediate supervisor in supporting staff during the process is warranted.

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CODE #____

APPENDIX A

Interview Guide For Nurses Participants

I am interested in learning more about what it was like for nurses to live through hospital restructuring and displacement at (Study Hospital). I would like to hear about your thoughts and feelings during this time.

Ask the following questions:

1. What are your thoughts and feelings about what it was like to live through hospital restructuring at (study hospital)?

2. What are your thoughts and feelings about what it was like to live through the bumping process at (study hospital)?

3. Did the bumping process and/or hospital restructuring affect your worklife?

   Yes No

   If participants answer Yes to above question, ask participants the following question.

4. How has hospital restructuring and bumping affected your worklife?

CODE #___

APPENDIX B

Demographic Information: Nurse Participants

1) When did you graduate from Nursing?

2) Educational Preparation?

3) Have you always worked in the study hospital? YES/NO

   If no, ask the following questions.

   a) What other areas have you worked?

   b) What is your years of nursing experience?

4) What is your current number of seniority hours?

5) When did you start working at (Study Hospital)?

6) What was your EFT at this hospital when layoffs were announced in March 1993?

CODE #___

APPENDIX C

ADDITIONAL QUESTIONS FOR NURSES
WHO EXPERIENCED POSITION DELETION OR BUMPING

1. Was your position deleted or were you bumped from your position?

2. How long had you worked on the unit when you were officially bumped?

3. When were you notified that you were being displaced from your position?

4. How much time elapsed between being notified of the bump and your meeting with the bumping office to discuss your options?

5. How much time elapsed between your notification of being bumped or deleted and the actual bump/ deletion date?

6. Did you bump into a similar area of practice?

7. What was your EFT after being displaced?

8. How many times were you bumped?

CODE #___

APPENDIX D

Potential Participant Screening Questionnaire

1. Do you currently hold a permanent Nurse II position at the study hospital?

   YES NO

2. Did you experience position displacement at the study hospital?

   YES NO

If the potential participant experienced position displacement, ask the following questions.

3. Did you exercise your seniority rights to maintain your employment status?

   YES NO

4. When you were displaced from your position, were you in a Nurse II position?

   YES NO

APPENDIX E

Advertisement in Hospital Newsletter
To Attract Potential Subjects

My name is Linda Kennedy. I am a Registered nurse and a Graduate Student in the Faculty of Nursing at the University of Manitoba. For my thesis, I am investigating the impact of displacement and organizational restructuring on General Duty Registered nurses and how it affected their worklife.

The study will involve an interview that will take approximately one to one and a half hours. The interviews will be audiotaped. The identity of participants will not be disclosed. At a later date, the investigator may contact you to clarify any data obtained during the interview if required.

I invite you to participate in this study of the impact of restructuring and displacement on General Duty Registered Nurses and how it affects their worklife. By telephoning the investigator, you will not be committing to participate in this study. It is to obtain more information about this study.

To obtain further information about this study, please contact Linda Kennedy at

APPENDIX F

Information Letter For Potential Participants

My name is Linda Kennedy. I am a Registered Nurse and a student in the Master of Nursing Program at the University of Manitoba. For my thesis, I will be conducting a study to learn more about the impact of organizational restructuring and displacement on General Duty Registered Nurses and how it affects their worklife. This study has been approved by the University of Manitoba Ethics Review Committee. I have received permission from the hospital to carry out this study.

I invite you to participate in this study. If you agree to participate, I will interview you for approximately one to one and a half hours at a place of your convenience. The interviews will be audiotaped. You are welcome to listen to the audio-tape after the interview. At a later date, the investigator may contact participants at home to clarify any information obtained during the interview. The investigator will be asking me some questions related to demographic information. As well, if you have been displaced from a position, the investigator will be asking you specific questions about the bumping process. Any information obtained about participants will be presented in a group form so as to assure anonymity of your participation. Your participation in the study is voluntary. At any point during the study, you may withdraw with no consequences to yourself or your employment.

All information obtained during the study is confidential. Data obtained during the interviews will only be available to the investigator and the thesis committee. Participants' names will not appear on any of the documentation. Participants and all information pertaining to participants will be assigned a number. The number and matching name will be kept in a locked filing cabinet, of which, only the investigator will have access. Confidentiality will be assured since only the researcher will be able to identify the participants and corresponding data gathered. All participant data will be presented in group form so as to protect your identity. Any data

that may trace your identity will be eliminated from any reports.

There is no monetary compensation for participating in this study. There is not any direct benefit to participating in this study but the study results may help nurses who will be affected by hospital restructuring and displacement in the future.

