



# Flexible Work Practices in Nursing





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developed by

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for the

International Centre for Human Resources in Nursing



International Council of Nurses

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# Table of Contents

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About this paper	4
About the authors	4
Acknowledgements	4
<b>Executive summary</b>	<b>5</b>
<b>Introduction</b>	<b>7</b>
Scope of this paper	8
<b>Chapter 1: Defining flexible work practices</b>	<b>11</b>
<b>Chapter 2: Factors associated with flexible work and nursing</b>	<b>13</b>
The incidence of flexible work practices in nursing	13
The nurse labour market context	14
Work conditions	16
<b>Chapter 3: Advantage and disadvantages of flexible work practices with substantive staff</b>	<b>19</b>
Organisational advantages	19
Nursing advantages	21
Organisational disadvantages	22
Nursing disadvantages	23
Summary	25
<b>Chapter 4: Strategies to enable flexible work practices: Global to local</b>	<b>27</b>
A global framework	27
Policy and legislation	27
Effective management	28
Communications and teamwork	29
<b>Conclusion</b>	<b>31</b>
<b>References</b>	<b>33</b>
<b>Appendix: Examples of flexible work practices</b>	<b>45</b>

## About this paper

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This paper is one in a series of documents developed for the International Centre for Human Resources in Nursing (ICHRN), a key project of the International Council of Nurses (ICN). The series aims to explore nursing human resources issues and offer policy solutions.

Launched in 2008 by the International Council of Nurses (ICN) and the Florence Nightingale International Foundation, ICHRN is dedicated to strengthen the nursing workforce globally through the development, ongoing monitoring and dissemination of comprehensive information and tools on nursing human resources policy, management, research and practice.

## About the authors

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## Executive summary

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This paper provides an overview of flexible work practices for substantive nursing staff. Substantive staff are considered the stable core of the workforce; temporary nurses are used to 'fill in' workforce gaps for short periods of time. This workforce model (core/periphery) originates from the "flexible firm" model of the 1980s, developed to increase organisational productivity and efficiency.

Productivity and efficiency are important organisational goals that influence managerial decisions with respect to workforce options - particularly during the current global economic recession. Organisational needs, however, are only one part of the picture. Research in human resource management has raised our awareness of what employees need in order to function effectively and efficiently. Nurses want substantive work and they want to balance their many work-life responsibilities. Flexible work options, particularly those reflecting the voluntary choices of nurses, are associated with nurses' greater job satisfaction, organisational commitment and intent to stay. The nursing workforce is a diverse mix of many generations: the Baby Boomer generation is retiring and there are many challenges associated with recruiting and retaining younger nurses. The nursing workforce is also highly gendered, being comprised of mostly women. Within health care environments, current work conditions are stressful, and the very nature of nurses' work adds to workplace stress: nurses do shift work that can be physically wearing and emotionally exhausting. Health care organisations, therefore, need recruitment/retention strategies to build and maintain a solid nursing workforce.

Flexible work options for substantive nursing staff can be a win-win situation for health care organisations and nurses. For organisations, these work options provide more staffing flexibility with nurses who know their patients, the organisation and each other. Some research evidence suggests, for instance, that use of temporary staff can negatively influence patient care delivery due to temporary nurses' lack of familiarity with team members, policies, protocols and geographic layout. Teamwork depends on effective communications and shared understandings among team members, and the question remains as to whether teamwork is as effective with temporary versus substantive staff. Better care and better continuity of care may be more difficult to achieve with temporary versus substantive nursing staff.

From nurses' perspectives, choice over work schedules is one of the most important components of a healthy work environment. Research from developed and developing countries has shown that flexible work options are powerful recruitment and retention tools. Many senior nurses, for instance, are interested in part-time work and phased retirement. Many younger nurses are interested in flexed hours and compressed work schedules. Regardless of age or country context, flexible work options provide the flexibility nurses need to more successfully manage life and work, while serving as organisational recruitment/retention strategies.

If done well, flexible work options for substantive nursing staff can be a successful long-term human resource strategy for organisations. Management must be prepared to handle more complex schedules and human resource issues. There must be policies and procedures, resources and supports. There must be data generated and used to determine what is working and what is not working. Organisations must be in compliance with government legislation, and

accreditation and regulatory processes can be more complex when there are diverse flexible work options. Careful planning and effective management, however, are keys to organisational success.

Nurses, too, must be aware of the advantages and disadvantages associated with flexible work options so that they can make informed choices that best suit their work-life needs. Employee advocacy for flexible work options will hopefully shift traditional work cultures that have been biased against new and different work arrangements. Individuals must also know that flexible work options are not a panacea - in many instances, other resources and supports are required to truly balance the demands of work and life.

There are many resources available to health care organisations and nurses to guide the way toward effective flexible work practices utilisation. We have the capacity, for instance, to virtually connect with each other, to tell our stories and share our best practices. We can learn from the lessons of other business and service communities. Flexible work is a human resource strategy with significant implications for our global nursing workforce. Systematic programme evaluation and research rigour will hopefully help us explore and discover the potential of flexible work practices during challenging times of limited resources - particularly health human resources.



## Introduction

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“Flexible work” became popular in the 1980s, particularly after the introduction of the “flexible firm” human resource management model (Atkinson 1984). Atkinson proposed a systematic core/periphery approach to managing human resources and enhancing workforce productivity. Atkinson focused on two types of worker contracts, differentiating between a core workforce of permanent, substantive, full-time employees and a peripheral workforce of temporary, casual or contingent workers. In this paper, we will use the terms *substantive* and *temporary* for consistency.

In Atkinson’s model, core workers are a full-time, stable core of employees, and peripheral workers fill in work gaps for short-term periods of time. Since the introduction of this earlier model, employers have been experimenting with different combinations of workers and flexible work practices. Substantive or temporary workers, for instance, can be engaged in part-time work, a flexible work practice. Due to many factors, including the global economic recession and work-life demands, employers are beginning to recognise the potential of utilising flexible work practices with substantive staff (Mercer et al. 2010).

There are several types of work flexibility:

- *Task or functional flexibility* addresses the adaptability of employees, such as multi-skilling and cross-training;
- *Numerical flexibility* refers to workforce size, such as variable numbers of staff to meet levels and patterns of demand;
- *Temporal flexibility* involves variations in work hour arrangements, such as flextime;
- *wage or financial flexibility* involves different payment arrangements, specifically a shift from uniform payment systems to individual pay based on performance; and
- *Locational flexibility* includes working from home (Reilly 1998; Perrons 1999; Grote & Raeder 2009).

In the human resources literature, employers often use combinations of numerical, temporal and wage flexibility to staff their organisations and control costs. Employees predominantly use flexible hours arrangements (i.e. temporal flexibility) to achieve better work-life balance. The meaning and importance of flexible work practices depends on the employer versus employee perspective. Flexible work practices are often described as employee- or employer-friendly, depending on perceptions of who benefits more – the employee or the employer. Some types of flexible work practices have been termed as “flexploitation” (Gray 2004 cited in Fleetwood 2007, p.389) due to the constraints they place on employee work-life balance. Neutral flexible work practices are perhaps the gold standard in that they meet the needs of employees and employers (e.g. flextime) (Fleetwood 2007). Some human resource experts claim that employee-friendly practices always benefit employers. According to Fleetwood (2007, p. 389) a business case can be made for these types of practices because “employee-friendly flexible work practices make satisfied employees, and satisfied employees are more profitable.”

We need to learn a great deal more about the right balance of employer- versus employee-controlled flexible work practices. Most of our knowledge originates from the business and human resources literature, although more research pertaining to flexible work practices is appearing in

the health care literature. We are beginning to appreciate how flexible work practices influence staff, patient and organisational outcomes. Better data management systems will assist health care managers and researchers with systematically evaluating and studying the impact of flexible work practices on outcomes (Mercer et al. 2010). Better data are also necessary to develop human resource policy and guide legislation (Diallo et al. 2003).

The majority of health care research related to flexible work practices is from developed countries, such as the United States (USA), Canada, the United Kingdom (UK) and Australia. In developing countries, such as African countries and the Philippines, work practices are primarily employer-controlled with few options from the employee standpoint. Lack of control over working conditions and work options is a “push” factor associated with migration of nurses from developing countries to developed countries (ICN 2006; Kingma 2007). As is true for most health services research, flexible work practices have been primarily studied in acute care settings. In a United Kingdom National Health Services (NHS) flexible nursing report by Mercer et al. (2010), work flexibility in community nursing was identified as a research and policy priority to complement the shift in health care delivery from traditional acute care settings to the community.

### **Scope of this paper**

In line with the research specifications, this paper seeks to analyse experiences to date with the implementation of flexible working practices for substantive nurses on permanent contracts with a health care employer/health care facility. Flexible work arrangements achieved through temporary contracts are not explicitly discussed, although research pertaining to temporary workers is used to contrast the advantages and disadvantages related to using substantive staff versus temporary staff. There are also instances when the sources did not clearly differentiate between flexible work practices with respect to type of employee.

This paper seeks to provide an overview of the advantages and disadvantages associated with flexible work practices from the perspective of organisations (employers) and nurses (employees). Necessary conditions for successful implementation are also considered, with examples of some helpful resources available to guide employers and employees in the identification, implementation and evaluation of flexible work practices.

The paper draws on articles, predominantly from peer-reviewed journals, that are found in the business, human resources, health services and nursing literature. Major reports from organisations such as the World Health Organization (WHO) and the International Council of Nurses (ICN) are cited, as well as government publications and flexible work practice examples from business and health care organisations. The majority of literature is based on flexible work practices in developed countries, such as Australia, Canada, Ireland, the UK and USA. Health care literature and flexible work practice examples are primarily based on the acute care sector. Specifically, this paper aims to

- Provide a brief background on flexible work practices in nursing;
- Define the most common flexible work practices in nursing;
- Provide an overview of some of the factors associated with flexible work practices with respect to nurses, work environments and the broader social context;
- Describe the advantages and disadvantages of flexible work practices from the perspective of organisations and substantive nursing staff;

- Identify key issues related to successful identification, implementation and evaluation of flexible work practices; and
- Provide some examples of best practices associated with flexible work practices.



## Chapter 1: Defining flexible work practices

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The term “flexible work” covers an array of employer-employee work arrangements that are structured to accommodate organisational and individual needs, including numbers of working hours, patterns or schedules of hours worked, work location and pay arrangements. Flexible working represents an opportunity for employers to provide a more efficient workforce and for employees to balance work-life demands (Grote & Raeder 2009; Becker et al. 2010).

Employment laws, customs and practices vary considerably by country, shaping the options available for flexible working. Some countries, for instance, offer some or all of the following paid or unpaid work-life options:

- paternity/maternity leave;
- dependent care leave;
- domestic emergency leave; and
- bereavement leave.

The Appendix to this paper (page 45) provides a table of definitions and comments for commonly noted types of flexible work practices: part-time work; flexible work hours/shifts (flextime), self-rostering or self-scheduling; job-sharing; flexible working year; shift swapping; annualised hours contracts; seasonal work; compressed hours; working from home; employer float pools; career breaks; purchased leave; and phased retirement.

These definitions and descriptions are based on literature from developed, well-resourced countries such as the USA and UK. They assume a level of regularity and stability that is rapidly changing in today’s health care environments. Full-time employment, for example, is considered at least 36 hours a week (Rogers et al. 2004) or an average of 75-78.5 hours in a two-week pay period (Blythe et al. 2005). Full-time status is associated with guaranteed hours, benefits and in many instances, priority work hours or shifts (with other staff fitted around them) (Blythe et al. 2005).



## **Chapter 2: Factors associated with flexible work and nursing**

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### **The incidence of flexible work practices in nursing**

A number of factors, including the ageing nursing workforce, chronic nursing shortages and work-life demands have resulted in the increased use of flexible work practices (Becker et al. 2010). Flexible work models seem to be a growing phenomenon among the nursing workforce, due perhaps, to "rapidly evolving nursing work environments" (Batch et al. 2009, p.20). Almost half of the nursing workforce in Australia works part-time with the greatest increase in part-time nurses occurring in the acute care sector (Australian Bureau of Statistics 2005). In the UK, 72% of National Health Service (NHS) substantive nurses are in flexible work arrangements and the most popular flexible work practices are self-scheduling, part-time and flextime contracts (Mercer et al. 2010). Annual ICN global workforce profiles report the percentage of nurses working part-time (less than 35 hours per week). In 2011 some part-time percentages for registered nurses (RNs) were: Canada (29%), Denmark (53%), Germany (40%), Iceland (73%), and New Zealand (48%). The most recent ICN RN workforce data (2010) for Asian countries reported lower part-time percentages than North American and European countries: Hong Kong (2%), Indonesia (15%), Korea (5%), and Thailand (20%) (ICN 2011).

