

**The 'realities' of part-time nursing: A grounded theory study.**

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**Introduction**

Approximately half of all Australian nurses work in part-time employment (AIHW 2005). A dearth of Australian and limited international literature establish that a meaningful picture of the experience of part-time nursing is not available. Current and projected nursing shortages with associated expectations of effective workforce planning and management provide a persuasive impetus to develop knowledge about this large segment of the nursing workforce.

In most industrial countries part-time workers are found in lower skilled occupations such as the service industries (de Ruyter & Burgess 2000). Consistent with the overall Australian part-time workforce, the Australian part-time nursing workforce is predominantly female (AIHW 2003). However, contrary to the wider Australian part-time workforce, part-time nurses are professionals which may distinguish them from other part-time workers.

In the early 1980s a review by Rotchford and Roberts (1982) identified that potential variations between part-time and full-time workers had been neglected in organisational research. The suggestion that part-time workers were ‘missing persons’ in this field of research galvanised researchers to learn more about part-time workers and the nature of part-time employment (Barling & Gallagher 1996). Much of the research that has been conducted since Rotchford and Roberts’ (1982) ‘missing persons’ suggestion has focussed on the attitudinal and behavioural differences between full-time and part-time workers (Barling & Gallagher, 1996). In more recent literature a number of authors have argued that part-time workers are a heterogenous

group and the assumption that all are alike is an overly simplistic approach (Hakim 1998).

The international literature has made comparison between full-time and part-time nurses' work attitudes, such as commitment and job satisfaction and the outcomes of congruent/ incongruent employment hours and/ or schedules (Havlovic et al. 2002, Burke 2004). UK studies have focussed on the limited opportunities for promotion and training that are available to part-time nurses (Edwards & Robinson 2004). Available literature is limited to description rather than explanation of the phenomenon of part-time nursing. Whether these findings were relevant to the Australian context was unknown.

## Method

Grounded theory methodology was chosen as it allows exploration of phenomena where little knowledge exists and is consistent with the study's aim to construct theory ((Lomborg & Kirkevold, 2003, McCann & Clark 2003). The conduct of this study was informed by Strauss and Corbin's (1998) grounded theory methods. Approval was gained from university and recruitment site Human Ethics Research Review Panels. Written informed consent was gained from all participants prior to data collection.

The overriding aim of this study was to discover and describe phenomena and develop a substantive theory that explains the 'realities' of part-time nursing. The research question started out broadly and became more specific as the study

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progressed, as commonly occurs in grounded theory (Strauss & Corbin 1998). Initially the research question was: ‘*What are part-time nurses’ experiences and motivators?*’. Data identified both positive and negative experiences. Although positive experiences continued to be collected as data, the study progressively became more focussed on exploration of the problem experienced. The study was ultimately guided by the questions:

- What is the problem that is experienced when nursing part-time?
- What are the conditions that influence the problem?
- What is the process that is used to respond to the problem?

**Sample**

‘Part-time’ employment is defined as being permanently contracted to work a fixed number of hours of less than thirty five hours per week and consists of the same industrial conditions (pro rata for hours of employment) as those working in full-time employment. ‘Casual’ nursing was excluded from the study.

Initial use of purposive sampling was superseded by theoretical sampling (Cutcliffe 2000). Part-time registered and enrolled nurses (n=86), nurse managers (n=13) and nurse educators (n=5) from five regional districts in Queensland, Australia contributed to the study. The study attempted to recruit part-time nurses from a diversity of personal and practice situations so that the theory would be well rounded and able to accommodate variation. Each participant was interviewed once. The developing theory was taken back to participants to establish representativeness.

Theoretical sampling drew part-time nurses from the public and private healthcare sectors, aged and residential care, mental health, community, private medical practice and acute care specialties. Participants varied in age, gender, their responsibility for dependents, years of nursing experience, employment hours and nursing qualifications (Table 1). As the study progressed, data analysis led to the theoretical sampling of nurse managers and nurse educators so that their perspectives of the issues could be gained to ground the theory and saturate categories. Part-time nurses, as the primary sample cohort, are reported as the 'participants' and references to the nurse manager and educator cohort are clearly noted.

