Constructing Nurses’ Professional Identity

Georgina Anne Parkes Willetts

Submitted in partial fulfilment of the requirements of the degree of Doctor of Education

September 2013

Faculty of Education
The University of Melbourne
Abstract

There is limited evidence, and research on nurses’ development of their professional identity within the social context of their daily work environments. The overall aim of this project was to investigate elements that constitute the performance of nurses’ professional identity within a specific work environment. The particular focus was on the interplay of nurses with other nurses, and with other health professionals in the context of their work environment.

This ethnographic case study investigated the interactions of nurses within two specific clinical wards/units. The application of the theoretical perspective Social Identity Theory was used to study two specific professional daily activities. These activities of shift handover, and multidisciplinary team meetings were videotaped as part of the data collection. Further qualitative methods of data collection included; participants viewing the videotapes, and then being interviewed (individual or focus group).

The findings generated evidence that the social context of the ward environment plays a significant role in the development of nurses’ professional identity. Professional activities such as handover contribute significantly to the formation of nurse professional identity. Handover is a structured formal social process developed, and performed entirely by nurses. This activity is a central mechanism by which nurses enculturate, new nurses, and construct, and sustain their professional identity through interaction with each other. In contrast the activity of the multidisciplinary meeting is a platform for the expression of professional identity through the interaction with other health professionals.

The findings have implications for understanding how nurses when they are together create, and self- categorise their identity, and how this is changed expressed, and lived differently in a multidisciplinary group. These findings generate important possibilities for further research, and need testing in other nursing work environments. Implicitly the findings are directly relevant to professional leadership, education, and service development in the nursing profession. Additionally the structure of the research design should enable similar investigation in different contexts.
Declaration

This is to certify that

(i) the thesis comprises only my original work towards the Doctorate except where indicated in the Preface,

(ii) due acknowledgement has been made in the text to all other material used,

(iii) the thesis is fewer than 60,000 words in length, exclusive of tables, maps, bibliographies, and appendices.

Signature

Georgina Anne Parkes Willetts
Minor editorial support for this thesis was provided by Dr Judy Greaves. This was done in consultation with my supervisor Professor David Clarke and in accordance with the University Of Melbourne Editor Guidelines Policy *The Editing Of Research Theses.*
Acknowledgments

To my participants’ thank you for your generosity in sharing your clinical practice, I have learned from you about nurse professional identity, your commitment to the profession, and each other.

Thank you to Professor David Clarke from Melbourne University for your supervision skills, and knowledge, and for his support during my candidature.

Thank you to my work colleagues for your support, and encouragement throughout my journey.

To my family, and friends, your steadfast love, and support has made all the difference. In particular to my husband Michael, who has demonstrated an enduring belief in my ability to achieve this, and as a result, endless support. To my two beautiful girls Megan, and Rhianne, and their constant encouragement, I have watched them grow from little girls to young women during the many years of undertaking this study. Lastly to my father Haydn who has withstood many Sunday evenings on the phone listening to the challenges of my research journey, and encouraging me with his own stories of endurance, and success. Thank-you.
# Contents

Abstract ................................................................................................................................. ii

Declaration ............................................................................................................................. iii

Preface ..................................................................................................................................... iv

Acknowledgments .................................................................................................................. v

List of Tables ........................................................................................................................... x

List of Figures ........................................................................................................................ xii

Definitions ............................................................................................................................. xiii

## Chapter 1: Introduction ........................................................................................................ 1

Aims of the Project ................................................................................................................... 1

Nursing in Context ................................................................................................................... 2

Theoretical Framework .......................................................................................................... 3

Research Question ................................................................................................................ 4

Methodology/Research Design .............................................................................................. 4

Significance of this Project .................................................................................................... 5

Outline of Chapters ................................................................................................................. 5

## Chapter 2: Literature Review ............................................................................................ 6

Search Strategy ....................................................................................................................... 6

Commentary Papers on the Nursing Profession ................................................................. 8

Nursing Research Literature, and Profession ................................................................... 11

Literature on the Definitions of Profession ........................................................................ 12

Social Identity Theory ......................................................................................................... 17

Social Identity Theory Defined ............................................................................................ 18

Group Performance .............................................................................................................. 19

Group Motivation .................................................................................................................. 19

Group Goals, and Group Norms ......................................................................................... 20

Group Efficacy ....................................................................................................................... 20

Social Identities ................................................................................................................... 21

Social Identity Salience ........................................................................................................ 21

Nested Identities ................................................................................................................ 22

Cross Cutting Identities ...................................................................................................... 23

Self-categorisation ................................................................................................................. 23
Social Identity Theory, and its Relevance to Nurses’ Professional Identity ........24
Handover and Multidisciplinary Meetings .........................................................25
  Nurse Group Handover .....................................................................................26
  Multidisciplinary Meeting (MDM) ......................................................................27
Conclusion ...........................................................................................................28

Chapter 3: Research Design .............................................................................29

The Case Context of Acute Care ......................................................................38
  Clinical, and Environmental Contexts within their Organisational Structures ...40

Chapter 4: Methods ..........................................................................................46

Fieldwork ............................................................................................................46
  Site Selection .......................................................................................................48
  Entry into the Environment ..................................................................................48
  Sampling and Recruitment .................................................................................50
  Demographic Information ..................................................................................52
  Participant Observation ......................................................................................52
  Fieldnotes ...........................................................................................................52
  Video Recordings ...............................................................................................53
  Interviews ............................................................................................................54
Conclusion ............................................................................................................59

Chapter 5: Ethnographic Results .....................................................................60