A Japanese nurse survey study from one large Tokyo hospital found that 86% of nurses were in full-time positions (Tanaka et al. 2010). According to these researchers, overwork (e.g. long working hours and mandatory overtime) is a major problem in Japan, and the Japanese government has been implementing work-life balance legislation to better protect employees. Despite labour laws, however, there are cultural expectations that people will work long hours. In the nurse survey, only 4% of respondents knew about work-life balance policies and laws, suggesting that this concept is not well understood or established among Japanese nurses. The country/cultural context, therefore, may explain why some countries have higher or lower percentages of workers in flexible work arrangements.

Cross-country comparisons of flexible work practice percentages are strongly constrained by the lack of uniform statistical definitions and the types of flexible work practices that are regularly monitored (Diallo et al. 2003). ICN, for instance, focuses on part-time nurse percentages. With respect to part-time work, the UK considers part-time as everything from a few hours to 30 hours/week while in Germany it is less than 36 hours/week. Some countries do not differentiate between substantive versus temporary part-time employees — hours worked are the only criterion for part-time status. In other countries, such as Japan, part-time employees are those workers with temporary versus substantive contracts — regardless of hours worked (Mayne et al. 1996; Kalleberg 2000).

Because flexible work practice definitions and measures often vary within and across countries and organisations, pure number comparisons may be meaningless. Rather, it may be more important to look at whether flexible work practices are meeting their intended effects with respect to staff, patient and organisational outcomes. In other words, if flexible work practices are considered integral to government and organisational economic and human resource strategy, are they working? (Mayne et al. 1996; Kalleberg 2000). In any specific health care context, flexible work practices should be part of a strategy. Mion et al. (2006) describe how phased retirement is one aspect of a multicomponent strategy designed to recruit and retain senior nurses. It is the

responsibility of governments and organisations to justify their strategies by carefully considering what flexible work structures and processes result in best possible outcomes. In health care, our unique and common focus should always be the quality of care (Donabedian 1988). Issues related to the implementation and evaluation of flexible work practices will be discussed further on.

## **The nurse labour market context**

The following sections provide a brief insight into some of the main contextual factors that may influence global trends regarding flexible work practices.

### **Global economic recession**

The global economic recession has had a significant, if variable, impact on current nurse employment and future nurse supply projections (WHO 2009a). The financial crisis of 2007 to the present is considered by many economists to be the worst financial crisis since the Great Depression of the 1930s, contributing to the failure of key businesses, declines in consumer wealth with substantial financial commitments incurred by governments, and a significant decline in economic activity (te Veldt 2008).

According to the Royal College of Nursing, UK, there is concern that funding cuts in the health sector and the drive for efficiency savings could result in cutbacks including bed closures, service cancellations and staffing reductions (Carvel & Carter 2009). In North America, the economic downturn has resulted in health care restructuring with reduced health care services and nursing staff cuts. Many nurses eligible for retirement are hanging on to their jobs. Some nurses who had retired have returned to the workforce, and nurses active in the workforce have increased their work hours. All of this has created a bottleneck for younger nurses who are having difficulty finding employment, often settling for temporary work or working more than one part-time job (Little 2007; Buerhaus et al. 2009). With constrained health budgets, Mercer et al. (2010) reported that changed economic circumstances are contributing to employer focus on flexible work practices that can maximise the efficient deployment of staff according to organisational needs and priorities.

### **Global nursing shortages**

As stated in the ICN report on global nursing shortages (ICN 2004, p. 7) "The world has entered a critical period of human resources for health." Shortages, as reflected by national nurse:population ratios, can vary from less than 10 nurses per 100,000 population in some countries to more than 1,000 nurses per 100,000 population: more than a one hundredfold variation. The average nurse:population ratio in high income countries is almost eight times greater than in low income countries, and in many countries, there is a maldistribution of nurses with fewer nurses in rural versus urban areas. African countries are facing the most challenging nurse shortages compounded by the impact of HIV/AIDS and internal and international migration of nurses seeking safer working conditions (ICN 2004).

A broad range of factors are contributing to the global nursing shortages from a demand-supply perspective (Oulton 2006). Demand factors include an ageing population, patients with more complex acuties, and emerging and re-emerging infectious diseases (e.g., HIV/AIDS, malaria, tuberculosis). Among nurse supply factors are an insufficient applicant pool of new nurses and an ageing nursing workforce (Oulton 2006). Unfavourable work environments are leading to nurse burnout and high turnover, particularly among younger nurses (Hayes et al. 2006). Some



predictions indicate that half of the current nursing workforce will be retiring within the next 15 years (Schofield & Beard 2006). The shortage of nurses is peaking in parallel with an ageing population, increasing demands on the health care system and its workers, and necessitating the use of innovative flexible work options (Buerhaus et al. 2009).

### **Nurse workforce characteristics**

#### *Women's participation:*

There has been a significant increase in the number of women working in the paid labour force globally (ILO 2007) due to a shift away from traditional notions of the family unit (i.e. working father, stay-at-home mother); women's improved access to education; the gender equality movement; and family friendly policies, such as those supporting flexible work practices (Harrington et al. 2008). The majority of the nursing workforce around the world is female (ICN 2011).

#### *The ageing workforce:*

The average age of nurses in many countries is over 40 years; some examples are: Canada (45), Ireland (41), US (47) and Thailand (41) (ICHRN 2007a). Given these average ages, in the near future, there are projections of a large exodus of nurses reaching retirement age (ICHRN 2007a). In Canada, for instance, 50% of currently employed nurses are expected to retire within the next decade (Oulton 2006). Despite retirement deferment due to the global recession (Buerhaus & Auerbach 2011), an expected retirement of the largest cohort of nurses, known as Baby Boomers (born 1946-1960), will dramatically affect the projected nursing workforce supply (Hart 2006; Palumbo et al. 2009).

Although definitions of the "older" nurse vary, there is research evidence that women who are 46 years or older are particularly taxed by physical workplace demands, long shifts, rotating shifts, overtime and inflexible scheduling (Letvak & Buck 2008). Given their experiential knowledge, older nurses are a vital human resource (Fitzgerald 2007; Jeffers et al. 2008). Labour force decisions of older working nurses are influenced by the availability of flexible work practices (Palumbo et al. 2009). Older nurses desire reduced hours and less physically demanding work. Some flexible work practices that may particularly suit older nurses are four, six or eight-hour shifts and job sharing (Fitzgerald 2007). With job sharing, two people share a full-time position and negotiate work hours to suit their needs (Gliss 2000). A Canadian study showed that job sharing had a greater impact on job satisfaction than either full-time or part-time status (Kane 1999).

One flexible work model piloted in Canada, the 80/20 model, schedules older nurses to work 80% of their schedule in direct care and 20% of their schedule mentoring and supporting new nurses (Bournes & Ferguson-Pare 2007; CFNU 2012). This model acknowledges older nurses' experiential knowledge and is an important retention strategy. Another retention strategy for the ageing workforce is phased retirement where nurses reduce their working hours as they approach retirement (Lavoie-Tremblay et al. 2006; Hart 2007; Blakeley & Ribeiro 2008). Given the seriousness of the nursing shortage, flexible work practices have also been proposed as a way to "call back" older nurses who have already retired (Lavoie-Tremblay et al. 2006).

### *The younger workforce:*

In developed countries, such as North America, the nursing workforce is characterised as consisting of four generational groups with different work ethics and values. The latest generational group, the “Generation Y” or Millennials (born 1980-2000) (ICHRN 2009) are considered the future of nursing (Lavoie-Tremblay et al. 2008). These nurses are described as being technologically savvy with naïve social skills; they expect frequent feedback and praise (Boychuk Duchscher & Cowin 2004); and they value and prioritise a balance between their personal and professional lives (Stuenkel et al. 2005). In a study of five countries Aiken et al. (2001) found that the percentage of younger nurses (under 30 years) intending to leave their present jobs within the next year was higher than other nurses. Turnover, or the process of transferring or leaving current jobs, is associated with negative outcomes for nurses, patients and organisations. Nurse turnover, for example, disrupts staff morale, decreases staff productivity and may influence quality of patient care delivery (Hayes et al. 2006). Other research has shown inverse relationships between age and turnover (Gray & Phillips 1996; Kiyak et al. 1997 both cited in Lavoie-Tremblay et al. 2008). In a Canadian survey study, Lavoie-Tremblay et al. (2008) found that younger nurses’ perceived imbalance between work effort and reward and lack of social support were key reasons why 61.5% of them intended to leave their current positions for another job in nursing. Approximately 13% of the study population intended to quit the nursing profession due to difficult working conditions and unstable employment. In a US nurse survey study, Wieck et al. (2010) found that one third of Millennial nurses (18-26 year-olds) planned to leave their jobs within the next two years.

Recruitment of younger nurses is a problem due to a variety of other career options that they perceive as more stable and less risky than nursing (Hart 2006). Innovative incentives and retention strategies, such as flexible work options, are necessary to attract and keep this youngest population of nurses. Flexible scheduling is considered a major recruitment and retention strategy for this generation (Broom 2010). Self-scheduling, an example of flexible scheduling, is the process whereby nurses collectively plan and implement their work schedules (Kilpatrick et al. 2006; Bailyn et al. 2007). Flexible work schedules are important to younger nurses who want to control their own time (Shader et al. 2001). A Finnish survey study of younger nurses (less than 30 years) found that 26% were thinking of leaving nursing. They were dissatisfied with salary, workload, uncertain work status and their working hours and shift work. Nurses who were dissatisfied with their work schedules’ impact on work-life balance thought more about leaving the profession (Flinkman et al. 2008).

### **Work conditions**

Work-related stress has significant health consequences for employees. When physiological stress mechanisms are activated too often or too intensely, they can increase the probability and severity of illness (Halpern 2005). For nurses, major sources of workload stress, job dissatisfaction, intent to quit and voluntary turnover are organisational factors such as heavy workloads, unsupportive management, lack of autonomy and control over practice, inflexible work schedules and few opportunities for career progression and professional development (Hayes et al. 2006; ICHRN 2007b).

Stress takes its toll on employees and their families, and it can be costly to employers with respect to absenteeism, voluntary turnover and new employee hiring and training (Halpern 2005). The replacement costs for one nurse in the USA have been estimated to range from \$82,000 to \$88,000. Most of this organisational expense is related to vacancy costs, such as temporary nurse utilisation, bed closures and patient deferrals (Jones 2008). There are costs, however, that are difficult to calculate, such as nurse burnout and low morale and unsafe patient care (Hayes et al. 2006; Jones 2008). As pointed out by Jones (2008), health care organisations may underestimate the significance of nurses' work conditions and turnover rates due to the "opacity" of nurse turnover costs. Nurse turnover has a similar economic impact on other countries. The United Nations (1998, cited in Hayes et al. 2006, p.244) found that nurse migration from South Africa represented an annual loss to the country of \$184,000 per nurse. In Lebanon, nurse migration is a serious problem where one out of five RNs with BSN degrees leaves the country within two years of graduation (El-Jardali et al. 2009). The factors influencing immigration, such as stressful work conditions, are similar to those factors affecting turnover (Hayes et al. 2006).

A US survey study by Strachota et al. (2003) sought to understand the reasons why 6.8% of the nurse population in one health system voluntarily left their nursing positions or changed to casual status over a nine month period. Although nurses often gave several reasons for their employment decisions, the most common reason (50%) was hours worked. Long shift hours, overtime, weekends, nights and holidays resulted in nurses seeking other employment. Inflexible scheduling compounded the issue of long hours. Several respondents (40%) included personal reasons for leaving, such as caring for children and elderly parents, returning to school, and physical and emotional illness. As stated by the authors (p. 115) "With sicker patients and less staff, nurses may feel overwhelmed at the end of the day, returning home remembering the many promises to patients they couldn't keep." Long shifts, overtime, weekends, nights, holidays and weekend overtime were key predictors of intent to leave in other studies (Shader et al 2001; Vetter et al 2001).

In South Africa a nurse survey (Pillay 2009) showed that excessive workloads were the chief source of dissatisfaction, particularly in the public sectors versus private sectors, and public sector rural nurses were the most dissatisfied with all working conditions. Workload issues were influenced by long, irregular and inflexible working hours. Dissatisfied nurses were significantly more likely to indicate a desire to change their sector of employment, quit the profession or work abroad. Because African countries are suffering the greatest nursing shortages globally, the author urged government consideration of flexible work practices, such as self-scheduling, to address nurse job satisfaction and retention.

Flexible work practices are sound business practices with respect to providing more employee control to manage stressful work conditions (Chang & Huang 2005; Halpern 2005). One large US study (Halpern 2005) of men and women from a wide variety of occupations found that availability of work policies that provided employees with the means to plan and to manage stressful work-life demands was significantly associated with fewer reported symptoms of stress, fewer cost reductions to employers (e.g. absenteeism), and greater loyalty to employers. These findings were true for men and women, parents and non-parents. Table 1 contains the six survey items used by Halpern (2005) to query employees about flexible work practices. As stated by Halpern (p. 163) "Everyone has a life outside of work and the benefits of time-flexible work schedules accrue to employers even when employees have few or no obvious family obligations, although flexibility

should offer the greatest benefit for those who need it the most – workers with family or other obligations.”