**Insert Table 1 about here**

### ***Data collection***

Grounded theory has emerged from symbolic interactionism and in keeping with this theoretical underpinning interviews were the prime source of data for this study (Anells 1996). Data were collected through individual interviews and four focus group (n=5+5+4+4) interviews. Participants were purposively recruited to four focus groups that were conducted early in the study as a means to enable the researcher to gather wide ranging data that founded further expansive exploration.

Focus group interviews (65 to 130 minutes) and individual interviews (20 to 95 minutes) were held in participants' personal time in a variety of settings including the researcher's home, participants' homes and in meeting rooms in participants' workplaces. Each interview commenced with two broad and open ended questions, 'Can you tell me what led you to work part-time?' and 'Can you tell me about your

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*nursing experiences as a part-timer?’*, as these were found to open up discussions allowing participants to lead the interview to issues important to them. Consistent with the grounded theory approach, a more semi-structured approach was used in the later parts of interviews to enable the researcher to more comprehensively explore issues of interest that had not spontaneously been brought into the discussion (Duffy et al. 2004). As the study progressed the interviews became more driven by emergent theory (Wimpenny & Gass 2000).

**Data analysis**

Data analysis followed Strauss and Corbin’s (1998) guidelines. All audio-taped interviews were transcribed verbatim and transcriptions were audited for quality. Memo writing and the constant comparative analysis technique were consistently used and analysis followed a process of open, axial and selective coding, as suggested by Strauss and Corbin (1998). The manual analysis process used the sorting facilities of QRS NUD\*IST Vivo (NVivo) software. The cyclic process of theoretical sampling, data collection and analysis continued until data saturation was achieved. The analytic process resulted in the development of categories explanatory of the problem experienced, the conditions that influenced the problem and the responses that were made to adjust and adapt to the problem. The ‘core’ category was identified and other categories related to the core built the theory, as described by Strauss and Corbin (1998).

## Findings

Study participants perceived that irrespective of the many positive experiences gained through part-time nursing, there were associated difficulties or ‘costs’. The categories that emerged related to these difficulties provided building blocks that founded the development of a substantive theory.

### *Inability to Achieve Personal Optimal Nursing Potential*

While much variation was found in the type and degree of difficulties experienced, the study found that all participants shared an overriding problem of an inability to achieve their perceived personal optimal nursing potential.

Though effective professional interaction with all stakeholders within the workplace was perceived as essential to professional nursing, part-time nursing was linked with a disconnection within the workplace and challenges in the provision of client care:

*... it's easy to feel left out of the loop... you're not actually there during the regular office hour time when decisions are made. If you're not there for ward meetings it's very hard. You can read the minutes but then it's a reactive sort of thing, it's not proactive. You haven't actually been involved in the decision making process. Also staff don't really know you as well either, they possibly don't see you as a regular staff member...And also even just with continuity of care with patients. If you've got complicated cases and you've had the flow of the roster where you've had an extended period off... it's very hard to update on their events over that period of time.*

Ineffective workplace communication was a considerable challenge that had wide reaching effects. Commonly used workplace communication strategies, such as verbal communication and the ‘communication book’, were not effectively meeting contemporary part-time nurses’ needs for information. Idioms such as ‘out of the