If you have any questions or would like further information, I can be contacted at . Your telephone call to the investigator will be to obtain further information about the study only. My thesis chair is Dr. Erna Schilder. If you would like to speak to her, she can be contacted at the Faculty of Nursing, University of Manitoba .

Thank you for your time and consideration.

CODE #___

APPENDIX G

Consent Form For Participants
Pilot Study

Linda Kennedy, a student in the Master of Nursing program at the University of Manitoba, is conducting a study on the impact of organizational restructuring and displacement on General Duty Registered Nurses and how it affects their worklife. The study has been approved by the University of Manitoba Ethics Review Committee. Linda has received permission from the hospital to carry out this study.

I have been asked by Linda to participate in a pilot study of the interview guide which she will be using in an upcoming study. If I agree to participate, I will interviewed by Linda for approximately one to one and a half hours at a place of my convenience. I am aware that the interviews will be audiotaped and that Linda will be taking notes during the pilot study. I understand that I will be questioned about the impact of displacement and organizational restructuring on General Duty Registered Nurses and how it affected my worklife

I am aware that my participation in this pilot study is voluntary. At any point during the pilot study, I may withdraw with no adverse consequences to myself or my employment.

All information obtained during the pilot study is confidential. Data obtained during the interview will only be available to Linda and the thesis committee. My name will not appear on any of the documentation. All information pertaining to me will be assigned a number. The number and my matching name will be kept in a locked filing cabinet, of which, only Linda will have access. Confidentiality will be assured since only Linda will be able to identify my name with the corresponding number.

There does not appear to be any direct benefit to me for participating in this pilot study. The pilot study results will be used to determine the suitability

and relevance of the interview guide which Linda will be using in a study entitled An Exploratory Study of Organizational Restructuring and Displacement on General Duty Registered Nurses and How It Affects Their Worklife.

I am aware that I am being asked to discuss a stressful aspect of my worklife and as such may experience some discomfort. I am aware that I may terminate the interview at any time.

I have discussed the pilot study with Linda. I have read this form and I give my consent to participate in the study.

_____	_____
Signature of Participant	Signature of Investigator
Date:_____	Date:_____

Ask the participant if she/he would like a copy of the findings of this study?

Yes ___ No ___

CODE #___

APPENDIX H

Consent Form For Participants
Individual Interview

Linda Kennedy, a student in the Master of Nursing program at the University of Manitoba, is conducting a study on the impact of organizational restructuring and displacement on General Duty Registered Nurses and how it affects their worklife. The study has been approved by the University of Manitoba Ethics Review Committee. Linda has received permission from the hospital to carry out this study.

I have been invited to participate in this study. If I agree to participate, I will interviewed by Linda for approximately one to one and a half hours at a place of my convenience. I am aware that the interviews will be audiotaped. At a later date, Linda may contact me at my home if clarification of information obtained during the interview is required. I understand that I will be questioned about the impact of displacement and organizational restructuring on General Duty Registered Nurses and how it affected my worklife and some questions related to demographic information. As well, if I have been displaced from a position, Linda will be asking me specific questions about the bumping process.

I am aware that my participation in this study is voluntary. At any point during the study, I may withdraw with no adverse consequences to myself or my employment.

All information obtained during the study is confidential. Data obtained during the interview will only be available to Linda and the thesis committee. My name will not appear on any of the documentation. All information pertaining to me will be assigned a number. The number and my matching name will be kept in a locked filing cabinet, of which, only Linda will have access. Confidentiality will be assured since only Linda will be able to identify my name with the corresponding number. All participant information will be reported in group form. My identity will be

protected and any data which could trace my identity will be omitted from reports.

There does not appear to be any direct benefit to me for participating in this study but the study results may help nurses who will be affected by restructuring and displacement in the future. I am aware that I am being asked to discuss a stressful aspect of my worklife and as such may experience some discomfort. I am aware that I may terminate the interview at any time.

I have discussed the study with Linda and I have read an information letter about the study. I have read this form and I give my consent to participate in the study.

_____ _____

Signature of Participant Signature of Investigator

Date:_____ Date:_____

Ask the participant if she would like a copy of the findings of this study?

Yes ___ No ___

Appendix I
Joint Study Hospital and Nurses' Union
Bumping Protocol (1992)

The following is a protocol that the Local would consider taking to membership for approval on a one time without prejudice, without precedent basis to deal with anticipated downsizing and reorganization. The term "affected nurse" will apply to a nurse whose position is "deleted" or to a nurse whose position is subsequently "bumped".

The parties agree to review and amend as required the deletion/layoff protocol as events arise that may impact upon the protocol.

A key factor in the bumping process is the nurses' ability, performance and qualifications for any given position within any given classification.