**Table 1. Flexible work practices survey items**

<ol style="list-style-type: none"><li>1. Can take time off to care for a sick child.</li><li>2. How difficult it is to take time off.</li><li>3. Can choose start/stop times for work.</li><li>4. Whether or not there is a penalty for using flexible work options.</li><li>5. Can work from home.</li><li>6. Can work full or part-time as needed.</li></ol>
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Source: (Halpern 2005, p. 163)

Self-scheduling (Vetter et al. 2001; Pryce et al. 2006) and job-sharing (Kane 1999) are cited in the nursing literature as effective flexible work solutions for problematic work schedules. In a Danish psychiatric hospital, for instance, an open rota (self-scheduling) system significantly improved nurses' reports of work-life balance and job satisfaction (Pryce et al. 2006). A UK study found that compressed schedules for substantive full time staff were associated with enhanced levels of job satisfaction and general well-being. These compressed schedules were also organised to enhance the management of patient care through improved continuity of care (Lea & Bloodworth 2003). Compressed scheduling allows employees to work their total number of hours over fewer days. Work hours, for instance, can be compressed into four or four and a half days a week, or nine days each fortnight. (Trinkoff et al. 2011).

### **Shift work**

A traditional work week consists of eight-hour days in a five-day work week with weekends off. Most health care is provided 24 hours a day, seven days a week. To deliver care around-the-clock, nurses' work is typically organised into shifts of approximately eight hours (day, evening, night shifts) or 12 hours (day, night shifts), and these shifts are organised into work schedules where shifts may be fixed (nurses work the same schedule for an extended period of time) or rotating (nurses work different shifts according to fixed or variable patterns). A variety of different shifts and work schedules exist to meet employer-employee needs, many of them considered flexible work practices, such as flextime and compressed hours. Shifts and work schedules that vary from traditional work weeks are often called alternative work schedules (Havlovic et al. 2002).

There is research evidence that employees perform better and are more satisfied with their jobs when they can work their preferred shifts and schedules (Shader et al. 2001; Havlovic et al. 2002; Pryce et al. 2006). In a Canadian survey study, nurses working preferred shifts and schedules reported less interference with their personal lives and they perceived better service to patients (Havlovic et al. 2002). In the Netherlands, two groups of nurses working in nursing homes were compared with respect to fatigue, health, performance and satisfaction; one group worked eight-hour shifts and the other group worked nine-hour shifts. Nurses working nine-hour shifts were generally more fatigued with more health complaints. They were less satisfied with their work hours and work-life balance, and they rated their performance lower than the eight-hour shift nurses. Over 70% of both groups of nurses preferred to work a maximum of eight-hour shifts. The researchers surmised that one reason for differences between the two groups was lack of choice with respect to shift length (Josten et al. 2003). In a Korean study on levels of nurses' work satisfaction, burnout and life satisfaction, control over shift schedules was a suggested strategy to reduce emotional exhaustion and increase nurses' work satisfaction (Lee et al. 2004).

## **Chapter 3: Advantages and disadvantages of flexible work practices with substantive staff**

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This chapter covers the major factors associated with flexible work practice advantages and disadvantages from the perspective of organisations and substantive nursing staff. Literature related to temporary worker arrangements is used to highlight advantages related to utilising substantive nursing staff.

### **Organisational advantages**

#### Organisational flexibility and cost-effectiveness

Flexible work practices are meant to enhance organisational performance or productivity, especially in uncertain health care environments with significant economic and health human resources constraints. Human resource models, such as the Atkinson model (1984), were introduced to increase organisational flexibility by creating different types of employee classifications to help meet organisational needs, particularly short-term needs. One UK survey study of manufacturing and service organisations found that investment in "progressive human resource practices," such as flexible work options, was positively associated with organisational productivity and profitability. Organisations that used cost-cutting strategies, such as temporary workers on short-term contracts, found less evidence of positive organisational outcomes (Michie & Sheehan 2005).

In health care systems, such as the National Health Service (NHS) UK, different types of nurse employees were established to streamline costs and improve care delivery. In the NHS, for instance, there are substantive nurses and temporary nurses supplied through nursing agencies or the NHS temporary staffing service (Mercer et al. 2010). The UK National Audit Office (NAO) monitors costs related to care provision, and its 2006 report indicated that temporary staffing costs were spiralling out of control (NAO 2006a). A more recent NHS policy mandate has been to reduce dependency on temporary staff with a switch to flexible work practices for substantive staff. Implementation of flexible work practices for substantive staff will hopefully provide the organisational flexibility needed to effectively, efficiently cover staffing needs. The introduction of flexible work practices for substantive staff has been complemented by the introduction of the Improving Working Lives Initiative and the Right to Request legislation (Mercer et al. 2010).

Temporary workers are often used to cover individual shifts and short-term leaves of absence, such as maternity leave. Temporary workers in health care and other industries are typically cost-effective when their work is short duration; temporary workers are not cost-effective when they are used to cover permanent vacancies (Houseman et al. 2003; Hurst and Smith 2011). Effective use of different types of nurses (i.e. temporary, substantive) depends on knowledge of the system, knowledge of human resources and careful planning. The wrong balance or inappropriate utilisation of different types of nurses can lead to increased costs to organisations and quality concerns (May et al. 2006; Mercer et al. 2010). Buchan and Thomas (1995) recommended that managers should "profile" their need for temporary staff by conducting regular audits of temporary nurses in order to use them effectively. Inappropriate use, such as using temporary staff to address chronic staffing shortages, should signal the need to re-visit the balance between temporary and substantive staff (Mercer et al. 2010).

In some instances, over-reliance on temporary nurses has resulted from the nursing shortage and managers have depended on short-term solutions, such as temporary staff, salary increases and sign-on bonuses to fill vacancies. Longer-term solutions, including substantive staff flexible work arrangements, are necessary to create a more sustainable nursing workforce (May et al. 2006). In a US study of hospital strategies related to nursing shortages, May et al. (2006) found that when hospitals' primary strategies were short-term approaches, such as heavy reliance on temporary staff, nurse shortages actually worsened. High costs were most attributed to the two most common short-term strategies, temporary staff use and increased salaries. Quality concerns were also related to use of temporary staff and inexperienced nurses to fill vacancies. As one nurse executive noted, "We have bodies, but we don't have seasoned bodies" (May et al. 2006, p.26).

### **Better quality; continuity of care**

Flexible work practices are an important organisational strategy for building an effective, sustainable workforce of substantive nursing staff (Mercer et al. 2010). There are quality and safety concerns associated with employing temporary versus substantive nurses. Temporary nurses may lack organisational knowledge (e.g. patient population, procedures, policies, physical layout and resources) which can hinder their effectiveness and burden other staff (Hurst & Smith 2010). Quality concerns are raised when temporary staff typically receive compressed orientations/inductions and are excluded from mandatory training and regular performance appraisals. In the UK, for instance, 70% of temporary nurses from hospital internal resource pools (versus external agency nurses) did not receive mandatory training over a 12 month period (NAO 2006a).

Highly effective health care teams are associated with safe, quality care delivery. Effective teams rely on sharing a common set of competencies related to their specific patient population and practice context (Marshall & Robson 2005; Baker et al. 2006). Temporary nurses are "unknowns" to the rest of the staff and the patients. In the UK, the National Patient Safety Agency found that 13% of clinical incidents were due to nurses' lack of familiarity with the environment and 8% were due to lack of experience or training (NAO 2006a). The use of temporary staff was identified as a barrier to sound infection control (NAO 2009). A Canadian study found that higher hospital death rates were associated with temporary staffing and other factors, such as inadequate continuing education (Estabrooks et al. 2005).

Temporary staff are one of the factors contributing to "churn" or the "degree of change to staffing" (Creegan et al. 2003; Duffield et al. 2009, p. 104). Churn can negatively influence continuity of care, and also contributes to turnover. As cited in Duffield et al. (2009, p. 104) continuity of care is associated with decreased hospitalisation and improved patient satisfaction (Beattie et al. 2005 in Duffield et al. 2009), improved quality of care (Solberg et al. 2006 in Duffield et al.), and cost effectiveness (Sander et al. 2008 in Duffield et al.). Continuity of care and turnover are related, because voluntary turnover significantly contributes to staff instability and lack of consistent care provision (Duffield et al. 2009). Turnover can be a vicious cycle for nurses and managers; nurse turnover leads to more nurse turnover due to the unstable work conditions that erode staff morale and increase stress (Hayes et al. 2006). Turnover is also costly to an organisation with respect to ongoing replacement costs (recruitment, orientation, supervision) where the costs of RN turnover can range from \$82,000 to \$88,000 (Jones 2008). Jones (2008) found that the most expensive component of turnover costs is staff vacancies — and filling them using temporary nurses.

Flexible work practices with substantive staff have not been associated with the same concerns in quality of care and continuity of care as those described for temporary work situations. In Australia, for instance, flexible work practices, such as self-scheduling and compressed shifts, did not increase the number of safety incidents and patient complaints (Sullivan 2002, cited in Mercer et al. 2010). One study in the UK (Hurst & Smith 2010) conducted a comparison of wards using only substantive staff versus wards with permanent/temporary staff mix. They found that the staff mix wards spent less direct time with patients and more non-productive down-time. This study also showed that substantive/temporary staff mix wards were more expensive to run than substantive staff wards.

### **Recruitment and retention: building a diverse workforce**

The current nursing workforce is comprised of several generations, each with different work-life demands and needs. Flexible work practices are a key recruitment/retention strategy for younger and older nurses (Hart 2006). Career breaks are associated with extended leave for personal reasons. Although these breaks have been traditionally associated with mothers who take time to raise infants and young children, more people are requesting time off for personal and professional development (Career Break Site 2012). A UK qualitative study by Durand and Randhawa (2002) found that flexible work practices, increased salaries and valuing of staff influenced their decisions to return to practice after taking a career break. An Australian study surveyed women who took career breaks for child-related reasons. Forty-five percent of these women would have worked part-time if the option had been available to them (Arun et al. 2004).

Flexible work practices have been linked with "magnet" hospital/healthy work environments that are known to attract and retain nurses (Aiken et al. 2001; Heath et al. 2004; Schmalenberg & Kramer 2008; ICHRN 2007b). The desire for flexible work practices appears to be a global nursing phenomenon (Stone et al. 2003; ICN 2004). The report by Buchan and Calman (ICN 2004, p. 39) on global nursing shortages states, "The key is to identify which flexible employment practices and pay and non-pay incentives are effective in specific labour market conditions, and for specific groups of nurses and other workers."

Flexible work practices are also considered diversity initiatives, or ways to recruit and retain a more diverse workforce pool (Jayne & Dipboye 2004). Diversity initiatives are becoming commonplace in countries, such as the USA, where the population and the labour workforce are growing in racial and cultural diversity (Jayne & Dipboye 2004). A growing body of evidence suggests that a more diverse health care workforce is needed to ensure better access and quality of care delivery for culturally and racially diverse patient populations. A more diverse nursing workforce is associated with culturally competent care — care designed to reduce racial and ethnic disparities (Anderson et al. 2003; Gilliss et al. 2010). Rather than being viewed as added work for management, flexible work practices are evidence of organisational diversity; "flexing" to meet the needs of diverse employees (e.g. Baby Boomers, women, people with disabilities, the next generation), who in turn, contribute to culturally competent health care systems.

## **Nursing advantages**

### **Work-life balance and choice**

Flexible work practices for substantive staff provide an array of work options to help meet work-life demands. As stated by Fleetwood (2007, p. 388), "the practices associated with work life balance

are inextricably linked to the practices associated with flexible working..." A Japanese study (Tanaka et al 2010) found that there were significant relationships between nurses' subjective health assessments and work-life balance: less healthy nurses reported worse work-life balance. In addition, lower job satisfaction and motivation were associated with worse work-life balance. Choice is an important consideration with respect to the link between better health and well-being and flexible work practices (Tanaka et al. 2010). Temporary working arrangements are primarily driven by employer demand - not employees (Houseman et al. 2003; Mercer et al. 2010). Health care restructuring has also forced many nurses into involuntary temporary positions (Grinspun 2003). When individuals have control or choice over their work, they are more satisfied and have lower intentions to leave (Holtom et al. 2002). When nurses can choose how to integrate their work schedules with family/personal commitments, they are more satisfied and more committed to their organisations (Ingersoll et al. 2002).