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3 loop', 'behind the 8-ball', 'missed the boat', not having their 'finger on the pulse' and  
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6 'playing catch-up' were regularly found in data describing the outcomes of ineffective  
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8 communication experiences. Not being known or valued by other healthcare  
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10 professionals and being excluded from decision making opportunities was a common  
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12 experience that led to isolation from the team that in turn limited part-time nurses'  
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14 ability to effectively contribute to client care and organisational functions:  
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18 *... So I always feel new all the time, even though I've been at the hospital for seven*  
19 *years, I still feel like I'm still new and not part of the team...*  
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23 Part-time nursing was associated with difficulties achieving continuity of care and  
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25 getting to know clients. Gaining sufficient information to enable continuity of care  
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27 was problematic when the hand-over report between shifts was short and shifts  
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29 commonly commenced at a busy pace. In these instances part-time nurses who may  
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31 have been away from the workplace for an extended period, did not have the time to  
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33 access the level of information needed for quality care, resulting in challenges in  
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35 providing client care.  
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42 Professional development was perceived to involve acquisition of knowledge and  
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44 skills and access to career progression. Difficulties experienced in these areas  
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46 negatively influenced part-time nurses' professional practice:  
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50 *Like, you're not here [in the workplace] as often, so you need to rely on your past*  
51 *experience to get you through. They [the organisation] don't give you any*  
52 *opportunity to get any education, like in-service, and so you have to do it in your*  
53 *own time which I don't mind particularly. And you get overlooked for that project*  
54 *type stuff which I do mind. And of course promotion is out of the question when*  
55 *you're part-time.*  
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Although participants' believed that nursing occurred in an environment of continual change, part-time nursing was associated with fewer opportunities to gain formal and experiential learning. Formal learning opportunities were often only available to part-time nurses who were willing to attend in their personal time and there was a common belief that full-time nurses were more likely to be released from work to attend staff development sessions.

Staff development sessions scheduled only during 'business hours' were a barrier to accessing formal learning that increased the importance of experiential learning. Part-time nursing was associated with reduced time spent in the workplace that limited opportunities for experiential learning. This was seen as especially difficult when learning the skills for a new specialty:

*... I started in a specialty area in a part-time capacity and I've always felt like I never had the solid body of knowledge and skills to fall back on. And I remember someone saying 'I've deskilled so much since I had a baby and went part-time'. And I thought 'You should try up-skilling from nowhere, it's hard'.*

Part-time nursing was perceived as a barrier to both horizontal and vertical career progression. Participants believed that they had less access to activities such as portfolio and project work that supported horizontal advancement. Promotional opportunities were emphasised as being significantly limited while in part-time employment. Many participants proposed that they were not interested in promotion opportunities and deeper exploration established that some were happy in their current role and did not want promotion. Others' interest in promotion had been dampened by previous inequitable experiences, negative managerial attitudes and promotional opportunities being offered as full-time positions.

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Working full-time employment hours was suggested to be more important to recruiters than a nurses’ ability to perform a role:

*... So you don’t always get the best people for the job. I went to something... a couple of years ago and it was talking about staffing and these people were saying that they often have to look at the quality of the person they’re getting be it full-time or part-time. The best person for the job isn’t necessarily the one who works five days a week. But that doesn’t seem to have filtered through to here [participant’s healthcare facility]...*

A requirement to work full-time was perceived as inequitable. The potential for job sharing was regularly suggested as a means to resolve this issue but most believed that their employer would not support this strategy. Limited horizontal and vertical advancement opportunities led part-time nurses to experience constrained career progression that limited their ability to work at their optimal potential.

Conditions influencing experiences were either ‘causal’ or ‘intervening’ (factors/ happenings that altered the impact of the causal conditions). The following five categories represent the contextual conditions discovered through this study. The complex interplay between these contextual conditions formed the basis for variations in the difficulties part-time nurses’ experienced. A complete understanding of the problem being experienced was recognised as unachievable until these conditions had been discovered.

***Motivators to Work Part-time***

Insight into nurses’ motivations to work part-time was important to understanding ‘why’ nurses chose an employment status that had negative influences on their experiences of nursing. Motivations included: the need to preserve health because of

the impact of shift work, work intensification and ageing; the need to be able to manage multiple life roles, especially caring responsibilities; the need to maintain workplace and professional links; and financial considerations (Jamieson et al. in Press). Gaining some level of 'control' was identified as a discernible motivator that was a consequence of other motivators. The primary motivator to work part-time for the majority of participants in the study was caring responsibilities.