Demographic Information ..................................................................................61
Group Performance .............................................................................................61
  Group Motivation ...............................................................................................62
    Insights from Interviews: Nurse Handover ......................................................62
    Insights from Interviews: MDM ........................................................................64
    Insights from Researcher Participant Observations, and Fieldnotes: Group Motivation ........65
      Insights from Researcher Participant Observations, and Fieldnotes: Nurse Group Handover ....66
      Insights from Researcher Participant Observations, and Fieldnotes MDM ..................68
  Group Goals .......................................................................................................70
    Insights from Interviews: Nurse Handover ......................................................70
    Insights from Interviews: MDM ........................................................................72
    Insights from Researcher Participant Observations, and Fieldnotes: Group Goals ..........72
      Insights from Researcher Participant Observations, and Fieldnotes MDM ..................73
  Group Norms .....................................................................................................74
    Insights from Interviews: Nurse Handover ......................................................74
    Insights from Interviews: MDM ........................................................................76
    Insights from Researcher Participant Observations, and Fieldnotes .......................78
Insights from Researcher Participant Observations, and Fieldnotes MDM ...................................... 80
Group Efficacy ................................................................................................................................. 81
Insights from Interviews: Nurse Handover ..................................................................................... 81
Insights from Interviews: MDM ....................................................................................................... 83
Insights from Researcher Participant Observations, and Fieldnotes ............................................. 84
Insights from Researcher Participant Observations, and Fieldnotes: MDM .................................... 85

**Explanation of Social Identities** .................................................................................................... 86
Social Identity Salience .................................................................................................................... 87
Insights from Interviews: Nurse Handover ..................................................................................... 87
Insights from Interviews: MDM ....................................................................................................... 93
Insights from Researcher Participant Observations, and Fieldnotes ............................................. 93
Insights from Researcher Participant Observations, and Fieldnotes: MDM .................................... 96
Nested Identities ............................................................................................................................. 98
Cross Cutting Identities ................................................................................................................ 102

**Self-Categorisation** ................................................................................................................... 103
Insights from Interviews: Nurse Handover ..................................................................................... 103
Insights from Researcher Participant Observations, and Fieldnotes ............................................. 105

**Conclusion** ................................................................................................................................ 111

**Chapter 6: Discussion** ................................................................................................................ 113

**Group Performance** .................................................................................................................. 115
Group Motivation ............................................................................................................................. 116
Group Think ..................................................................................................................................... 118
The Use of Humour .......................................................................................................................... 119
Ethnographic Hypothesis Development for Motivation ................................................................. 120
Group Goals ..................................................................................................................................... 120
Ethnographic Hypothesis Development for Group Goals ............................................................ 122
Group Norms .................................................................................................................................. 122
Recognition of the Attributes that the Group Identified with Experience ....................................... 122
Recognition by Nurses of the Complexity of Nursing Work .......................................................... 123
Dissemination of Non-clinical Patient Information at the Handover ............................................. 124
Reinforcement of Patient Advocacy .................................................................................................. 124
Ethnographic Hypothesis Development for Group Norms ........................................................... 125
Group Efficacy ............................................................................................................................... 125
Ethnographic Hypothesis Development for Group Efficacy .......................................................... 126
Conclusions on Group Performance ............................................................................................... 127

**Social Identities** .......................................................................................................................... 127
Social Identity Salience .................................................................................................................... 128
Identification with the Collective Self .............................................................................................. 128
The Emphasis on Team .................................................................................................................... 129
The Expectation of Conformity to the Handover Process ............................................................... 131
The Reinforcement of Identity Salience through the Communications that occurs within the Handover ......................................................................................................................... 132
Ethnographic Hypotheses: Development for Social Identity Salience ....................................................................................................................... 132
Nested Identities .......................................................................................................................... 132
Ethnographic Hypothesis Development for Nested Identities .................................................................................................................... 133
Cross Cutting Identities ................................................................................................................ 134
Ethnographic Hypothesis Development for Cross-cutting Identities ........................................................................................................ 134
Conclusion to Social Identities ........................................................................................................ 134
Self-categorisation .......................................................................................................................... 135
Group Activity as a Cognitive Process .......................................................................................... 135
Context Sensitive: Sharing Category Membership .......................................................................... 136
Mutual Social Influence .................................................................................................................. 137
Ethnographic Hypotheses Development for Self-categorisation ..................................................... 138

Chapter 7: Conclusion ..................................................................................................................... 143

Nurses Professional Identity - Generally ......................................................................................... 143
Group Performance ......................................................................................................................... 144
Social Identities ............................................................................................................................... 145
Self-categorisation .......................................................................................................................... 145
Nurses Professional Identity - Nursing Group Handover ................................................................ 145
Group Performance ......................................................................................................................... 146
Social Identities ............................................................................................................................... 146
Self-categorisation .......................................................................................................................... 147
Reflections on the Methodology ...................................................................................................... 147
Implications ....................................................................................................................................... 147

References ..................................................................................................................................... 151

Appendices ..................................................................................................................................... 162

Appendix A: Demographic Information ......................................................................................... 163
Appendix B: Focus Groups ............................................................................................................... 165
Appendix C: Individual Nurse Interview: After Handover ............................................................ 167
Appendix D: Individual Nurse Interview: After MDM ................................................................. 169
Appendix E: Plain Language Statement ........................................................................................ 171
Appendix F: Consent Form .............................................................................................................. 173
List of Tables

Table 1: Structural Elements of the Context ................................................................. 36
Table 2: Behavioural Elements of the Context .............................................................. 36
Table 3: Thematic Analysis Framework for SIT ........................................................... 43
Table 4: Nurse Handover, and MDM Composition ...................................................... 51
Table 5: Summary of the Data Collection .................................................................. 51
Table 6: The Structure of the Videoing, and Interviews during Data Collection ....... 55
Table 7: Interview, and Focus Group Analysis ............................................................. 57
Table 8: Interview for Testing Emergent Themes ......................................................... 59
Table 9: Abbreviations Used in Relation to Quotations ............................................. 60
Table 10: Demographic Information .......................................................................... 61
Table 11: Nurse Group Handover 1 ........................................................................... 79
Table 12: Social Identity Framework for Nurses’ Professional Identity .................... 140
Table 13: Nursing Group Handover, and its Influence on Professional Identity ....... 141
List of Figures

Figure 1: Social Identity Theory & Professional Identity Search Strategy.......................... 7
Figure 2: Search Strategy Clinical Handover & Multidisciplinary Meetings..................... 8
Figure 3: Specific Activities Related to the Organisational Ethnography..........................30
Figure 4: Relationship of the Methods to the Ethnographic Processes............................47
Figure 5: Video 1: Unit A MDM......................................................................................68
Figure 6: Video 2: Unit B MDM.....................................................................................69
Figure 7: The Grouping of Staff Names............................................................................71
Figure 8: The Handover Space in Unit B..........................................................................84
Figure 9: Unit A MDM....................................................................................................107
Figure 10: Unit B Nurse Group Handover.......................................................................110
Definitions

Handover
The meeting that occurs at the change of shift. It is led by the nurse in charge of the finishing shift presenting to the nurses of the oncoming shift. It involves a communication strategy of handing over information on all the patients within the clinical unit.