### **Security and belonging**

Social cohesion or a sense of belonging is an important aspect of nurse job satisfaction (Shader et al 2001; DiMeglio et al. 2005). Group cohesion is associated with more stable work schedules, less stress and anticipated turnover (Shader et al. 2001). Yeh et al. (2007) found among Taiwanese nurses that substantive nurses had less job stress and higher affective commitment to their organisations than temporary nurses. Affective commitment is associated with decreased turnover (Hayes et al 2006).

There is some research evidence that suggests psychological differences between temporary workers and substantive staff. Temporary workers may have stronger withdrawal intentions, less job satisfaction and less commitment than substantive staff (De Witte & Naswall 2003; Thorsteinson 2003). They may also engage in fewer organisational citizenship behaviours. Organisational citizenship behaviours are considered employee "extra role behaviours" that go above and beyond typical role behaviours. These behaviours enhance organisational functioning and the quality of work relationships. Some examples include offering to help peers or participating in meetings and functions that are not mandated (Van Dyne & Ang 1998). Substantive staff may, therefore, be more disposed to feel a sense of commitment to their peers and the organisation.

When nurses' sense of belonging and workplace social support networks are disrupted, they can experience a sense of loss and increased stress (MacPhee 2000; Schoolfield & Orduna; Yeh et al. 2007). Temporary nurses or lack of consistent staff can contribute to breakdowns in team cohesiveness (Kalisch & Begeny 2005) and sense of community (Manion & Bartholomex 2004). A mix of temporary workers, therefore, may influence the sense of group cohesion and community that is important to substantive staff. As mentioned by Yeh et al. (2007 p. 119), "The long term consequences of high levels of job stress and low organisational and occupational commitment among temporary nurses need to be taken into consideration when calculating the short-versus-long term benefits of hiring them."

### **Organisational disadvantages**

#### **Scheduling complexity; managerial workload**

Although flexible work practices can create a more diverse pool of nurses to meet staffing needs, the many flexible work arrangements can add to managers' span of control and workload.



Managers are responsible for coordinating care delivery across the different flexible work arrangements, and all these staff require guidance, performance appraisals and mandatory training (Duffield et al. 2009). Managers are accountable for ensuring that appropriate organisational supports are in place with respect to different flexible work practices, such as policies and education (Becker et al. 2010). Generating stable or consistent staffing patterns amongst many flexible work arrangements also increases managers' responsibilities. Kalisch et al. (2008) found that flexible schedules of four, six and eight-hour shifts resulted in frequent staff changes, ineffective teamwork and constant shifting of staff that disrupted continuity of care and posed patient safety risks. To manage their workloads, managers have sometimes limited the number of flexible contracts under their management (Curtis et al. 2006).

### **Organisational investment; culture change**

Flexible work practices should be supported by a human resource (HR) strategy with accompanying policies, practices and procedures. Development, implementation and evaluation of HR strategy require a considerable organisational investment to do it well (Biggs 1998; Diallo et al. 2003; Harrington et al. 2008; Rondeau et al. 2009). Culture can also be difficult to change, particularly with lack of support from management and staff. In one Australian example (Biggs 1998), flexible work policies were in place, but the organisational culture focused on meeting business objectives and, because "it had never been done before", management and co-workers were resistant to change. There may be negative outcomes on employee work relationships and hidden organisational costs when organisations are unable to align flexible work practices with traditional work models. Alignment problems are more acute within cultures that still value previous industrial notions of the "full time 'ideal worker'" (Batch et al. 2009, p.23). Particularly within complex health care organisations, there can be a variety of sub-cultures with different priorities. In these instances, management needs to support a common vision and strategy with respect to flexible work practices (Biggs 1998; Berwick 2003).

Many organisations do not systematically collect quantitative data related to the costs and benefits of flexible work practices. Business cases often depend on these data to evaluate and provide concrete evidence that supports flexible work practices as important components of organisational HR strategy. As health care organisations seek to develop more efficient business models in our global recession, the need for reliable quantitative data which can support the business case for flexible work practices is highlighted (Halpern 2005; Harrington et al. 2008). Systematic data are also needed to meet accreditation and regulation standards. The array of flexible work practices can increase the resources needed to demonstrate regulatory and legislative compliance (Quinlan 2003).

### **Nursing disadvantages**

#### **Risks: job security, skills erosion, fatigue**

Some flexible work practices, particularly part-time work or reduced hours, are often associated with no/reduced benefits and job insecurity. Although many nurses, such as older nurses and nurses with young children, may prefer part-time status, they may be unwilling to lose guaranteed hours or full-time benefits (Blythe et al. 2005). Lack of job security and the stressors associated with it, however, are more commonly associated with temporary work contracts (Yeh et al. 2007).

Depending on the nature of the work, some flexible work practices, such as part-time work, may lead to skills erosion if reduced hours result in employees' inability to maintain their competencies and keep pace with innovations. Inability to maintain and acquire work-based knowledge and skills can result in these employees being shunted to a narrower range of tasks, creating a vicious cycle of skills erosion (Gourlay 2002). The nature of the work and specific flexible work practices have to be carefully considered by nurses and management to prevent the loss or under-utilisation of nurse competencies (Edwards & Robinson 2004).

Although compressed schedules can be popular with nurses, the organisation of worked hours/shifts also needs to be carefully considered by nurses and management. An extended work schedule is defined as a schedule that extends beyond eight hours/day and 35-40 hours/week. Nurses' extended work schedules have been associated with chronic fatigue, stress, emotional exhaustion, and performance and reaction time deficits. Some nurses may want to work extended hours, but safety-sensitive organisations and governments are beginning to regulate work hours for employee and public safety (Trinkoff et al. 2006).

### **Gender dynamics**

Flexible work practices should apply to all employees, but they are "highly gendered" with more women than men seeking them out. This may be due to perceptions that flexible work options are intended for those with caretaking responsibilities – traditional female roles (Whittock et al. 2002). These beliefs are particularly prevalent within work cultures based on traditional male career ladders (Brewer 2000; Harrington et al. 2008; Maher et al. 2008). Some reports from the UK have indicated that men will not utilise flexible work practices because they are perceived as a lack of career commitment – adversely influencing career progression opportunities (Hogarth et al. 2001; Kodz et al. 2002). Based on an Irish interview study with 14 women from nursing, health care administration and speech therapy who had used flexible work options, Harrington et al. (2008) documented how female interviewees used terms such as "parked" and "plateaued" to describe their careers after reducing hours or taking breaks to raise their children. "None of the interviewees spoke of the 'traditional' career with long term goal setting and clearly defined career objectives" (Harrington et al. 2008, p 174). Although flexible work practices are valued for their capacity to accommodate work-life demands, they may contribute to a gender bias that can hinder women's career opportunities. In Australia, female nurses utilising flexible work options also equated flexible work opportunities with limited career progression and development. They found that senior nursing positions and management roles, in particular, were often not available to them because these positions were not offered as flexible work options (e.g. part-time) and often required significant overtime (Maher et al. 2008).

### **Disconnection**

"Face-time" or physical presence (versus actual productivity) is often regarded as a sign of organisational commitment. Many work cultures place a great deal of significance on visible presence (Harrington et al. 2008). In the Irish survey study by Harrington et al. (2008) some interviewees felt that managers and peers equated reduced hours with decreased commitment. On the contrary, these individuals felt very committed to their organisations. They felt that access to flexible work arrangements had actually strengthened their psychological contract or attachment to the organisation. Individuals who seek flexible work options, therefore, may have to cope with the cultural importance of visible presence (Brewer 2000; McDonald et al. 2007).

In one Australian interview study, part-time nurses felt disconnected from the workplace and unable to achieve their “personal optimal nursing potential” (Nagle et al. 2008). Their feelings of disconnection were influenced by lack of access to regular workplace communications and professional development opportunities. These nurses also had the impression that they were unable to actively contribute to practice environment decision-making, and they sensed fewer opportunities for career progression. Additionally, they felt that they had to spend more time than their full-time peers to stay connected with the workplace, such as attending meetings on their own time. They felt strong demands on them to conform to traditional organisational expectations and often juggled their schedules ("corrective juggling") to attend meetings and educational sessions. Examples of corrective juggling included part-time nurses' decisions to increase or re-schedule their work hours to accommodate workplace demands (Nagle et al. 2008).

### **The need for additional resources**

Particularly in the current economic climate, flexible work hours may not be enough to meet the demands of work and family (Maher et al. 2008). In Australia, a study from the Centre for Women's Studies and Gender Research (Maher et al. 2008) found that the traditional assumptions about the family life cycle no longer hold. In the study, women assumed that they would reduce their work hours while their children were young and resume their careers as children moved into school. In reality, family schedules became more complex due to extra-curricular activities. Work hours, even reduced flex hours, became more difficult to balance with family needs. Flex hours allow employees to vary their work hours within specified guidelines (HRSDC 2011). Flexible work options, therefore, are an important consideration with respect to work-life balance, but these options, by themselves, may not be sufficient to meet contemporary work-life demands. Work-life policies may need to include other resources and supports necessary to augment existing flexible work options (Crompton & Lyonnette 2006; Maher et al. 2008).

### **Summary**

Table 2 summarises the major advantages and disadvantages associated with flexible work practices for organisations and substantive nursing staff. These advantages and disadvantages must be considered with respect to the health care/country context and the presence of effective HR strategy.

**Table 2. Major advantages and disadvantages of flexible work practices**

<p><b>Major organisational advantages</b></p> <ul style="list-style-type: none"> <li>• Increased flexibility to meet staffing needs</li> <li>• Improved continuity of care</li> <li>• Healthy work environments (e.g. meeting nurses' work preferences)</li> <li>• Committed, satisfied nurses</li> <li>• Multi-generational nurse recruitment and retention</li> </ul> <p><b>Better staffing, continuity of care, healthy work environments, committed, satisfied nurses=safe, quality care for patients, staff, the organisation. These same factors serve as powerful nurse recruitment and retention strategies.</b></p>
<p><b>Major organisational disadvantages</b></p> <ul style="list-style-type: none"> <li>• Increased complexity to managerial work</li> <li>• Increased complexity to accreditation and regulatory processes</li> <li>• Vigilant monitoring, astute appraisal of staffing patterns and outcomes</li> <li>• Human resource policies, protocols, resources</li> <li>• Culture change</li> </ul> <p><b>For innovative, excellent health care organisations, are these really disadvantages — or are they signs of organisational capacity to be flexible, adapt and innovate?</b></p>
<p><b>Major nursing advantages</b></p> <ul style="list-style-type: none"> <li>• Work-life balance</li> <li>• Choice</li> </ul> <p><b>Nurses need flexible work options to manage work-life demands, and choice or control over flexible work options is associated with less stress and better health.</b></p>
<p><b>Major nursing disadvantages</b></p> <ul style="list-style-type: none"> <li>• Potential job insecurity, lack of benefits (e.g. part-time work, reduced work hours)</li> <li>• Skills erosion</li> <li>• Decreased connection with colleagues, organisation</li> <li>• Career progression obstacles</li> <li>• The need for additional resources, services to meet work-life demands</li> </ul> <p><b>Flexible work practices require employee-employer collaboration to reduce the impact of potential skills erosion, lack of connection, career obstacles, and complex work-life challenges, such as the need for child-care services. Employers and employees, in turn, need the support of government to ensure real work-life balance.</b></p>

## Chapter 4: Strategies to enable flexible work practices: Global to local

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### A global framework

Flexible work is a human resources strategy intended to recruit and retain nurses. The World Health Organization (WHO) recommends a lifespan approach to monitor and evaluate countries' human resource management. There are three lifespan stages: the *entry stage* focuses on educational investments and ethical recruitment practices; the *active workforce stage* highlights strategies for enhancing available human resources; and the *exit stage* deals with migration and attrition. The WHO stresses that flexible work practices should be essential strategies in each WHO lifespan phase (WHO 2009b).

The WHO lifespan stages require standardised indicators or measures to assess and evaluate the effectiveness of human resource strategies, such as flexible work practices. A collaboration between WHO, the World Bank, and the United States Agency for International Development created a handbook with a defined set of indicators and measurement strategies for evaluating countries' health care workforce status: The handbook was especially designed for low and middle income countries (WHO 2009b). Although low income and middle income countries tend to have the most fragmented and unreliable human resource data, "Most, if not all countries lack a harmonised dedicated system for collecting, processing and disseminating comprehensive, timely information on their health workforce, including stock, distribution, expenditures and determinants of change....As a result, ministries of health and other stakeholders often depend on ad hoc reports compiled from different sources, for which the completeness, timeliness and comparability are widely variable" (WHO 2009b p.7). The WHO handbook, therefore, provides a global framework – a starting point, perhaps, for how countries can "harmonise" their approaches to human resources data collection, collation and evaluation.

### Policy and legislation

Policy and legislation enable the enactment of flexible work practices. Workforce planning and human resources policies need to be informed by reliable data and guided by visionary leadership (Diallo et al. 2003; WHO 2009b). In a Canadian province, for instance, ineffective workforce planning may have been due to lack of informed leadership (Scott-Findley et al. 2002). As stated by Quinlan (2003, p.17), "It is essential that the nature and quality of jobs become a central issue of national and multinational policy development, not an afterthought."