1. Notice of Deletion/Layoff:

   The Union and each nurse initially affected under Phase I shall be given layoff/deletion notice in accordance with the employment security memorandum or a greater notice period.

2. Exercising Seniority Rights:

   The protocol for exercising seniority rights or "bumping" will be as follows:

   a) The affected nurse will first choose the unit she/he prefers to bump into;

   b) The affected nurse will choose an existing E.F.T. (code) as she/he requires and for which she/he is more senior. The nurse may choose an E.F.T. greater or less than her/his present;

   c) The affected nurse will choose between a day/night, day/evening, night or evening rotation as may exist within any E.F.T. for which she/he is more senior;

   d) The affected nurse shall be placed on the unit she/he has indicated in 2(a) into the positions she/he has chosen which matches 2(b) and 2(c); whenever possible, displacing the least senior nurse.

   e) A position shall not be created on a given unit to accommodate a given nurse.

   f) The Hospital reserves the right to limit the numbers of nurses who bump to any one shift or to any one unit. This will be done in consultation with Local 5.

3. Vacancies and Preferential Consideration:

Preferential consideration will be given to affected nurses for existing vacant positions, but not for positions created as the result of approved alternative programs. Positions, as a result of new programs, will be competed for as normal. The protocol for preferential consideration will be as follows:

a) All existing vacant positions will be offered to the affected nurses, in order of seniority (seniority as per Article 2501). Affected nurses will be given the option for those vacancies for which they are interested and qualified.

b) Preferential consideration will only apply to a nurse seeking a position at an equal or a lower classification than her/his previous position. This will not aply to those seeking employment at a higher classification than their former position.

c) Laid off nurses shall be entitled to apply for vacancies other than those to which they have recall rights (Article 2704).

4. Orientation Period:

a) The affected nurse shall be entitled to bump once. Once the nurse has assumed the new position, the nurse shall be provided with the "normal orientation" provided to nurses when they are hired or transferred into the area.

b) The orientation period shall be of sufficient length, taking into account the nurses' past experience, knowledge, and the fact that these nurses are being affected by the Hospital's reorganization and downsizing.

5. Term Positions:

a) In order to facilitate the process of deletions/layoffs and subsequent "bumping" procedure, all term positions will terminate effective the date of implementation of deletions. Article 3006 will apply. This process will be worked out on paper well in advance of the deletion deadline.

b) Nurses in term positions prior to the reorganization shall return to their former positions and shall be entitled to exercise their seniority rights in accordance with Article 32 if their former position is "affected".

6. Leave of Absence:

a) Positions of individuals on leave of absences shall be included in positions available for "bumping".

b) The nurse on a leave of absence whose position is "bumped" or whose position is "deleted" shall be contacted and given the opportunity to exercise her/his seniority rights in accordance with Article 32 and the deletion/layoff protocol. The nurse will not be required to return to the position selected until the expiry of her/his leave of absence.

c) If there is a nurse filling the original L.O.A. term position, then she/he shall be treated in accordance with Section 5 of this protocol.

d) Nurses on Leaves of Absence related to W.C.B., L.T.D. or medical illness who are deemed ready for a gradual re-entry trial shall be given the same opportunities for such trials as occurred prior to reorganization.

7. Laid Off Nurses:

a) Laid off nurses will be recalled as per the Collective Agreement Article 2705. The nurse may decline a permanent position that is not within ± .2 E.F.T. of the nurses' former position and this will not be considered a "refusal". The nurse will not be penalized and will remain at the top of the recall list while she/he awaits an offer for a permanent position within ± .2 E.F.T. of their former position.

b) A laid off nurse who declines a permanent position because she/he does not feel competent and able to perform in said position, will not be considered to have "refused". A laid off nurse who declines a position on the basis of a documented medical restriction, will not be considered to have refused. In both cases, the nurse will not be penalized and will remain at the top of the recall list while she/he awaits the next available position.

c) Notwithstanding Article 3402, available shifts shall be offered to a nurse on layoff before part time and casual nurses, provided she/he is qualified, competent and willing to perform the required work. The available shifts accepted by the nurse on layoff may equal the E.F.T., but not greater than the E.F.T. of the affected nurse. Available shifts may be those occasioned by sick, vacationing, leave of absence, etc.