Multidisciplinary meeting
A daily meeting of a representative of all the healthcare team within a clinical unit. For the intent of this project a medical team member was not involved in this meeting. However, all other allied health representatives were present. This construct of allied health representatives differed between each of the two units. In each of the units the nurse led this meeting.

Profession
An occupation that can successfully meet the criteria of

- a unique systematic body of theory;
- a professional authority;
- a sanction of the community, and
- a regulative code of ethics. (Greenwood, 1957)

Professionalism
"Professionalism ...the institutional circumstances in which the members of occupations rather than consumers or managers control work" (Freidson, 2001, p. 12)

Professional Identity
All the attributes that define a person according to their career or profession, these include cognitive, behavioural, and social constructions.

Social Identity Theory
The theory developed by Tajfel and Turner (1974; 1987). This theory is an explanatory framework focusing on the psychological underpinnings of intergroup relations, and the distinctiveness of in-groups (Haslam, 2004, p. 281). There are three key categories from this theory used in this research project; these are Social Identities, Group Performances, and Self-Categorisation.
Chapter 1: Introduction

This first chapter provides an overview of this research project. The aim of this research, an overview of nursing in context, and theoretical framework used for this research are initially explained. The research question is then stated, and an overview of the research methodology presented, a concise summary of the significance of this project is provided, and finally an outline of the chapters to follow completes this introductory chapter.

Aims of the Project

The overall aim of this project was to investigate elements that constitute the performance of nurses’ professional identity within a specific work environment. The interest to investigate this came from my years of working as a nurse, and more recently as an educator, leader, and manager of nurses. I have often been struck by the way the nursing group within a clinical ward or unit can affect, shape, and mould the identity of an individual nurse.

This interest combined with the knowledge that there is limited research into the influences that social working group has on the development of professional identity in nursing led to the undertaking of this research. I set out to put together a research project to study in detail the social performances within the clinical unit, and their relation to professional identity. I suspected that there were specific activities that might clearly demonstrate this social interplay. From many years of being a participant in the group handover activity, I had an awareness that this activity was significant to the development of the professional nursing group within a specific work context. I also wanted to find another activity that afforded professional significance to the nurses within their daily work activities. The multidisciplinary meeting was another activity that I had frequently been involved in, where social interplay occurs within a formal timeframe on a daily basis within the clinical unit. Therefore, these activities were chosen as appropriate occurrences to study the social performance of nurses in relation to their professional identities.

The legitimate imperative to investigate this came from a known lack of research into professional identity specifically related to the work of nurses. There is research about the development of professional identity during the training of undergraduate nurses, but little relating to professional identity, and its development in the workplace after the attainment of undergraduate nursing training. There is a gap in the knowledge about how this extends beyond training. Work contexts are significant arenas where nurses’ professional identity is refined, and
expressed. This research contributes new, and important knowledge about social processes in the work environment that sustain the construction of nurses’ professional identities.

**Nursing in Context**

The focus of this research was on the professional interactions of nurses with other nurses in the context of their work environment. However, the use of interactions between other healthcare professionals was also valuable to ensure comparisons, and recognition of the complexity of nurses’ social interactions throughout their daily work. Nursing is a complex profession due to both the varied contexts, and varied practices that are considered nursing. A definition of nursing is provided by the International Council of Nurses (ICN):

Nursing encompasses autonomous, and collaborative care of individuals of all ages, families, groups, and communities, sick or well, and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled, and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy, and in patient, and health systems management, and education are also key nursing roles. (ICN, 2010)

Nurses, and midwives make up the largest group (63%) of health care professionals within Australia (AIHW, 2012, p. 501). Nurses account for more than half (57%) of staff numbers in acute public hospitals in Australia in 2009–10 (AIHW, 2012, p. 411). Nurses can be defined as:

Nurses are by far the main occupational group in the (Australian) health workforce. There are two main types of nurses, registered, and enrolled nurses. Enrolled nurses typically work alongside registered nurses to provide basic nursing care, undertaking less complex tasks than registered nurses. (AIHW, 2008, p. 445)

There continues to be shortages within the nursing workforce, and this is not isolated to Australia, with reasons for this being cited as: cultural change, globalisation, organisational values, professional values, and advancement in technology (Horton, Tschudin, & Forget, 2007, p. 716). As a result nursing is not always considered a career of choice; “it is likely that the prevalent view of nursing as being undervalued, and underpaid will have an adverse effect on recruitment”(Miers, Rickaby, & Pollard, 2007, p. 1207). As the nursing profession struggles to identify why the profession may have become a less attractive career option for many younger people, there is a need to study nurses within specific work contexts to produce new, and
valuable knowledge that contributes to a better understanding of the profession of nursing. The literature identifies the influence that culture plays on the recruitment, and retention within (Tillott, Walsh, & Moxham, 2013).

Integrating this current demographic of the nursing workforce, and a personal interest in the advancement of the nursing profession, the outline for this project was created. The most common work environment for nurses is the hospital space. This space is recognised as the usual work environment for nurses, with 62% of all registered nurses identify this as their usual work environment (AIHW, 2010, p. 5). The dominance of this place of work generated impetus for this location as a context for examination of how nurses construct and perform their professional identity. The data for this project was collected from an acute public hospital which would be a familiar working environment to the majority of nurses.