In the UK, the NHS has a series of initiatives (e.g. Improving Working Lives) and Right to Request legislation to address nurse shortage issues. In the European Union, the European Working Time Directive has been responsible for the implementation of flexible work practices and other systems reforms meant to reduce health care professionals' workloads (Mercer et al. 2010). Quality of work life legislation in the European Union arose from "an integrated strategy to promote productive, satisfying and healthier jobs" (Quinlan 2003, p. 17). These actions originated in 2001, accompanied by a series of work quality indicators to evaluate the structures, processes and outcomes associated with new work arrangements. Australia's Fair Work Act (Fair Work Australia n.d.) was legislated in 2009 to balance the needs of employers, employees and unions. In South

Africa, a recent (2008) Nurse Strategy to recruit and retain nurses is based on a 2003 National Health Act that advocates for flexible scheduling and deployment (Department of Health Republic of South Africa 2008). In Asia, Singapore, for instance, is becoming a pioneer for other Asian countries. The government conducted a study that showed how a one dollar investment in enacting work-life policies translated into almost double (\$1.68) return with respect to higher productivity and decreased turnover. As a result, one Singapore company implemented job sharing, part-time jobs and flextime based on new (2006) work-life policies (CNBC 2010). With 7% estimated productivity loss occurring on a global basis, flexible work policies are becoming the norm in organisations committed to human resource retention (CNBC 2010).

## **Effective management**

Leadership/management training and development should be a priority to ensure the presence of competent managers at local levels who know how to balance employer-employee priorities and other stakeholder (e.g. government, public) demands. Effective nurse managers are especially important to address the multi-generational issues related to recruitment and retention (ICHRN 2009; Wieck et al. 2010).

Active manager involvement in matching flexible work options to nurse work-life needs results in better outcomes (McDonald et al. 2007). Managers need to know how to "bundle" human resource practices, such as flexible work options and other work-life practices, that complement each other and fit with organisational strategy (Harrington et al. 2008). Thompson et al. (1999) found that managerial support of work-life balance policies was the most important factor with respect to employee use of family-friendly options, such as flexible work arrangements. Managers can be an important buffer against cultural pressures to conform to traditional work models (Blair-Loy & Wharton 2002; McDonald et al. 2007); they can ensure that substantive employees who are using flexible work practices receive the same training and career progression opportunities as other employees; they can evaluate staff on objective performance outcomes versus "face time;" and they can pave the way for others by modelling use of flexible work options (McDonald et al. 2007).

Managers are responsible for ensuring a good 'fit' between patient care needs and availability of competent staff. They monitor and evaluate indicators related to workforce practices such as flexible work options (Yukl 2006). Traditionally, they have focused on cost controls, but a new emphasis needs to be placed on analysing real-time data patterns and variations so that best use can be made of flexible work options, creating a better congruence between staffing needs and employee preferences (Mercer et al. 2010). The UK National Health Service, for example, uses an electronic rostering system to provide managers with truer pictures of effective versus ineffective staffing patterns (NAO 2007). Managers can also use data to internally and externally benchmark (i.e. comparing quality indicators across and between organisations). Managerial day-to-day analyses of staffing patterns and regular benchmarking activities can help identify flexible work best practices. "New technology and improved metrics are also giving managers scope to better understand the links between staffing and outcome/quality indicators" (Mercer et al. 2010, p. 35).

Health care managers can draw upon the business/service community for human resources innovations. Business in the Community (BITC) UK profiles best practices and has a number of online resources: opportunities to benchmark with similar organisations and access to research

findings associated with a variety of human resources topics, such as workplace diversity and the ageing workforce. Table 3 provides examples of some BITC management best practices to successfully enact flexible work options.

**Table 3. Flexible work best practices from Business in the Community UK (BITC 2012).**

- Management should regularly review the uptake of flexible work options and hold focus groups with staff to garner their opinions.
- Flexible work requests should be reviewed and customised on a case-by-case basis.
- Obtain union support.
- Pilot and fully evaluate new flexible work options. Incorporate employee input to find the best way to make it work.
- Hold ongoing training for management and ongoing workshops (e.g., work-life balance, career development) for employees.
- Share organisational data (e.g., scorecards or dashboards) so that employees know more about staffing issues and staffing needs.
- Set up employee support networks to encourage knowledge/idea sharing (e.g., Parents and Carers Network, Flexible Working Network)
- Create a bank of flexible work exemplars (e.g., Flexible Working Champions) and publicise, share success stories through different avenues (e.g. flyers, bulletin boards, website).
- Collaborate with researchers to demonstrate how flexible work practices make a difference with respect to staff, patients and the organisation.

### **Communications and teamwork**

Effective organisational communications are necessary to build and maintain effective working relationships between staff, management and other stakeholders (i.e. individuals/groups with a vested interest in the organisation) (Batch et al. 2009). Effective communications are also associated with better teamwork and patient care delivery (Leonard et al. 2004). Effective communication strategies are particularly important when employees are working in a variety of flexible work arrangements (Batch et al. 2009). Communications and teamwork training should be available to all employees and management, championed by leaders within the organisation (Leonard et al. 2004; Batch et al. 2009). A popular teamwork training model is Team STEPPS (Strategies, Tools to Enhance Performance and Patient Safety) that was developed by the US Agency for Healthcare Research and Quality (AHRQ) and the US Department of Defense. This model emphasises the importance of leadership, situational awareness and monitoring, mutual support and effective communications. The model is based on crew work within the aviation industry, adapted for health care systems (AHRQ 2006), and has been tested and used in US health care settings (Clancy & Tornberg 2007; Salas et al. 2008). Five health care sites in Australia implemented Team STEPPS over an eight-month period. A case study of one mental health site showed that this approach had a significant positive impact on communications, teamwork and patient safety culture (Stead et al. 2009).





## Conclusion

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When managed responsibly, flexible work practices can benefit employers and employees. Although current evidence is promising, more research is needed to establish direct links between flexible work practices and nurse, patient and organisational outcomes. Governments and organisations can pave the way by using existing data sources to look for trends and patterns to promote better human resource policy and action, while the adoption and utilisation of technology will further enhance our knowledge base. Technology will also enable us to communicate more broadly, globally, as share what we know about flexible work practices.

In our complex, constantly changing world, flexible work practices are necessary to meet nurses' work-life demands, and they are necessary for health care organisations to meet staffing needs. Some simple rules apply to support a win-win situation for nurses, patients and organisations:

1. There must be choice. Flexible work practices have better outcomes when they are voluntary versus involuntary.
2. There must be collaboration. Nurses know best what will work for them, and their involvement in staffing and scheduling decisions can make the difference between success and failure.
3. There must be give and take — a willingness from employers and employees to adapt to the needs of the other.

Flexible work practices hold the greatest relevance with respect to the bigger picture — global nursing shortages. Evidence suggests that everywhere in the world, flexible work practices are a major recruitment and retention strategy. Nurses are the major care providers in every health care context and their presence, perhaps, is a gauge of the health care systems' capacity to meet the needs of the world's people (Johnstone 2007). As stated by Rosemary Bryant, President of the International Council of Nurses, "without nurses there can be no health system." (cited in Johnstone 2007 p.37).



## References

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Agency for Healthcare Research and Quality (2006). *TeamSTEPPS Instructor Guide*. Rockville, Md. (AHRQ Publication No. 06-0020-0.)

Aiken LH, Clarke SP, Sloane DM, Sochalski JA, Busse R, Clarke H, Giovannetti P, Hunt J, Rafferty AM and Shamian J (2001). Nurses' reports on hospital care in five countries. *Health Affairs*, 20 (3): 43-53.

Anderson L, Scrimshaw S, Fullilove M, Fielding J, Normand J, and the task force on community preventive services (2003). Culturally competent healthcare systems: A systematic review. *American Journal of Preventive Medicine*, 24 (3S): 68-79.

Arun S, Arun T and Borooah V (2004). The effects of career breaks on the working lives of women. *Feminist Economics*, 10(1): 65-84.

Atkinson J (1984). Manpower strategies for flexible organisations. *Personnel Management*, August: 28-31.

Australian Bureau of Statistics, Social Trends (2005). Paid work: Nursing Workers. Available at: [www.abs.gov.au/Ausstats/abs@.nsf/0/8A87EF112B5BCF8BCA25703B0080CCD9](http://www.abs.gov.au/Ausstats/abs@.nsf/0/8A87EF112B5BCF8BCA25703B0080CCD9). Accessed on 3 January 2012.

Australian Government/Australian Agency for International Development (2009-2011). Enterprise Agreement (see *Purchased Leave* on p. 27). Available at: [www.ausaid.gov.au/Publications/Documents/ea-0911.pdf](http://www.ausaid.gov.au/Publications/Documents/ea-0911.pdf). Accessed on 3 January 2012.

Bailyn L, Collins R and Song Y (2007). Self-scheduling for hospital nurses: an attempt and its difficulties. *Journal of Nursing Management*, 15: 72-77.

Baker D, Day R and Salas E (2006). Teamwork as an essential component of high reliability organisations. *Health Services Research*, 41(4): 1576-1598.

Batch M, Barnard A and Windsor C (2009). Who's talking? Communication and the casual/part-time nurse: A literature review. *Contemporary Nurse*, 33 (1) : 20-29

Becker S, McCutcheon H and Hegney D (2010). Casualisation in the nursing workforce-the need to make it work. *Australian Journal of Advanced Nursing*, 28(1): 45-51.

Berwick D (2003). Disseminating innovations in health care. *Journal of the American Medical Association*, 289(15): 1969-1975.

Bester M, Nieuwoudt I and Van Vuuren J (2007). Finding good nurse duty schedules: A case study. *Journal of Scheduling*, 10(6):387-405.

- Biggs S (1998). *Flexible Work Practices: The Reality Versus the Rhetoric*. Australian Institute of Family Studies (AIFS) Conference paper. 6<sup>th</sup> AIFS conference, Melbourne 25-27 1998. Available at: [www.aifs.gov.au/conferences/aifs6/biggs.html](http://www.aifs.gov.au/conferences/aifs6/biggs.html). Accessed on 3 January 2012.
- Blair-Loy M and Wharton A (2002). Employees' use of family-friendly policies and the workplace social context. *Social Forces*, 80(3): 813-845.
- Blakely J and Ribeiro V (2008). Early retirement among registered Nurses: Contributing factors. *Journal of Nursing Management*, 16(1): 29-37.
- Blythe J, Baumann A, Zeytinoglu I, Denton M and Higgins A (2005). Full-time or part-time work in nursing: preferences, tradeoffs and choices. *Healthcare Quarterly*, 8(3): 65-77.
- Bournes D and Ferguson-Pare M (2008). Human becoming and 80/20: An innovative professional development model for nurses. *Nursing Science Quarterly*, 20(3): 237-253.
- Boychuk Duchscher J and Cowin L (2004). Multigenerational nurses in the workplace. *Journal of Nursing Administration*, 34: 493-501.
- Brewer A (2000). Work design for flexible work scheduling: Barriers and gender implications. *Work Design for Flexible Work Scheduling*, 7(1): 33-44.
- Broom C (2010). Entice, engage, endure: adapting evidence-based retention strategies to a new generation of nurses. *Journal of Healthcare Leadership*, 2: 49-60.
- Brunelli L (2012). *What is Telehealth?* Available at: <http://workathomemoms.about.com/od/medicalandnursingjobs/g/telehealth.htm>. Accessed on 3 January 2012.
- Buchan J and Thomas S (1995). Profiling flexible nursing staff: Bank nurses in Scotland. *International Journal of Nursing Studies* 32(3): 288-300.
- Buerhaus P and Auerbach D (2011). The recession's effect on hospital registered nurse employment growth. *Nursing Economic\$,* 29(4): 163-167.
- Buerhaus P, Auerbach D and Staiger D (2009). The recent surge in nurse employment: causes and implications. *Health Affairs*. Doi 10.1377/hlthaff.28.4.w657. Accessed on 10 January 2012.
- Business in the Community (BITC) Available at: [www.bitcdiversity.org.uk/about\\_us/index.html](http://www.bitcdiversity.org.uk/about_us/index.html). Accessed on 13 January 2012.
- Canadian Centre for Occupational Health and Safety (CCOHS) (2008). *Flexible Work Arrangements (See Leaves and Sabbaticals)*. Available at: [www.ccohs.ca/oshanswers/psychosocial/flexible.html?print](http://www.ccohs.ca/oshanswers/psychosocial/flexible.html?print). Accessed on 3 January 2012.