### ***Employment Hours***

The condition 'employment hours' was closely associated with nurses' motivators to work part-time and was found to be the primary condition influencing the difficulties experienced when nursing part-time. Data clearly established that greater numbers of hours spent in the workplace resulted in fewer professional difficulties. When considering the issue of employment hours from the perspective of optimal professional nursing practice, a considerable data suggested that if at all possible a nurse needed to work at least twenty hours per week, with some suggesting at least twenty four hours was needed:

*I think you have to work at least three days [3 X 8 hour shifts] a week to keep up honestly. Having worked two days a week for a number of years and then having gone to five days a fortnight, that extra day even made a big difference. But I think if you really want to be an integral part of the workforce in your unit you have to do at least three days a week. That's my personal observation.*

### ***Specialty Factors***

A nurses' specialty formed a condition that influenced the difficulties participants faced. Client's typical lengths of stay differed according to specialty. Irrespective of the employment hours worked, there was no experience of fragmentation of care and

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difficulty getting to know the patients when nursing occurred in a specialty typified by short length of stay, such as in peri-operative and emergency nursing. In these situations continuity of care could be achieved within one shift and all stakeholders had expectations of short term nurse-client relationships. Specialties with longer typical lengths of stay, such as residential care and renal nursing, also appeared to be less problematic:

*Like in the nursery [neonatal special care nursery] we have a rapport with the mums because they're [babies are] there long term. So you might see them for two days but when you come back in three days time after days off they're still there. Whereas it's probably not so much of an issue in labour ward because you only have the women there for a certain period of time. But out there [in the antenatal and postnatal ward] the women are there for a few days so continuity of care is more of an issue because everything changes when you have days off.*

Challenges experienced in providing client care were depicted as more important for particular clientele, such as mental health and paediatric clients. These groups of clients were seen as more vulnerable, requiring increased levels of continuity of care and care providers. Certain specialties were perceived to require more advanced nursing knowledge and skills than other specialties:

*... I had worked in a couple of areas [specialties] before I came to CCU [Coronary Care Unit]. But when I came here I really had a steep learning curve. You just need a much higher level of knowledge and practical skills to do cardiac nursing than I needed in those other areas...*

**Individual Factors**

Many individual factors influenced experiences of difficulties when nursing part-time. Participants regularly benchmarked experiences by making comparisons with other nurses who worked greater or fewer numbers of hours or their own past experiences of working greater or fewer hours. The 'frame of reference' that was used for these

comparisons influenced perceptions. Individual prioritisation of importance also influenced perceptions. For example, part-time nurses who were happy in their current role did not perceive the barriers to career progression as a difficulty.

The individual's level of nursing practice had a considerable influence on their experiences of part-time nursing. Being new to a specialty and/or having an undeveloped knowledge and skills base exacerbated the difficulties. In contrast, a well developed specialist knowledge and skills base had an 'intervening' influence on the experience of difficulties while nursing part-time:

*... So I guess if you know the area [specialty] and you only work a couple of days a week then there is no negative sort of thing because you still know what you are doing and still know the area. Whereas I'm still sort of fresh meat [new], so it's very difficult to up-skill when you are working part-time...*

### **Organisational Factors**

Organisational factors were found to have a considerable influence over part-time nursing experiences. Inflexible work scheduling created a barrier to meeting other life demands and was closely related to motivators to work part-time. Inflexible scheduling of workplace meetings and staff development opportunities negatively influenced part-time nurses' ability to contribute to team decision making and to access professional development. Work settings with high levels of staff rotation or turnover were associated with greater experiences of isolation from the team as there was more difficulty getting to know and be known by other healthcare professionals.

Participants felt 'accepted' within their workplaces. Acceptance of part-time nurses, especially those preferring limited work hours, was seen as a relatively recent

phenomenon. However, acceptance did not automatically translate to support.