**Theoretical Framework**

This project adopted the constructivist theoretical perspective using naturalistic inquiry. The principal theoretical framework used was Social Identity Theory (SIT) (Abrams & Hogg, 2008; Haslam, 2004; Haslam, Reicher, & Reynolds, 2012; Hogg, Abrams, & Marques, 2005; Hogg & Terry, 2000, 2001; Postmes & Branscombe, 2010). This theory underpins all aspects of the project, and was central to the development of the research design, and analysis. SIT was developed in the 1970s by Tajfel, and Turner (Worchel & Austin, 1979). This theory has been used extensively in social psychology, and there is much empirical data to support the hypotheses that were established predominantly by Tajfel, and Turner (Postmes & Branscombe, 2010). SIT studies groups from the psychological premise of intergroup relations, and the distinctiveness of in-groups (Haslam, 2004, p. 281). The initial work on SIT was undertaken on isolated groups: what developed later was an interest specifically in social identity, and work, and social identity in organisations (Haslam, 2003, 2004; Hogg & Terry, 2001). SIT differs from other social psychology theories as it moves away from the individualistic psychologies, and recognises the interconnectedness of the individual with groups (Haslam, et al., 2012).

Rather than reducing the individual–society relationship to one or other of the elements, here the focus is on understanding how the psychological field within the individual is socially structured. This requires attention to the nature of the psychological processes that allow us to be social, and cultural beings, and also to the way in which these processes reflect, and are responsive to variability in social context, and ongoing social, and political dynamics. Specifically, given
that our everyday realities are structured by group memberships, this involves an examination of the way in which psychological processes make group life possible, and an elaboration of the implications for our understanding of mind, and behaviour. (Haslam, et al., 2012, p. 202)

SIT is therefore considered an interactionist meta-theory that supports the interactionist stance of Kurt Lewin (Cartwright & Zander, 1968; Newcomb & Hartley, 1951).

This project is a preliminary study of nurses effecting the key concepts of SIT. This project has not used the methodological instruments of SIT, rather the use of a descriptive approach was adopted to identify, and organise the data into a qualitative framework using the three core areas of SIT, group performance, social identities, and self-categorisation.

**Research Question**

- What are the group dynamics within the ward that assist/impede the performance of professional identity within nursing work?
  - What constitutes the professional practice of the ward nurses within the hospital ward environments studied in this research project?
  - How are the professional positions of nurses within the hospital ward organised in practice in relation to each other, and to other health professionals?

**Methodology/Research Design**

Organisational ethnography was the methodology of choice to investigate SIT dynamics within the culture of two clinical units of a metropolitan hospital. The key principles of ethnographic inquiry centre around the understandings of elements of cultural knowledge from the perspective of those who are part of the specific culture (Spradley & McCurdy, 1972, p. 60). The premise of organisational ethnography is to “explicate the ways in which people in particular work settings, come to understand, account for, take action, and otherwise manage their day-to-day situation” (Van Maanen, 1979, p. 540). Fieldwork underpins all methods within this organisational ethnography, and the use of participant observation included the researcher as an instrument. As a nurse with over thirty years of clinical experience I took the position of an insider already well embedded in the culture of nursing. The organisational ethnographic methodology of this study utilised the case context of acute care, and investigated two clinical wards.
The data was collected during two routine professional nursing activities. These activities were the clinical handover, and the multidisciplinary team meeting (MDM). This project looked explicitly at the development of the group dynamic, and its relationship to professional identity.

**Significance of this Project**

This research is particularly significant to the discipline of nursing as it undertakes an inquiry into professional identity from a differing perspective of previous nursing research. The development of this study was informed by the existing gaps in nursing research investigating the social dynamic of nursing, and its implication on the shaping of nurses’ professional identity.

There continues to be debate amongst nurses that nurses do not understand what they do, they cannot adequately define nursing work. For this to be possible nurses’ must first understand their identity. Nurses work in teams, and therefore need to be studied within their teams. This research emphasises the internal elements of the nursing team. It was the nurses’ perspective of themselves, and their colleagues that was of particular interest. Although the SIT framework is relatively new to the context of nursing, it has been extensively tested within other organisational contexts. Systematically, SIT has demonstrated significant findings that emphasise the importance of the in-group and to the identity of the individual.

**Outline of Chapters**

This thesis has a straightforward structure, and the chapters are logically sequenced. The main focus of Chapter 2 is the literature around four key themes: profession, social identity, nursing group handover, and the multidisciplinary meeting (MDM). The research design in Chapter 3 includes a detailed account of organisational ethnography as the overarching research methodology. The use of case as organisational context, and the SIT framework in relation to the ethnographic intent is outlined. The methods used to collect the data are discussed in Chapter 4. The results are presented in Chapter 5. The findings of the research are discussed in Chapter 6. Implications and conclusions from the research are presented in Chapter 7.
Chapter 2: Literature Review

The literature was reviewed for common theoretical understandings of profession, professional, and professional identity within the context of nursing. The focus of this research was to examine the influence the clinical nursing team has on defining professional identity of nurses, both registered, and enrolled nurses. In order for this to be undertaken the literature was examined to review nursing’s relationship with the concept of profession, and professional identity. Relevant literature on the historical development of the profession of nursing, and other seminal writings in nursing was included.

Also provided in this chapter is a commentary of past, and current literature on SIT that had a potential to inform a research framework that would be applicable to the nursing context. The general hypotheses of SIT are reviewed. These are social identities, group performance, and self-categorisation.

Literature, and research related to the professional activities of clinical handover, and the multidisciplinary team meeting were also reviewed. Both handover, and the multidisciplinary team meeting are used as the professional activities from which the data for this project were collected. The Chapter ends with an explanation for the use of SIT in relation to researching professional identity within particular nursing contexts.