Canadian Federation of Nurses Unions (CFNU) (2012). *Applied Workplace Solutions for Nurses: The Research to Action Project Special Report, Canadian Journal of Nursing Leadership*. Available at: [www.longwoods.com/content/22815](http://www.longwoods.com/content/22815). Accessed on 20 March 2012.

Career Breaks Site (2011). *What Is A Career Break?* Available at: [www.thecareerbreaksite.com/about-career-breaks](http://www.thecareerbreaksite.com/about-career-breaks). Accessed on 3 January 2012.

Carvel J and Carter P (2009). *Nursing and the Economic Downturn*. A roundtable discussion, Royal College of Nursing: London, UK. Available at: [www.rcn.org.uk/\\_data/assets/pdf\\_file/0006/281445/003559.pdf](http://www.rcn.org.uk/_data/assets/pdf_file/0006/281445/003559.pdf). Accessed on 3 January 2012.

Chang WJ and Huang T (2005). Relationship between strategic human resource management and firm performance: A contingency perspective. *International Journal of Manpower*, 26(5): 434-449.

Clancy C and Tornberg D (2007). TeamSTEPPS: assuring optimal teamwork in clinical settings. *American Journal of Medical Quality*, 22(3): 214-217.

Consumer News and Business Channel (CNBC) (2010). "Once unheard of in Asia, flexible work practices gain traction. Available at: [www.cnn.com/id/39946535/Once\\_Unheard\\_of\\_in\\_Asia\\_Flexible\\_Work\\_Practices\\_Gain\\_Traction](http://www.cnn.com/id/39946535/Once_Unheard_of_in_Asia_Flexible_Work_Practices_Gain_Traction). Accessed on 13 January 2012.

Creagan R, Duffield C and Forrester K (2003). Casualisation of the nursing workforce in Australia: driving forces and implications. *Australian Health Review*, 26(1): 201-208.

Crompton R and Lyonette C (2006). Work-life 'balance' in Europe. *Acta Sociologica*, 49(4):379-393.

Curtis P, Ball L and Kirkham M (2006). Flexible working patterns: Balancing service needs or fuelling discontent? *British Journal of Nurse Midwifery*, 14(5):260-264.

Cyr J (2005). Retaining older hospital nurses and delaying their retirement. *Journal of Nursing Administration*, 35(12): 563-567.

Department of Health Republic of South Africa (2008). *Nursing Strategy for South Africa*. Available at: [www.sanc.co.za/pdf/nursing-strategy.pdf](http://www.sanc.co.za/pdf/nursing-strategy.pdf). Accessed on 13 January 2012.

Department of Jobs, Enterprise and Innovation, Ireland (2011). *Zero Hours: The Organisation of Working Time Act, 1997*. Available at: [www.employmentrights.ie/en/media/The%20Organisation%20of%20Working%20Time%20Act,%201997%20Explanatory%20Booklet%20for%20Employers%20and%20Employees%20July%202011.pdf](http://www.employmentrights.ie/en/media/The%20Organisation%20of%20Working%20Time%20Act,%201997%20Explanatory%20Booklet%20for%20Employers%20and%20Employees%20July%202011.pdf). Accessed on 3 January 2012.

De Witte and Naswall K (2003). Objective versus subjective job insecurity: Consequences of temporary work for job satisfaction and organizational commitment in four European countries. *Economic and Industrial Economy*, 24(2): 149-188.

- Diallo K, Zurn P, Gupta N and Dal Poz M (2003). Monitoring and evaluation of human resources for health: an international perspective. *Human Resources for Health*, 1(3): 1-13.
- DiMeglio K, Padula C, Piatek C, Korber S, Barrett A, Ducharme M, Lucas S, Piermont N, Joyal E, DeNicola V and Corry K (2005). Group cohesion and nurse satisfaction: Examination of a team-building approach. *Journal of Nursing Administration*, 35(3): 110-120.
- Donabedian A (1988). The quality of care: How can it be assessed? *Journal of the American Medical Association*, 260(12): 1743-1748.
- Duffield C, Roche M, O'Brien-Pallas L and Catling-Paull C. (2009). The implications of staff 'churn' for nurse managers, staff, and patients. *Nursing Economics*, 27(2): 103-110.
- Durand M and Randhawa G (2002). Nurses' views about returning to work after a career break. *British Journal of Nursing*, 11(7): 477-485.
- Dzuiba-Ellis J (2006). Float pools and resource teams: A review of the literature. *Journal of Nursing Care Quality*, 21(4): 352-359.
- Edwards C and Robinson O (2004). Evaluating the business case for part-time working amongst qualified nurses. *British Journal of Industrial Relations*, 42(1): 167-183.
- El-Jardali F, Merhi M, Jamal D, Dumit N and Mouro G (2009). Assessment of nurse retention challenges and strategies in Lebanese hospitals: the perspective of nursing directors. *Journal of Nursing Management*, 17: 453-462.
- Estabrooks C, Midodzi W, Cummings G, Ricker K and Giovannetti P (2005). The impact of hospital nursing characteristics on 30-day mortality. *Nursing Research*, 54(2): 74-84.
- Fair Work Australia (no date). [www.fwa.gov.au/index.cfm?pagename=home](http://www.fwa.gov.au/index.cfm?pagename=home) Accessed 13 January 2012.
- Fields H, Hessler C, Hibbits S, Jamerson P and Mintun M (2006). Develop a hospital-based nursing sabbatical program. *Nursing Management*, 37(11): 10,12.
- Fitzgerald D (2007). Aging, experienced nurses: Their values and needs. *Contemporary Nurse*, 24(2): 237-242.
- Fitzpatrick J, While A and Roberts J (1999). Shift work and its impact upon nurse performance and research issues. *Journal of Advanced Nursing*, 29(1): 18-27.
- Fleetwood S (2007). Why work-life balance now? *The International Journal of Human Resource Management*, 18(3): 387-400.
- Flinkman M, Laine M, Leino-Kilpi H, Hasselhorn HM and Salanterä S (2008). Explaining young registered Finnish nurses' intention to leave the profession: A questionnaire survey. *International Journal of Nursing Studies*, 45: 727-739.

- Galinsky E, Bond J and Hill J (2004). *When Work Works: A Status Report on Workplace Flexibility*. Families and Work Institute. Available at: <http://familiesandwork.org/3w/research/downloads/status.pdf>. Accessed on 3 January 2012.
- Geiger-Brown J and Trinkoff A (2010). Is it time to pull the plug on 12-hour shifts? Part 3. Harm reduction strategies if keeping 12-hour shifts. *Journal of Nursing Administration*, 40(9):357-359.
- Gilliss C, Powell D and Carter B (2010). Recruiting and retaining a diverse workforce in nursing: From evidence to best practices to policy. *Policy, Politics & Nursing Practice*, 11(4): 294-301.
- Gliss R (2000). Job sharing: an option for professional nurses. *Nursing Economic\$*, January, 2000. Available at: [http://findarticles.com/p/articles/mi\\_m0FSW/is\\_1\\_18/ai\\_n18610961/](http://findarticles.com/p/articles/mi_m0FSW/is_1_18/ai_n18610961/). Accessed on 3 January 2012.
- Gourlay S (2002). Knowledge management and HRD. *Human Resource Development International*, 4: 127-146.
- Grinspun D (2003). Part-time and casual nursing work: The perils of healthcare restructuring. *International Journal of Sociology and Social Policy* 23 (8, 9): 54-75.
- Grote G and Raeder S (2009). Careers and identity in flexible working: Do flexible identities fare better? *Human Relations*, 62(2): 219-244.
- Halpern D (2005). How time-flexible work policies can reduce stress, improve health and save money. *Stress and Health*, 21(3): 157-168.
- Harrington D, Linehan M and Cross C (2008). Flexible working in an Irish public sector organisation: Still a gender issue. *International Journal of Business and Management*, 3(9):166-178.
- Hart K (2007). The aging workforce: Implications for health care organizations. *Nursing Economics*, 25(2): 101-102.
- Hart S (2006). Generational diversity: Impact on recruitment and retention of registered nurses. *Journal of Nursing Administration*, 36(1): 10-12.
- Havlovic S, Lau D and Pinfield L (2002). Repercussions of work schedule congruence among full-time, part-time and contingent nurses. *Health Care Management Review*, 27(4): 30-41.
- Hayes L, O'Brien-Pallas L, Duffeld C, Shamian J, Buchan J, Hughes F, Laschinger H, North N and Stone P (2006). Nurse turnover: A literature review. *International Journal of Nursing Studies*, 43: 237-263.
- Heath J, Johanson W and Blake N (2004). Healthy work environments: A validation of the literature. *Journal of Nursing Administration*, 34(11): 524-530.

Hinshaw A (2006). Keeping patients safe: a collaboration among nurse administrators and researchers. *Nursing Administration Quarterly*, 30(4): 309-320.

Hogarth T, Hasluck C, Pierre G, Winterbotham M and Vivian D (2001). *Work-Life Balance 2000: Baseline Study of Work-Life Balance Practices in Great Britain*. DfEE Research Report No. 249, Nottingham: DfEE Publications. Available at: [www.education.gov.uk/publications/eOrderingDownload/RR249.pdf](http://www.education.gov.uk/publications/eOrderingDownload/RR249.pdf). Accessed on 3 January 2012.

Holtom B, Lee T and Kidd S (2002). The relationship between work status congruence and work-related attitudes and behaviours. *Journal of Applied Psychology*, 87(5): 903-915

Houseman S, Kalleberg A and Erickcek G (2003). The role of temporary agency employment in tight labor markets. *Industrial and Labor Relations Review*, 57(1): 105-127.

Hurst K and Smith A (2011). Temporary nursing staff-cost and quality issues. *Journal of Advanced Nursing*, 67(2): 287-296.

Ingersoll G, Olsan T, Drew-Cates J, DeVinney B and Davies J (2002). Nurses' job satisfaction, organisational commitment and career intent. *Journal of Nursing Administration*, 32(5): 250-263.

Institute of Management Services (2012). *Annualised Hours*. Available at: [www.ims-productivity.com/page.cfm/content/Annualised-Hours/](http://www.ims-productivity.com/page.cfm/content/Annualised-Hours/). Accessed on 10 January 2012.

Institute of Medicine (2004). *Keeping Patients Safe: Transforming the Work Environment of Nurses*. Washington, DC: National Academies Press.

International Centre for Human Resources in Nursing (ICHRN) (2007a) *An Ageing Nursing Workforce*. International Council of Nurses. Available at: [www.icn.ch/images/stories/documents/pillars/sew/ICHRN/Facts\\_Sheets/An\\_Ageing\\_Nursing\\_Workforce.pdf](http://www.icn.ch/images/stories/documents/pillars/sew/ICHRN/Facts_Sheets/An_Ageing_Nursing_Workforce.pdf). Accessed on 10 January 2012.

International Centre for Human Resources in Nursing (ICHRN) (2007b) *Positive Practice Environments*. International Council of Nurses. Available at: [www.icn.ch/images/stories/documents/pillars/sew/ICHRN/Facts\\_Sheets/Positive\\_Practice\\_Environments.pdf](http://www.icn.ch/images/stories/documents/pillars/sew/ICHRN/Facts_Sheets/Positive_Practice_Environments.pdf). Accessed on 12 January 2012.

International Centre for Human Resources in Nursing (ICHRN) (2009). *Managing the Multi-Generational Nursing Workforce: Managerial and Policy Implications* by Manion J. International Council of Nurses: Geneva, Switzerland.

International Council of Nurses (2004). *The Global Shortage of Registered Nurses: An Overview of Issues and Actions* developed by Buchan J and Calman L: Geneva, Switzerland.

International Council of Nurses (2006). *The Global Nursing Shortage: Priority Areas for Intervention*. International Council of Nurses: Geneva, Switzerland.



International Council of Nurses (2011). *Workforce Profile*. Available at: [www.icn.ch/images/stories/documents/pillars/sew/DATASHEET\\_SUMMARY\\_NURSING\\_PROFILE\\_2011.pdf](http://www.icn.ch/images/stories/documents/pillars/sew/DATASHEET_SUMMARY_NURSING_PROFILE_2011.pdf) Accessed on 10 January 2012.

International Labor Organization (2007). *Global Employment Trends for Women*. Available at: [www.wunrn.com/news/2007/03\\_07/03\\_19\\_07/032507\\_ilo.htm](http://www.wunrn.com/news/2007/03_07/03_19_07/032507_ilo.htm). Accessed on 3 January 2012.

Jayne M and Dipboye R (2004). Leveraging diversity to improve business performance: Research findings and recommendations for organizations. *Human Resource Management*, 43(4): 409-424.

Jeffers L, Moseley A and Paterson J (2008). The retention of older nursing workforce: A literature review exploring factors that influence the retention and turnover of older nurses. *Contemporary Nurse*, 30: 46-56

Johnston P and Conway C (1981). Hospital-based "on call" nurses versus outside contract nurses: A creative approach to cost and quality control. *Nursing Forum*, 20(2): 200-212.