Differences in nurse manager and nurse educator attitudes and managerial techniques were perceived to lead to wide variations in support:

*... I can't even remember the last in-service that I had, I don't know if I've had any. I seem to be missing all these opportunities for education... there's a real breakdown in communication here [participant's practice unit] whereas information gets sent out to other wards and they have a definite area and a definite system to go to, to find out what's available... even someone to speak to... With myself, we don't have these systems and I find it hard to pin my nurse manager down to discuss anything...*

Data from the nurse manager and nurse educator cohort of the sample commonly identified a failure to adequately acknowledge the heterogeneity of nurses' motivators to work part-time and the professional aspirations of part-time nurses. A typical comment from a nurse manager was:

*Most part-timers work the amount of hours they need to match their financial commitments. Not many work more hours than they need... And because they have other commitments, family commitments and some of them wouldn't work if they didn't have to, I don't think most of them particularly want career progression...*

Notable variations were found in attitudes towards part-time nurses and the techniques used to manage them, including differences within the same healthcare facility. Considerable variations were found related to the information resources used to guide the management of part-time nurses. Creative solutions to address the difficulties faced by part-time nurses and to enhance the support provided were offered but analysis established that a consistent approach to the management of part-time nurses was not available. Data from part-time nurses, nurse managers and nurse educators also identified that all perceived that those at the executive levels within their healthcare facilities/ organisations did not actively support part-time nurses' career progression.

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6 The interweaving of conditions influenced variations in experiences. Exploration of  
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8 previously collected data and a further cyclic process of theoretical sampling, data  
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10 collection and analysis resulted in a plethora of data establishing that participants  
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12 were constantly making responses to adjust and adapt to the challenges that they  
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14 experienced. Conceptualisation of the findings in data led to discovery of the  
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16 following category.  
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### 19 20 21 22 *Corrective Juggling*

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24 'Corrective juggling' was found to be the process used to attempt to correct (or limit)  
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26 the professional interaction and development difficulties experienced when nursing  
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28 part-time. The process involved making adjustments to the conditions that had a  
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30 'causal' influence on the difficulties with an underlying aim to gain a synergy and  
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32 forward progression of professional practice. Correcting problems were not fully  
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34 achievable while remaining in part-time employment and the process of corrective  
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36 juggling continued across the trajectory of part-time employment. Nonetheless,  
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38 amelioration of difficulties was achievable. The category 'corrective juggling' was  
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40 related to all categories and appeared frequently in data and was therefore established  
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42 as the core category of this study.  
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51 Recognition of specific difficulties provided an impetus and focus for participants to  
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53 respond through adjustment and adaptation. Corrective juggling included wide  
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55 ranging strategies with the most common being to increase the number of hours  
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worked and/or reschedule work hours to include routine business hours and/or to work shifts on consecutive days:

*... I've increased my shifts from thirty two hours a fortnight to forty hours... So forty hours a fortnight and just cram it into one week. Nothing to do with things being easier [at home] but just to find a bit of continuity at work. Because I've found that you do one shift, you have a few days off, you do two [shifts], you have a longer stretch off and you just don't seem to be having any continuity of care or keeping up to date with anything that might be going on...*

At times these corrective strategies provided a temporary solution, using short-term increases in work hours to full-time or close to full-time to up-skill to a new specialty or to gain a temporary promotion.

Changes to the condition 'specialty factors' was also commonly found in the data. For example, some specialties catered for clientele that enabled operational hours to be routine business hours. These specialties were perceived to limit communication difficulties, feelings of isolation from the team and difficulties accessing structured learning:

*I used to work shift work in the acute section... I also found it difficult to keep up with things... Like, I was never there for meetings or education times and stuff. This is much better [working in a specialty that has routine business hours]. I only work two days a week but when I do work I'm here when everyone else is here. So that is when everything happens and if it happens on the days that I work then I'm here for it. It's much better and I'm glad I changed.*

'Individual factors' founded implicit corrective strategies with adjustments made to perceptions, attitudes and personal prioritisations. The condition 'organisational factors' was not used by part-time nurses for corrective juggling as this condition was perceived to be out of their control. However, the findings included many suggested changes to this condition. For example, participants believed that there was potential



for greater flexibility of staff development scheduling, videotaping of these sessions so that all could have access, more flexible work scheduling and job sharing.