Search Strategy

An integrative review was undertaken to determine current research, and knowledge on the concept of profession, and nursing, and the existence of any works relating SIT, and nursing. This search strategy was applied initially, and subsequently throughout the research process. The implementation of the online search included the key topic areas of SIT, Professional Identity, and Nursing, Nursing Profession, Clinical Handover, and MDMs. The search terms included social identity theory, professional identity, professional identity nursing, and nursing profession, these were searched separately to clinical handover, nurse handover and the multidisciplinary meeting. The databases systematically searched were CINHAL, Cochrane Library, Embase, SAGE research methods online, SCOPUS online, Web of Knowledge, OVID MEDLINE, Proquest Social Science journals, and Social Theory.

Literature searches utilising Profession identified some key seminal works. These works have been drawn upon extensively throughout the literature review chapter to ensure a clear, and consistent definition of Profession. There was much literature focusing on professional identity
and undergraduate training to the nursing profession, there was limited literature connecting professional identity and nurses’ workplaces. Literature focusing on the training of undergraduates, and its relation to profession was excluded. Some key seminal nurse theorist works were included. These papers were included due to their specific relevance to either the development of professional identity or the nursing profession.

**Figure 1: Social Identity Theory & Professional Identity Search Strategy**

The literature search for both Clinical Handover, and Multidisciplinary Meeting (MDM) was quite focused, and therefore, included only a small amount of literature. Inclusion criteria for Handover focused on two key areas. The first was the concept of handover as a nursing activity. The second area focused on literature that discussed issues of group handover, impetus to change the process of group handover to bedside handover.
Commentary Papers on the Nursing Profession

Historically, nurses have had a troubled relationship with the image of nursing, and legitimising as a profession. Often public perception reinforces the negative image of nursing, this is demonstrated in the paper by Morris (2010), where nurses’ work is described as “nasty, dirty, and unpleasant tasks” (Morris, 2010). In Morris’ summation of a marketing campaign undertaken in the UK to address nursing's image, it was concluded that the public perception of nursing was removed from the reality of nursing, and, therefore, the public image of nursing was potentially damaging to the nursing profession. As well as an image problem nursing continues to struggle with legitimising itself as undertaking autonomous practice, an important attribute in characterising a profession (Liaschenko & Peter, 2004). Liaschenko, and Peter (2004) discuss in their paper the complexities of the contexts within which nurses work, identifying the complex hierarchies where nurses are "subordinate to organisational structures" (Liaschenko & Peter, 2004, p. 489).Grice Robinson (2013, p. 43) in her commentary piece recognises that “most of the real work of nursing is intangible”. As a result other authors (Aranda & Law, 2007; Daly, Speedy, & Jackson, 2004; Duffield, 1986; Grice Robinson, 2013) identify the continuing struggle nursing has to identify, describe, and clarify an identity, and establish a right to autonomy. Aranda, and Law (2007, p. 565) identify the struggle nursing has had with professionalisation that:
In claiming to develop, and use both its own, and others theoretical, and practice-derived forms of knowing, nursing attempts to either make the dualism of nursing, and medicine more inclusive through its insistence upon sameness with medicine in making similar occupational claims to professionalism, and scientific knowledge, or in its attempts to reverse the binary, whereby nursing has asserted its difference, and distinctiveness from medicine (Aranda & Law, 2007, p. 565).

However here it must be acknowledged that Carper (1978) in her seminal work on patterns of knowing in nursing, very clearly identified the unique body of knowledge required to be a nurse, which is multifaceted, and includes four areas: the science of nursing, the art of nursing, the personal knowledge of nursing, and the moral, and ethical knowledge of nursing.

Further literature supports this ongoing issue of nursing’s place as a legitimate profession (D’Antonio, 2006; Fairman & D’Antonio, 2008; Muehlbauer, 2012; White, 2012). Muehlbauer (2012) in her editorial piece identifies the poor portrayal of nurses in the media, but identifies that the nursing profession needs to take ownership of this if it is to change. D’Antonio (2006) takes the stance that nursing is a practice profession. This essay identifies the need for historical research questions to focus on the nursing profession as “at the center of an institution’s (hospital’s) history” (D’Antonio, 2006, p. 242). The paper written by Fairman, and D’Antonio (2008) identifies nurses significance in the history of clinical practice, that nursing has made hospital, and medical practices possible. This paper identifies the significance of nursing practice to enact what is identified in medical theory, nursing practice is therefore integral to clinical practices (Fairman & D’Antonio, 2008). The inherent need to link clinical practices as complex undertakings of a team of clinicians renders the notion of autonomy as limited within the clinical context. Both these papers legitimise the importance of nursing to clinical practice.

Historically the validation of the nursing profession in Australia is best recalled in Duffield’s paper (1986). The first move towards nursing gaining full recognition as a profession was focused on legitimising nurse training, shifting it into higher educational institutions. In Australia this move was sometime after similar OECD (Organisation for Economic Co-operation and Development) countries. In the 1960s to 1980s there was a deliberate move across the UK, North America, and Australia, and New Zealand to make nursing stand independently as a professional occupation. The recognition of nursing as a profession within Australia did not truly emerge until the mid-eighties when nursing gained entry into the tertiary education sector (Duffield, 1986). Even though the work towards professionalisation of nursing in Australia
commenced in the mid-sixties it took another twenty years before the actualisation of nursing education progressed to the level of other healthcare professions. After much opposition from the medical profession (Duffield, 1986) by the 1990s all Nursing education within Australia had been moved into tertiary educational institutions. This move began the long path to legitimise nursing as a profession alongside the traditionally recognised professions of Medicine, and Law (Freidson, 2001).