Johnstone M-J (2007). Nurse recruitment and retention: Imperatives of imagining the future and taking a proactive stance. *Contemporary Nurse*, 24(2): iii-v.

Jones C (2008). Revisiting nurse turnover costs: adjusting for inflation. *Journal of Nursing Administration*, 38(1): 11-18.

Josten E, Ng-A-Tham J and Thierry H (2003). The effects of extended workdays on fatigue, health, performance and satisfaction in nursing. *Journal of Advanced Nursing*, 44(6): 643-652.

Kalisch B and Begeny S (2005). Improving nursing unit teamwork. *Journal of Nursing Administration*, 35(12):550-556.

Kalisch B, Begeny S and Anderson C (2008). The effect of consistent nursing shifts on teamwork and continuity of care. *Journal of Nursing Administration*, 38(3): 132-137.

Kalleberg A (2000). Nonstandard employment relations: Part-time, temporary and contract work. *Annual Review of Sociology*, 26: 341-365.

Kane D (1999). Job-sharing: A retention strategy for nurses. *Canadian Journal of Nursing Leadership*, 12(4): 16-22.

Kilpatrick K and Lavoie-Tremblay M (2006). Shiftwork: What health care managers need to know. *The Health Care Manager*, 25(2): 160-166.

Kingma M (2007). *Nurses on the Move: Migration and the Global health Care Economy*. Ithaca, NY: ILR Press.

Koch S (2006). Home telehealth-current state and future trends. *International Journal of Medical Informatics*, 75(8): 565-576.

- Kodz J, Harper H and Dench D (2002). *Work Life Balance: Beyond the Rhetoric*. Research Report No. 384. Brighton: Institute for Employment Studies. Available at: [www.employment-studies.co.uk/pubs/summary.php?id=384](http://www.employment-studies.co.uk/pubs/summary.php?id=384). Accessed on 10 January 2012.
- Lavoie-Tremblay M, O'Brien-Pallas L, Gelinac C, Desforges N and Marchionni C (2008). Addressing the turnover issues among news nurses from a generational standpoint. *Journal of Nursing Management*, 16:724-733.
- Lavoie-Tremblay M, O'Brien-Pallas L, Viens C, Brabant L and Gelinac C (2006). Towards an integrated approach for the management of ageing nurses. *Journal of Nursing Management*, 14: 207–212.
- Lea A and Bloodworth C (2003). Modernising the 12-hour shift. *Nursing Standard*, 17(19): 33-36.
- Lee H, Hwang S, Kim J and Daly B (2004). Predictors of life satisfaction of Korean nurses. *Journal of Advanced Nursing*, 48(6): 632-641.
- Leonard M, Graham S and Bonacum D (2004). The human factor: The critical importance of teamwork and communication in providing safe care. *Quality and Safety in Health Care*, 13: 185–190.
- Letvak S and Buck R (2008). Factors influencing work productivity and intent to stay in nursing. *Nursing Economics*, 26(3): 159-165.
- Little L (2007). Nurse migration: A Canadian case study. *Health Research and Educational Trust*, 42(3): 1336-1351.
- MacPhee M (2000). Hospital networking: Comparing the work of nurses with flexible and traditional Schedules. *Journal of Nursing Administration*, 30(4): 190-198.
- Maher J, Lindsay J, Bardoel A and Advocat J (2008). Flexibility and More? Nurses Working and Caring. School of Political and Social Inquiry & The Australian Centre for Research in Employment and Work (ACREW) Monash University: Australia. Available at: [www.buseco.monash.edu.au/mgt/research/acrew/nurses-report.pdf](http://www.buseco.monash.edu.au/mgt/research/acrew/nurses-report.pdf). Accessed on 3 January 2012.
- Manion J and Bartholomew K (2004). Community in the workplace: A proven retention strategy. *Journal of Nursing Administration*, 34(1): 46-53.
- Marshall P and Robson R (2005). Preventing and managing conflict: Vital pieces in the patient safety puzzle. *Healthcare Quarterly*, 8 (special issue): 39-44.
- May J, Bazzoli G and Gerland A (2006). Hospitals' responses to nurse staffing shortages. *Health Affairs*. Doi: 10.1377/hlthaff.25.w16.
- Mayne L, Trgaskis O and Brewster C (1996). A comparative analysis of the link between flexibility and HRM strategy. *Employee Relations*, 18(3): 5-24.

McDonald P, Pini B and Bradley L (2007). Freedom or fallout in local government? How work-life culture impacts employees using flexible work practices. *International Journal of Human Resource Management*, 18(4): 602-622.

Mercer M, Buchan J and Chubb C (2010). *Flexible Nursing, Report for NHS Professionals*, Institute for Employment Studies (ies), UK. Available at: [www.nhsprofessionals.nhs.uk/download/comms/184\\_Nursing%20Report\\_Final\\_07.07.2010.pdf](http://www.nhsprofessionals.nhs.uk/download/comms/184_Nursing%20Report_Final_07.07.2010.pdf). Accessed on 3 January 2012.

Michie J and Sheehan M (2005). Business strategy, human resources, labour market flexibility and competitive advantage. *The International Journal of Human Resource Management*, 16(3): 445-464.

Mion L, Coletta H, Cap M, Fusilero J, Podmore M and Szweda C (2006). Retaining and recruiting mature experienced nurses: A multicomponent organizational strategy. *Journal of Nursing Administration*, 36(3): 148-154.

Nagle L, Williams L, Lauder W and Dwyer T (2008). The realities of part-time nursing: a grounded theory study. *Journal of Nursing Management*, 16: 883-892.

National Audit Office (2006a). *Improving the Use of Temporary Nursing Staff in NHS Acute and Foundation Trusts*. HC1176 Session 2005/2006, 12 July. Available at: [www.nao.org.uk/publications/0506/improving\\_the\\_use\\_of\\_temporary.aspx](http://www.nao.org.uk/publications/0506/improving_the_use_of_temporary.aspx). Accessed on 10 January 2012.

National Audit Office (2006b). *Good Practice in Managing the Use of Temporary Nursing Staff*. Department of Health, UK, 12 July. Available at: [www.nao.org.uk/](http://www.nao.org.uk/). Accessed on 10 January 2012.

National Audit Office UK (2007). *Electronic Rostering: Helping to Improve Workforce Productivity*. Available at: [www.nhsemployers.org/Aboutus/Publications/Documents/E-Rostering%20guidance.pdf](http://www.nhsemployers.org/Aboutus/Publications/Documents/E-Rostering%20guidance.pdf). Accessed on 3 January 2012.

National Audit Office UK (2009). *Reducing healthcare associated infections in hospitals in England*. Available at: [www.nao.org.uk/publications/0809/reducing\\_healthcare\\_associated.aspx](http://www.nao.org.uk/publications/0809/reducing_healthcare_associated.aspx). Accessed on 10 January 2012.

Oke M and Oke A (2011). Implementing innovative flexible work practices in Nigerian local firms: Implications for management of change in less-developed countries. *Journal of Occupational and Organizational Psychology*, 84: 518-543.

Oulton J (2006). The global nursing shortage: An overview of issues and actions. *Policy, Politics, and Nursing Practice*, 7(3 Suppl): 34S-39S

Palumbo M, McIntosh B, Rambur B and Naud S (2009). Retaining an aging nursing workforce: perceptions of human resource practices. *Nursing Economic\$* 27(4): 221-232.

Perrons D (1999). Flexible working patterns and equal opportunities in the European Union: Conflict or compatibility? *European Journal of Women's Studies*, 6: 391-418.

Pillay R (2009). Work satisfaction of professional nurses in South Africa: A comparative analysis of the public and private sectors. *Human Resources for Health*, 7(15): 1-10.

Pocock B, Skinner N and Ichii R (2009). *Work, Life & Workplace Flexibility: The Australian Work and Life Index 2009*. Available at: <http://w3.unisa.edu.au/hawkeinstitute/cwl/documents/AWALI-09-exec.pdf>. Accessed on 3 January 2012.

Pryce J, Albertsen K and Nielsen K (2006). Evaluation of an open-rota system in a Danish psychiatric hospital: A mechanism for improving job satisfaction and work-life balance. *Journal of Nursing Management*, 14(4): 282-288.

Quinlan M (2003). *Flexible Work and Organisational Arrangements-Regulatory Problems and Responses*. Working Paper No. 16. National Research Centre for Occupational Health and Safety Regulation. Available at: [http://regnet.anu.edu.au/sites/default/files/u86/WorkingPaper\\_16.pdf](http://regnet.anu.edu.au/sites/default/files/u86/WorkingPaper_16.pdf). Accessed on 3 January 2012.

Reilly P (1998). Balancing flexibility-meeting the interests of employer and employee. *European Journal of Work and Organizational Psychology*, 7(1): 7-22.

Rogers A, Hwang W-T, Scott L, Aiken L and Dinges D (2004). The working hours of hospital staff nurses and patient safety. *Health Affairs*, 23(4): 202-212.

Rondeau K, Williams E and Wagar T (2009). Developing human capital: What is the impact on nurse turnover? *Journal of Nursing Management*, 17(6): 739-748.

Salas E, Cooke N and Rosen M (2008). On teams, teamwork, and team performance: Discoveries and developments. *Human Factors*, 50(3):540-547.

Schmalenberg C and Kramer M (2008). Essentials of a productive nurse work environment. *Nursing Research*, 57(1): 2-13.

Schmidt L and Nelson D (1996). A seasonal staffing model. *Journal of Nursing Administration*, 26(4): 52-55.

Schofield D and Beard J (2005). Baby boomer doctors and nurses: Demographic change and transitions to retirement. *The Medical Journal of Australia*, 183: 80-83.

Schoolfield M and Orduna A (2001). Understanding staff nurse responses to change: Utilization of a grief-change framework to facilitate innovation. *Clinical Nurse Specialist*, 15(5): 224-229.

Scott-Findlay S, Estabrooks C, Cohn D and Pollock C (2002). Nurse human resource planning in Alberta. What went wrong? *Policy, Politics and Nursing Practice*, 3(4): 348-357.

- Shader K, Broome M, Broome C, Mary E and Nash M (2001). Factors influencing satisfaction and anticipated turnover for nurses in an academic medical center. *Journal of Nursing Administration*, 31(4): 210-216.
- Silvestro R and Silvestro C (2000). An evaluation of nurse rostering practices in the National Health Service. *Journal of Advanced Nursing*, 32(3): 525-535.
- Silvestro R and Silvestro C (2008). Towards a model of strategic roster planning and control: an empirical study of nurse rostering practices in the UK National Health Service. *Health Services Manager*, 21: 93-105.
- Stead K, Kumar S, Schultz T, Tiver S, Pirone C, Adamas R and Wareham C (2009). Teams communicating through STEPPs. *Medical Journal of Australia*. 190 (11): S128-S132.
- Stone S, Tourangeau A, Duffield C, Hughes F, Jones C, O'Brien-Pallas L and Shamian J (2003). Evidence of nurse working conditions: A global perspective. *Policy, Politics & Nursing Practice*, 4(2): 120-130.
- Strachota E, Normandin P, O'Brien N, Clary M and Krukow B (2003). Reasons registered nurses leave or change employment status *Journal of Nursing Administration*, 33(2): 111-117.
- Stuenkel D, Cohen J and de la Cuesta K (2005). The multigenerational nursing work force. *Journal of Nursing Administration*, 35(6): 283-285.
- Tanaka S, Maruyama Y, Ooshima S and Ito H (2010). Working condition of nurses in Japan: awareness of work-life balance among nursing personnel at a university hospital. *Journal of Clinical Nursing*, 20: 12-22.
- Teahan M (1998). Implementation of a self-scheduling system: a solution to more than just schedules! *Journal of Nursing Management*, 6(6): 361-368.
- te Velde DW (2008). *The Global Financial Crisis and Developing Countries: What Countries Are at Risk and What Can Be Done?* Available at: [www.odi.org.uk/resources/docs/3339.pdf](http://www.odi.org.uk/resources/docs/3339.pdf). Accessed on 6 January 2012.
- Thompson C, Beauvais L and Lyness K (1999). When work-family benefits are not enough: The influence of work-family culture on benefit utilization, organizational attachment and work-family conflict, *Journal of Vocational Behaviour*, 54: 392-415.
- Thorsteinson T (2003). Job attitudes of part-time versus full-time workers: A meta-analytic review. *Journal of Occupational and Organisational Psychology*, 76(2): 151-177.
- Trinkoff A, Geiger-Brown J, Brady B, Lipsomb J and Muntaner C (2006). How long and how much are nurses now working? *American Journal of Nursing*, 106(4): 60-71.
- Trinkoff A, Johantgen M, Storr C, Gurses A, Liang Y and Kihye H (2011). Nurses' work schedule characteristics, nurse staffing and patient mortality. *Nursing Research*, 60(1): 1-8.