Data analysis established that it was rare for a corrective strategy to ‘act’ on one condition alone. Any corrective strategy involved actions/ interactions with a number of conditions:

*Sometimes I think I'd like to work more hours purely from a professional point of view. I'd like to be more in touch and more up to date. But that's just not possible. I've increased my shifts [number of hours worked] a couple of times over the years and to do that I had to sacrifice my family. It gets very frustrating because you can't be good at everything, you can't give 100% to everything. Either you are a fantastic nurse and a shoddy mother or you're an okay mother and a terrible nurse. And sometimes you just feel 'Well ... I'm bad at everything because I'm not doing anything properly'. But you still do continually try to work out ways to fix things so that you become more the fantastic nurse. But it is always important to make sure that at the same time you are not becoming the shoddy mother.*

Diminished self-confidence was another consequence that was found when difficulties continued to exist after corrective strategies were used.

## Discussion

The study has discovered the problem shared by part-time nurses, the conditions that influenced the problem and the responses that were made to adjust and adapt to the challenges. The reported categories that emerged were saturated in data and have provided the building blocks that founded theory development. Figure 1 presents a visual model illustrative of the developed substantive theory that accommodates and is explanatory of wide variations in experiences, conditions and responses.

**Insert Figure 1 about here**

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The professional interaction and development difficulties experienced contributed to part-time nurses' inability to achieve their optimal potential. Part-time nurses responded by making adjustments to the conditions that had a 'causal' influence on their difficulties. However, they were disempowered to change organisational practices that limited their ability to access information, contribute to decision making, and to access structured learning and horizontal and vertical advancement opportunities. Part-time nurses were surrounded by a glass ceiling and walls. Their constructs of professional identity established that they needed to reach beyond their confines to be effective professional nurses but barriers remained firmly in place whilst they continued to work part-time. Utilisation of part-time nurses' full productive potential was limited by organisational factors that contributed to the marginalisation and ghettoising of these nurses.

Part-time nurses in the current study felt 'accepted'. Nonetheless, there were strong demands for part-time nurses to conform to traditional organisational practices. Examples of these conformity pressures were rigid work schedules, resistance to promotion of part-time nurses and inflexible scheduling of meetings and education sessions. Lawrence and Corwin (2003) argue that marginalisation of part-time workers is more likely when strong pressures for conformity exist. There was much evidence in the current study that part-time nurses were expected to conform to traditional organisational practices rather than organisations changing their practices to integrate part-time nurses.

Lee, MacDermid and Buck (2000) reported that differences in organisational responses to part-time employment could be represented by the terms 'accommodation', 'elaboration' and 'transformation'. Accommodation responses are situated in a reluctance to appropriately support part-time employment and the rationale for accepting these employment arrangements is to retain valued employees (Lee et al. 2000). A very narrow range of jobs is perceived to be 'do-able' through part-time employment and there is likely to be a marginalising effect on the part-time worker's career (Lee et al. 2000). In these organisations there is no development of new routines to adapt to part-time employment and the status quo is maintained (Lee et al. 2000). It is suggested that 'accommodation' may be a more accurate term than 'acceptance' to describe current healthcare organisational responses to part-time nurses.

An 'elaboration' response investigates part-time employment and responds by developing new routines while retaining the basic status quo in relation to work structuring and careers (Lee et al. 2000). In the current study there was evidence of innovative strategies used by nurse managers and nurse educators that responded to part-time nurses' needs without changing other work rituals. There was no evidence from the current study of a 'transformation' response by healthcare organisations. 'Transformation' responses were described by Lee and colleagues (2000) as a greater willingness to accept non-routine behaviour, movement away from the status quo by providing a highly supportive continuous reorganisation of work and career paths to adapt to changing workforce issues such as part-time working.

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This study provided much evidence that part-time nurses were not willing to passively accept the difficulties that they experienced. In an era of current and projected nursing shortages, ‘accommodating’ part-time nurses and expectations of ‘conformity’ are no longer adequate managerial strategies. In a healthcare environment of diminishing resources, part-time nurses require support to limit the difficulties that they encounter to permit more successful achievement of each individual’s professional potential. Harnessing the full productive potential of part-time nurses will in turn will enable healthcare organisations to more effectively optimise services.