This was clearly evidenced in the difficulty of nurses to gain recognition as a profession in the latter part of the 20th century (Duffield, 1986). This difficulty, specifically in Australia, has been attributed to two main reasons. The first being the opposition posed by the powerful medical profession, and secondly the threat to nursing shortages with the withdrawal of student nurses from the nursing workforce during the initial transition into university training (Duffield, 1986). However, by the 1980s nursing had gained professional status internationally. Nursing now meets all the accepted criteria required for a profession as outlined by Greenwood (1957), and will be discussed in more detail later in this chapter. Nevertheless nurses continue to have trouble describing their work in a way comparable with other professions, and there remains a lack of research by nurses to describe, and clarify their identity within a professional context (Grice Robinson, 2013). This project intends to contribute to this literature.

Much of the literature reviewed relates in some way to nurses’ professional identity or the development of professional position. However there is an overemphasis in the literature on the academic preparation and the first year graduate nurse programs with little on the other aspects that contribute to professional practice (Betts, 2006; Daly, et al., 2004; Gray & Pratt, 1991; Grealish & Trevitt, 2005; McAllister, John, & Gray, 2009; Ousey & Johnson, 2007; S.D Scott, 2008). Andrew (2012) in her paper on nursing in the United Kingdom focuses on the academic identity of nursing. She argues that in relation to training nursing has “now attained parity with other disciplines” (Andrew, 2012, p. 848). Although academic preparation remains fundamentally to a profession, it is only one factor attached to professional identity. This paper (Andrew, 2012) is a commentary piece, and not based in research. For Corbin (2008) the pursuit of professionalism may well have decreased the focus on caring in nursing. This paper highlights the conflict of between nurses as professionals and the possibility that this may lead to the undermining of caring in nursing.

This section has reviewed commentary papers, which demonstrates that the literature is thick with commentary papers, there is less evidence of research literature focusing on nurses’ professional identity. This shows a lack of research targeting the meaning of professional identity, and nursing. There also appears to be gaps in research into the social context of
nursing practice, and this potential link to professional identity. The research that was considered significant and relevant to this project is reviewed in the following section. This literature although limited in amount highlights some of the key issues, and challenges of the profession of nursing.

**Nursing Research Literature, and Profession**

Morris et al. (2011) undertook a qualitative research survey, collecting data from both nurses, and the public. The results support the complex notion of nursing image, and found that there were ten (10) main themes that affect nursing, and its image: nurses have a high awareness of the issue (of the image of nursing), the cliché nurse, suffering by comparison, lack of visibility, faceless, and female, focus of (blamed for) system's ills, belief that sometimes criticism are true, nursing seen as a vocation, low self-regard/confidence, leading to, low energy, and passivity. However the public also have a positive perception of nursing work: nursing is difficult, and nasty work but of real value, nurses are underpaid, and make real sacrifices, nurses are people of principle, nurses care, and try their best against many odds (Morris-Thompson, et al., 2011). Another research paper by Emeghebo (2012) undertook descriptive exploratory qualitative project that identified that:

- nurses working in hospitals have negative perceptions of the profession; nurses working in maternal–child health have positive perceptions; nurses' perceptions of nurses working in areas different from theirs are negative; nurses perceive senior nurses in a negative light, and senior nurses have negative perceptions of new nurses (Emeghebo, 2012, p. e49).

These research projects further contribute to the issues of nursing, and its clarity of professional identity.

There has been some recognition in the literature that the social context of nursing is important to the nursing profession. Two significant studies have influenced the development of this research. These were Propp, Apkar, and Ford (2010); and Levett-Jones, and associates (Levett-Jones & Lathlean, 2009a, 2009b; Levett-Jones, Lathlean, Maguire, & McMillan, 2007b; Levett-Jones, Lathlean, McMillan, & Higgins, 2007). Apkar, et al (2009) undertook a study to look at the relationships among “nurse–team communication, identification (organisational, and team), and intent to leave” (J. Apker, et al., 2009, p. 106). Analysis of surveys utilising the principles of SIT was new to nursing research. The conclusions were that the organisational identification was a stronger predication of intent to leave than team identification. This study was significant in its use of SIT as an influence on nurses’ practice. Apkar et. al. (2005) had also previously identified
that nurses are more likely to identify with their hospital, and the nursing professions if they feel socially supported by their co-workers.

Another significant study that has influenced the development of this research project was the work in relation to nurses' professional identity as is seen by the valuable work undertaken by Levett-Jones, and associates (Levett-Jones & FitzGerald, 2005; Levett-Jones, Gersbach, Arthur, & Roche, 2011; Levett-Jones & Lathlean, 2008, 2009a; Levett-Jones & Lathlean, 2009b; Levett-Jones, Lathlean, Higgins, & McMillan, 2009; Levett-Jones, Lathlean, Maguire, & McMillan, 2007a). This work was predominantly researching nursing students, and graduate nurses and did not extend beyond these initial stages of introduction to the profession. What was concluded from this research was the need of nursing students to belong to the nursing team when on clinical placement, facilitating a successful clinical placement. The importance of belongingness within nursing practice in relation to the nursing team opens up questions around the nursing working group.

Again it is emphasised that the actual research studies into professional identity, and nursing are limited, and this research has certainly attempted to assist in addressing this gap.

**Literature on the Definitions of Profession**

Once the literature relating nursing, and profession was reviewed there was an obvious need to clarify the concept of profession. The literature tends to make assumptions that the concept of profession is commonly understood but fails to clearly define profession. The words profession/professional/professionalism are frequently seen as signifying an attribute that a person can develop within an occupation. As long as societal attitudes of the individual are upstanding, then they are considered professional, some articles list these attributes, as demonstrated in the paper by Pavlish (2009). Pavlish (2009) undertook a study looking at how palliative care nurses perceived their roles, and the professional attributes from this study were identified as, clinical expertise, honesty, family orientation, perceptive attentiveness, presence, collaboration, and deliberateness. These attributes are certainly significant in relation to the ingroup attributes of a professional group but do not provide a clear recognition of profession in relation to a whole occupation of like workers.

To ensure there was clarity around the concepts of profession throughout the current research project the seminal work of Greenwood (1957), and the works of Freidson (2001), and Sullivan (2005) were drawn upon to create a clear definition of profession. Rather than personal attributes professional attributes, are specific elements that "permit the members of an occupation to make a living while controlling their own work" (2001, p. 17) In 1957, Greenwood
(1957) identified four of these attributes as: a systematic body of theory; professional authority; sanction of the community, and regulative code of ethics.