University of Newcastle, Australia (2012). *Purchased Leave Scheme*. Available at: [www.newcastle.edu.au/service/remuneration-benefits/purchased-leave-scheme.html](http://www.newcastle.edu.au/service/remuneration-benefits/purchased-leave-scheme.html). Accessed on 3 January 2012.

Van Dyne L and Ang S (1988). Organizational citizenship behavior of contingent workers in Singapore. *Academy of Management Journal*, 41(6): 692-703

Vetter E, Felice L and Ingersoll G (2001). Self-scheduling and staff incentives: Meeting patient care needs in the neonatal intensive care unit. *Critical Care Nurse*, 21(4):52-59.

Whittock M, Edwards C, McLaren S and Robinson O (2002). The “tender trap”: gender, part-time nursing and the effects of “family –friendly” policies on career advancements. *Sociology of Health and Illness*, 24(3): 305-326

Wieck K, Dols J and Landrum P (2010). Retention priorities for the intergenerational nurse workforce. *Nursing Forum*, 45(1): 7-17.

Working Time Solutions© (2012). *Annualised Hours*. Available at: [www.workingtime-solutions.com/expertise\\_annualised.htm](http://www.workingtime-solutions.com/expertise_annualised.htm). Accessed on 10 January 2012.

World Health Organization (2009a). *The Financial Crisis and Global Health*. Report of a high-level consultation, WHO: Geneva, Switzerland, January 19, 2009. Available at: [www.who.int/mediacentre/events/meetings/2009\\_financial\\_crisis\\_report\\_en .pdf](http://www.who.int/mediacentre/events/meetings/2009_financial_crisis_report_en.pdf). Accessed on 3 January 2012.

World Health Organization (2009b). *Handbook on Monitoring and Evaluation of Human Resources for Health (with special applications for low- and middle-income countries)*. Geneva, Switzerland.

Yeh Y, Ko J, Chang Y and Chan C (2007). Job stress and work attitudes between temporary and permanently employed nurses. *Stress and Health*, 23(2): 111-120.

Yukl G (2006). *Leadership in Organizations 6<sup>th</sup> edition*. Upper Saddle River, NJ: Pearson Prentice Hall.

## Appendix: Examples of flexible work practices

Type of employment/ arrangement	Definitions	Comments
Part-time work/ reduced hours	<p>Less than full-time work without benefits. (Edwards &amp; Robinson 2004)</p> <p>An Australian source defines part-time work in nursing as working less than 35 hrs per week (Nagle et al. 2008)</p>	<p>One of the most commonly reported flexible work practices (Edwards &amp; Robinson 2004).</p> <p>Although part-time nurses do not receive benefits, they may receive an additional percentage (e.g. 13%) in lieu of benefits. If part-timers have partners with benefits, extra pay and increased work-life flexibility are two advantages of this flexible work practice (Blythe et al. 2005).</p> <p>Part-time nurses typically commit a certain number of hours to their employer, and this may be as little as 2 shifts in a 2-week pay period. There are implications with respect to continuity of care and hence, quality of care (Duffield et al. 2009).</p> <p>Some literature cautions that part-time work may be associated with increased job insecurity and decreased employee well-being (Quinlan 2003; Duffield et al. 2009).</p>
<p>Flexitime/flexible hours or shifts</p> <p>Traditional flexitime</p> <p>Daily flexitime</p>	<p>Flexitime is a contractual arrangement where employees can vary their work schedules within specified guidelines (e.g. negotiations with employers and unions). Employees, for instance, can negotiate start and end times for their shifts and there may be contractual clauses related to flexible lunch periods (HRSDC 2011).</p> <p><u>Traditional flexitime</u> is arranged around core operating hours or peak times when all employees need to be present/available. Employees are expected to stick with their specified flexitime schedule for a certain amount of time (Galinsky et al. 2004).</p> <p><u>Daily flexitime</u> allows employees to select starting and quitting times around core operational hours on a daily basis (Galinsky et al. 2004).</p>	<p>Between 1992-2002, a US National Study of the Changing Workforce showed an increase in flexitime workers from 29 to 43%. Despite an assumption that flexitime is most valued by women with caretaking responsibilities, this study showed that the majority of men (68%) and non-parents (70%) used flexitime when it was available to them (Galinsky et al. 2004).</p> <p>An Australian study showed that employee work flexibility requests (e.g. flexitime) were granted more often to parents of preschoolers versus non-parents, suggesting a bias. In addition, this study showed that most requests were associated with individuals who reported work-life interference/ imbalance problems. After requests were granted, these individuals had decreased reports of work-life interference. The authors noted that governmental and organisational policies should protect the rights of all employees' requests (Pocock et al. 2009).</p>
Self-rostering Self-scheduling	<p>Self-rostering is the process that nurses use to collectively plan and implement their work schedules, typically on a monthly basis. This process requires line manager involvement and scheduling rules and guidelines to address organisational and employee needs</p> <p>In unionized environments, self-scheduling</p>	<p>The National Audit Office (NAO), UK (2006a, b, 2007) found self-rostering worked best on wards where rules had been imposed to ensure a fair allocation of unpopular shifts.</p> <p>Self-scheduling is associated with decreased physiologic stress symptoms (Fitzpatrick et al. 1999).</p> <p>Self-scheduling is a successful retention strategy for younger and older/senior nurses (Silvestro &amp; Silvestro 2000, 2008).</p>

Type of employment/ arrangement	Definitions	Comments
	mechanisms are often part of collective agreements (Kilpatrick & Lavoie-Tremblay 2006; Bailyn et al. 2007).	Self-scheduling difficulties may be encountered with staff mix (not an all-RN staff) and large units with over 70 staff (Teahan 1998; Silvestro & Silvestro 2000).
Job sharing	Two people occupy one full-time position and negotiate and share work hours that suit their needs. There are typically part-time benefit plans. Internal scheduling issues, such as weekend and holiday coverage, are negotiated or determined on a rotating basis (Gliss 2000).	Job-sharing positions often require more complex skills or have more demanding job expectations than traditional part-time positions (Gliss 2000). One Canadian study showed that job sharing has a greater positive impact on nurse job satisfaction than either full-time or part-time status (Kane 1999).
Flexible work year	Extended leave options (48/52 weeks) are granted to permanently employed staff for personal reasons. *	*This site provides policies related to a flexible work year for an Australian university <a href="http://policy.cqu.edu.au/Policy/policy_file.do?policyid=627">http://policy.cqu.edu.au/Policy/policy_file.do?policyid=627</a> .
Compressed hours	Employees may request to work their total number of hours over fewer days. Examples of compressed hours working patterns include working time being re-organised to allow the weekly hours to be worked in 4 or 4½ days a week or over 9 days each fortnight. Policies are typically established to limit total numbers of hours works per day/pay period, particularly for safety reasons (Trinkoff et al. 2011)	Although nurses like compressed schedules, such as 10-12 hour shifts versus 8 hour shifts, some research suggests that quality of sleep is negatively influenced by working extended hours (Geiger-Brown & Trinkoff 2010). Poor quality of sleep is associated with decreased vigilance and the potential for patient care delivery errors (Hinshaw 2006). The US Institute of Medicine (2004) recommends that nurses limit their work hours to no more than 60 per week or 16 in a 24-hour period.
Annualised hours contracts (AHC)  Seasonal work	Annualised hours contracts allows for a total number of hours to be agreed between employer and employee, which are then worked in variable quantities over the year (Working Time Solutions 2012).  Seasonal work contracts are similar to annualised hours contracts: they have similar employer-employee benefits. Seasonal contracts are very effective when there are consistent, seasonal fluctuations, such as census peaks during winter months with census dips during summer months (Schmidt & Nelson 1996).	Employers typically use this approach to better meet seasonal demands and reduce the need for overtime and temporary workers. Employees are freed up for specified periods of time to seek additional employment or to meet personal needs. (Institute of Management Services, UK 2012). One study in Nigeria showed that in some workforce cultures, an annualised hours contract (AHC) is perceived by employees as being too risky or novel with potentially higher financial unknowns and social costs than other flexible practices that are easier to understand with less risks, such as flextime contracts. Study authors emphasized the importance of effective management when undertaking flexible work practice innovations, such as AHC (Oke & Oke 2011).  In a US survey study, seasonal staffing models were an identified incentive to extend retirement among senior nurses with a strong preference (50%) to work winter months with summers off (Cyr 2005). For one seasonal staffing model, employees' annual work schedule was <b>compressed</b> during the peak census season, equating to an additional 4-12 hours maximum per week. Employees received 3-month sabbaticals over off-peak times.



Type of employment/ arrangement	Definitions	Comments
		To avoid leave of absence without pay during these sabbaticals, employees were salaried with wages distributed evenly over the entire year (Schmidt & Nelson 1996).
Zero-hours contracts	These are employment contracts where an employee is required to be available for work for a certain number of hours per week or when required-or a combination of both. *	*In Ireland, the Organisation of Work Time Act (1997) protects employees on zero-hours contracts. The Act stipulates that if an employee works less than 25% of their required or contracted hours in any week, they must be compensated. Compensation level depends on number of hours worked. Compensation stipulations protect employees when there is no work or limited work (Department of Jobs, Enterprise, Innovation, Ireland 2011).
Shift-swapping	Subject to service demands, employees may, in consultation with their line manager swap shifts with each other, as long as they ensure that agreed staffing levels are met at all times	Whether a request is approved or not will usually depend upon the circumstances of each case. It is the responsibility of the line manager to approve such request and ensure that the swapping of shifts will not have a negative impact on service delivery or employee effectiveness (Bester et al. 2007).
Working from home	An employee's request to work from home can be considered in relation to any job role that may be carried out equally on site or from a remote location, usually the employee's home. It is evident that some roles do not lend themselves to any form of working from home, as they can only be carried out on site (Brewer 2000).	Telehealth is paving the way for nursing work-at-home opportunities. Telehealth refers to the delivery of health-related services via telecommunications technology. Nurses, for example, can triage, provide information and education, check patients' health status and provide legal consultation via phones and computers (Koch 2006). Many components of nurse management and case management can be done via telecommunications (Brunelli 2012).
Employer's float pool	A pool of full-time and/or part-time nurses is available to provide nursing services across patient care programmes (Dziuba-Ellis 2006).	Float pools and resource teams are a popular way for employees to address staffing needs on an "as needed" basis. Float pool nurses can be deployed to units or programmes based on sick calls, vacation and maternity leaves, etc. Although this approach provides staffing flexibility, nurse competencies and patient safety need to be considered (Dziuba-Ellis 2006; Mercer et al. 2010). Traditional floating (e.g. floating a nurse from her unit to another unit based on staffing needs) is often associated with stress (Dziuba-Ellis 2006). There are nurses, however, who join float pools because of the patient care variety and other flexible work practice incentives, such as self-scheduling, that are frequently associated with float pools (Johnston & Conway 1981; MacPhee 2000).
Career breaks	Career breaks are associated with extended leave for personal reasons, such as motherhood (Arun et al. 2004). Although career breaks were traditionally associated with mothers taking time off to raise infants and young children, more people are taking time off for personal and professional development (Career Break Site, UK 2012).	An Australian study surveyed women who took career breaks, primarily for child related reasons. Many of the women (45%) would have worked part-time if the option had been available to them. The authors concluded that policies of statutory maternity leave and family-friendly, flexible work practice policies should be in place to better support work-life balance. They noted that in counties without these types of policies in place, women, in particular, suffer negative effects on salary, job status and career progression (Arun et al. 2004). Six months to 2 years is the most common period of time for a career break

Type of employment/ arrangement	Definitions	Comments
		according to a survey conducted by the Career Break Site, UK (2012).
Purchased leave	This is a voluntary arrangement where employees can purchase additional leave from work. Employees can usually purchase between 2-8 weeks of additional leave in a 12 month period (Australian Government 2009-2011).	From an Australian example, salary payments are annualized and paid in 26 equal instalments over a 52-week period, thereby spreading the salary impact of taking off up to 8 weeks leave without pay (The University of Newcastle, Australia 2012).
Phased retirement	A gradual retirement scheme with or without benefits that allows employees to take more leave and scale down working hours over a specific time period (Blakeley & Ribeiro 2008).	Phased retirement is an important retention strategy for senior nurses, often influencing their decision to stay in the workforce longer (Lavoie-Tremblay et al. 2006; Hart 2007).
Leaves  Sabbaticals	Authorized periods of time away from work without loss of employee rights. Leaves are paid or unpaid – generally granted for family, health or education reasons. Sabbaticals are usually paid or partially funded, such as academic sabbaticals. (CCOHS 2008)	In some instances, self-funded leaves are possible where a portion of salary is withheld and returned to the employee as pay during the time away from employment (CCOHS 2008). Fields et al. (2006) provide an example of a hospital-based sabbatical programme for nurses.