The sample was large for a grounded theory study and included wide demographic diversity in a deliberate attempt to enhance the potential for discovering variation that could be accounted for by the developed theory. Although previously developed theoretical constructs on part-time professional work have assisted understanding the part-time nursing phenomenon, the developed substantive theory provides a comprehensive insight and explanation of the phenomenon of part-time nursing that was not previously available. This substantive theory must be tested in other national and international contexts to determine the applicability of the theory’s explanatory capacity.

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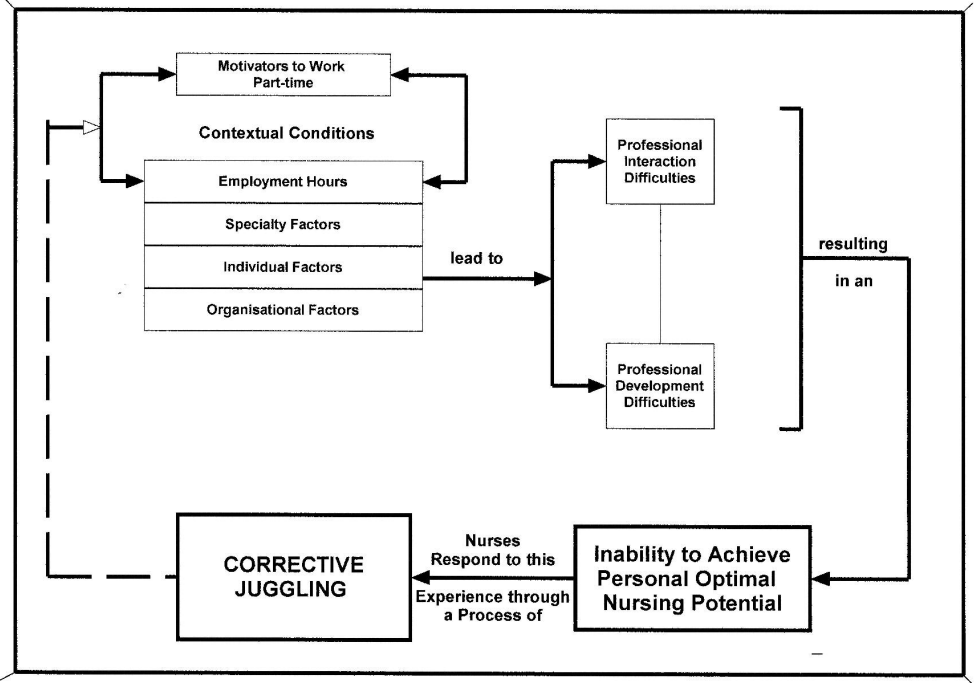
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Table 1. *Part-time Nurse Sample Demographic data*

	f	%
<b>Age</b>		
< 25 years	0	0
25 - < 30 years	3	3.5
30 - < 40 years	30	35
40 - < 50 years	40	46.5
≥ 50 years	13	15
<b>Gender</b>		
Male	6	7
Female	80	93
<b>Employment Hours per Week</b>		
32 hours	29	34
28 hours	9	10
20 - 24 hours	23	27
16 hours	17	20
12 - 14 hours	3	3
4 - 8 hours	5	6
<b>Years of Nursing Experience</b>		
< 2	1	1
2 - < 5	5	6
5 - < 10	8	9
10 - < 15	12	14
≥ 15	60	70
<b>Years Employed in Current Organisation</b>		
< 2 years	15	17.5
2 - < 5 years	18	21
5 - < 10 years	21	24.5
10 - < 15 years	9	10
≥ 15 years	23	27
<b>Highest Post-registration Nursing Qualification Held</b>		
Nil	25	29
Other	8	9
Hospital Based Certificate	14	17
Bachelor – post registration	13	15
Graduate Certificate	12	14
Graduate Diploma	8	9
Master	5	6
Ph.D	1	1
<b>Youngest Child Dependant</b>		
Not yet School	24	28
Attending Primary School	23	27
Attending Secondary School	15	17.5
Finished Secondary School	9	10
NA	15	17.5

### Demographic Data

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Theory of Part-time Nursing