Sullivan (2005), built upon these original attributes and emphasised that the characteristics of a profession depend on a shared body of knowledge, skills, and attitudes. As a result, professions “have been able to exert considerable social influence on the basis of their claim to expert knowledge, and skill” (Sullivan, 2005, p. 11). Social influence of a profession has significance in maintaining standards within society. Professions are seen to contribute to prosperity, and technical development in advanced societies (Sullivan & Benner, 2005). One last significant attribute of a profession is identified as, those belonging to a profession to have the ability to self-reflect on practice (Sullivan & Benner, 2005). The ability of self-reflection is fundamental to the scholarship of research within all professions (Sullivan & Benner, 2005).

Literature supports the proposition that nursing has the attributes of a profession. The first being the systematic body of knowledge. The seminal work of Carper (1978) gives a clarity to what is the unique body of knowledge of the nursing profession. In her paper (Carper, 1978), she outlines the sameness, and uniqueness of nursing knowledge to other health professions. Carper (1978) identifies four key areas of nursing knowledge these are, science of nursing, the art of nursing, the personal knowledge of nursing, and the moral, and ethical knowledge of nursing. This work was fundamentally important to recognising the unique ways of knowing within nursing that differ from the other health professions, clarifying the systematic body of knowledge of nurses

Benner’s (2001) seminal work on novice to expert aligned nurses ability to work towards a level of professional expertise by moving through the practice phases of novice, advanced beginner, competent, proficient, and expert. Benner (2001) identified that not all nurses will reach a level of expertise but this was something to aspire to through both theory, and practice development. Given that there has been a clear recognition of the first attribute a systematic body of theory, there remains a lack of confidence within the nursing profession to claim this body of knowledge. The literature identifies the reasons for this may be due to the continued questions around autonomy of practice. A research survey undertaken by Katrinli, Atabay, Gunay, and Gureri (2009) in Turkey suggested that "incorporating autonomy to nurses' jobs, and increasing their acceptance of responsibility, and personal accountability may have direct positive effects on patient well-being" (2009, p. 71). This research also acknowledged that nurses work in teams, and as has been discussed earlier this focus on individual autonomy is possibly the wrong focus. Instead, a focus on team autonomy may be more realistic, given clinical practice does not lend itself necessarily to individual autonomy, but rather “the development of roles,
and relationships in clinical practice is ultimately a matter of historical contingency” (Fairman & D'Antonio, 2008, p. 436).

This ongoing debate around nurses' professional standing ultimately affects professional identity which then clouds the rich descriptions, and vast research that identifies nurses’ independent body of knowledge (Corbin, 2008; Flatley & Bridges, 2008; Maben, 2008). At a clinical unit level this body of knowledge is readily on display, and there is clearly a distinction between nurses' work, and knowledge, and other health care professions. Continued emphasis on developing nursing knowledge within the empirical scientific realm continues to confuse developments of the uniqueness of nursing knowledge (Aranda & Law, 2007). Taking into account how identities are developed within social contexts may assist in understanding some of the uniqueness of nursing knowledge. Capturing the complexities of current contemporary nursing contexts where nurses now juggle complicated patient care in institutional settings, and bureaucracies whilst maintaining economic, and industrial developments (Giddens, 2010, pp. 451-453) is worthy of further investigation.

In relation to professional authority there are some very distinct attributes recognised in the literature relating to the profession of nursing. One of these attributes being integrity (Cribb, 2011, p. 119). In Cribb’s (2011) commentary paper he identifies that integrity is the successful negotiation between the "moral burden of occupying a professional role, and having to negotiate tensions between the normative expectations attached to that role, and one’s own personal moral compass". Edgar (2011, p. 119) also discusses the importance of integrity to professional practice, but he does this in light of the complexity of practice (Edgar & Pattison, 2011). Altruism is also attached to attributes relating to the profession of nursing "professional identity appears to evolve from a general altruistic motivation to a set of values which are specific, and differentiated" (Fagermoen, 1997, p. 440).

Caring is recurring attribute of nursing. Williams, Dean, and Williams (2009) undertook a study, identifying that nurses are “significantly more caring, conscientious, and resilient” (Williams, et al., 2009, p. 162) than adult females outside the nursing profession. This study excluded nurses who were male. The concept of care, and the profession of nursing is well documented in the literature, and is valued amongst nurses as a fundamental attribute of the profession (Corbin, 2008; Flatley & Bridges, 2008; McCormack, Dewing, & McCance, 2011; Williams, et al., 2009).

The attribute of patient advocacy is also emphasised within the literature. The notion of patient advocacy is defined as “the identification, promotion and upholding of human values (Cameron 1996). There were nine (9) articles that were reviewed relating to patient advocacy for this chapter (Baldwin, 2003; C. Cameron, 1996; Cook, 2011; Mahlin, 2010; Segesten, 1993; A. P.
Smith, 2004; Ulrich, 2011; Woodward, 2011). Mahlin (2010) undertook a qualitative study to determine practice nurses interpretation of patient advocacy. The findings indicate that practice nurses aimed to protect patient through both direct, and indirect means, resulting in both positive, and negative outcomes. Mahlin (2010) in her commentary paper identifies that patient advocacy is usually the result of individual nurses advocating for individual patients. This paper suggests that “through collective advocacy, professional nursing associations ought to extend the reach of individual nurses in order to address systemic problems in health care institutions, and bureaucracies” (Mahlin, 2010, p. 247). In the commentary paper by Cameron (1996) there is an alternative view to patient advocacy particularly in relation to the patient with cancer. Cameron (1996) identifies that there are difficulties for the nurse to adequately advocate for these patients. Instead Cameron suggests “perhaps the most ethical way of caring is by empowering patients, and promoting self-advocacy” (1996, p. 81). The editorial by Ulrich (2011) clearly states that patient advocacy is core to the nursing profession, while Smith (2004) discusses in her commentary paper the conundrum of patient advocacy. In summary there are key attributes awarded to the professional authority of nursing. These include integrity, altruism, caring, and patient advocacy. The literature identifies these as important but often controversial in the pursuit of nurses’ professional identity.