In the event the nurse accepts available shifts, the provisions of the Collective Agreement shall be applicable except as modified hereinafter;

i) vacation pay shall be calculated in accordance with Section 2102 and shall be paid at the prevailing rate for the nurse on each pay cheque, and shall be pro-rated on the basis of hours paid at regular rate of pay,

ii) income protection accumulation shall be calculated as follows:

$$\frac{\text{Additional available hours worked by the laid-off nurse}}{\text{Full-time hours}} \times \text{Entitlement of Full-time Nurses}$$

iii) In the event that the nurse is laid off for 26 weeks or less, seniority shall be calculated in accordance with Article 3406(a) and (b).

iv) The nurse shall be paid four and one-quarter percent (4.25%) of their basic rate of pay in lieu of time off on Recognized Holidays. Such holiday pay shall be calculated in all paid hours and shall be included in each pay cheque,

(v) Participation in benefit plans is subject to the provisions of each plan.

8. Classifications:

a) L.P.N.'s can bump L.P.N.'s.
R.P.N.'s can bump R.P.N.'s.
R.N.'s can bump R.N.'s (General Duty Level).

As per Article 25, accrual of seniority is clearly identified for these classifications.

Exception:

For recall - of laid off R.P.N.'s and R.N.'s into positions where the qualification on the posting requires M.A.R.N./ R.P.N.A.M. registration, then Article 2501 (a) would apply so that the most senior nurse shall be recalled whether R.N. or R.P.N.

b) The Collective Agreement encompasses various groups whose job functions have been defined separately. These classifications include a variety of Nurse IV, Nurse Educators and Head Nurses, all of whom have different job responsibilities and varied job qualifications, but who are paid at the same salary level.

c) For the purposes of bumping Nurse IV, Nurse Educators, and Head Nurses would be deemed "equal"; and "lower" would be deemed to be Nurse III and G.D.R.N.

PROCESS REGARDING HANDLING OF DOWNSIZING/DELETION/LAYOFF

1. Letters of deletion and protocol sent to individuals and the Union.

2. Update seniority listings.

3. Prepare a list of existing vacant positions.

4. Using the deletion/layoff protocol and the Collective Agreements:

   (a) Meet with each individual nurse, in order of seniority (a rep. from Union and Management to be present) to review possible options with the nurses.

   (b) The affected nurses may prepare a resume with an accompanying letter outlining how she/he meets the posting requirements (required for all classifications above GDRN);

   (c) All written materials will be reviewed;

   (d) For classifications above GDRN, the nurse meets with the Nursing Director to discuss job responsibilities, expectations, and orientation;

   (e) The affected nurse makes a final decision regarding her/his desire to "bump".*

5. All positions/bumping to be worked out on paper prior to deletion date.

* *NOTE: Final decision to be made within 2 weeks of initial meeting outlined in 4(a).*

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APPENDIX J
Letter of Ethical Approval
Faculty of Nursing

THE UNIVERSITY OF MANITOBA

FACULTY OF NURSING

Room 246 Bison Building
Winnipeg, Manitoba
Canada R3T 2N2

Tel: (204) 474-8202
Fax: (204) 275-5464

October 11, 1995

Ms. Linda Kennedy
204 Belvidere St.
Winnipeg, Manitoba
R3J 2H2

Dear Ms. Kennedy:

Re: Proposal #95/44 An Exploratory Study of Displacement and Organizational Restructuring on General Duty Registered Nurses and How It Affects Their Worklife

With the additions you submitted to the Ethical Review Committee on October 3rd and 10th, your proposal is approved.

On behalf of the Committee I would like to wish you every success in completing your study.

Sincerely,

Karen Chalmers RN, PhD
Associate Chair
Ethical Review Committee

APPENDIX K

November 6, 1995 Study Hospital Access Approval

Linda Kennedy

Re: Access to for Study Entitled:
AN EXPLORATORY STUDY OF DISPLACEMENT AND ORGANIZATIONAL RESTRUCTURING ON GENERAL DUTY REGISTERED NURSES AND HOW IT AFFECTS THEIR WORKLIFE

Dear Linda Kennedy:

I am pleased to inform you that your research access request has been approved. You may proceed with your study on the understanding that:

1) any significant changes in your proposal will be submitted to my attention prior to implementation;
2) you review the enclosed policy on confidential information and then sign and return the enclosed Pledge of Confidentiality;
3) you inform us when your data collection is complete. This information helps us coordinate research access requests and minimize competing demands of research study protocols on patients and nursing staff time;
4) you inform us of the funding status of your study.

We may call you to make presentations to hospital staff about your research at our Brown Bag Research Luncheons held monthly. Upon completion of your study, we request that you provide us with a brief summary of your final report.

Thank you for selecting as the site for recruiting participants for your study. Please feel free to contact me with your questions or concerns. Should you encounter any site-related difficulties during the course of your study, I would appreciate being notified of these.

All the best with the completion of your study.

Sincerely,

Katherine Stansfield, R.N., M.N.
Nursing Program Development
and Evaluation Specialist

KS/mj

Encl: Confidential Policy & Pledge