There also exists a strong notion that as a profession there is a requirement to serve, and perform within the public’s interest, whilst having the ability to self-regulate, which allows for protection of the professions own interests (Sullivan & Benner, 2005). This self-regulation is important as it ensures the profession controls the entry point to the profession through the completion of specific educational qualifications that are exclusive to that profession. All professions require the existence of professional bodies/associations that control, and monitor conduct, and performance within their profession (Giddens, 2010). Since the 1970s there has been a progressive and purposeful move for nursing to develop these attributes, and self-regulation in nursing. This has been successfully achieved ensuring nursing fits all required criteria of a profession. The development of a code of practice, and a code of conduct, and a competency based framework under which all Australian nurses must be registered, and adhere to; further validate nursing as a profession. The competency framework was accepted in 1992 (AHPRA, 2012), and regulates the registration of, registered nurses, enrolled nurses, and midwives. The Australian Health Practitioner Regulatory Board (AHPRA) which came into effect in July 2010 requires all nurses, and midwives to be registered in order to practice nursing, and/or midwifery. This national registration was the result of a national law requiring regulated registration for the fourteen (14) recognised Health professions within Australia. The Nursing,
and Midwifery board of Australia being one of these regulatory boards. This has legitimised nurses’ place in Australia as a recognised profession.

It can be confidently stated that nursing in Australia is a profession. Nonetheless, although nursing meets the criteria of a profession, the debate around whether nursing justly fits the categories required of a profession continues both within the profession, and from some sections of the community. It may be considered that this debate could be developed through further understanding the identities of nurses by nurses within their social working contexts. The construct of identity becomes even more relevant when it is put in the context of professionalism as shaping personal identity, "binding an individual’s voluntary efforts into a common life, and purpose" (Sullivan, 2005, p. 15).

This current research project was further influenced by the work undertaken by Apker, and associates (Apker & Eggly, 2004; Apker, Ford, & Fox, 2003; Apker, et al., 2009; Apker, et al., 2005), and Levett-Jones, and associates (Levett-Jones, et al., 2011; Levett-Jones & Lathlean, 2008, 2009a; Levett-Jones & Lathlean, 2009b; Levett-Jones, et al., 2009; Levett-Jones, Lathlean, et al., 2007a). This has led to reflection on the social impact nurses have on other nurses, and whether the application of SIT sheds any light on developments and performances of nurses’ professional identity. The literature on professional identity is quite diverse from discourses in professional identity, and their assistance in work readiness (Grealish & Trevitt, 2005) to students learning from elders, and history (McAllister, et al., 2009). Fagermon (1997) discussed the values of nurses in relation to professional identity, and there are other articles looking at different aspects of professional identity (Andrew, 2012; Edgar & Pattison, 2011). However the work done by Drew (2011) is of particular interest given the focus on data collected from community nurse handover, and also the consideration to the significance of group identity. Drew (2011) undertook a small qualitative study into the culture of community nursing. This research is interesting in that it looked at the handover as a point of data collection; the findings were that reporting time serves to enhance group identity, reduce anxieties, and relieve isolation, and were important in both the culture, and the professional identity within this group of community nurses.

Other work that has influenced the development of this current research project includes the research undertaken by Clouder (2003) on professional socialisation. Although this research was focussed on students’ professional socialisation it recognised the significance of social conformity to professional contexts, supporting the findings from Levitt- Jones et al (2007b) work. Clouder (2003) discusses the significance of the clinical environment “fieldwork placements provided the dynamic for learning to play the game because, as all students found,
the rules in terms of behaviour seemed to be more prescribed in practice than within the university” (2003, p. 217). Further work undertaken by Clouder, and associates (2011; 2010) has focused on interprofessional learning, and the development of professional identity. Although this is not as specific to the current research project, the findings are potentially significant in that interprofessional learning was found to have a positive impact on where one’s own profession fits in into the healthcare team, and therefore reinforcing professional identity.

However, the overall majority of current research focuses on students’ experiences, and there remains a lack of literature that focuses on working contexts of trained nurses, and the potential relationship of these contexts to the construction of professional identity. As a result this project focuses on nurses who have completed their undergraduate nursing training working within their clinical work contexts. This is where social psychology, and particularly the theory of Social Identity has the potential to advance understanding into professional identities in Nursing.

**Social Identity Theory**

This section will overview the work of SIT, and review key published works from SIT research. The importance of social identities is well researched within social psychology, and the SIT contribution to understanding of groups may have particular significance to the nursing context. Since it was first described, SIT has developed a well-established research framework with empirical data to support the theoretical underpinnings (Abrams & Hogg, 2008; Haslam, 2004; Haslam, et al., 2012; Hogg, et al., 2005; Hogg & Terry, 2000, 2001; Postmes & Branscombe, 2010). A brief review on the literature of SIT, and its key concepts follows.

SIT was first described in the 1970s by Tajfel, and Turner (Worchel & Austin, 1979) Original studies using SIT aimed to describe intergroup discrimination (Haslam, 2004, p. 18). These first studies were called minimal group studies, and Tajfel (1974) concluded that the process of categorising oneself as a group member gives an individual’s behaviour a distinct meaning, creating a positively valued social identity. This identity then becomes an integral aspect of an individual’s sense of who they are (Haslam, 2004, pp. 18-20). What became clear from the original studies was the importance of context in determining in-group behaviours. Therefore, the importance of context in relation to social identity is a foundational principle within SIT. When the context is defined along group-based lines, an individual will think from the perspective of group membership (Haslam, 2003, p. 23). Nursing practice is undertaken in many varying contexts but usually within a group. A key hurdle for the profession of nursing has been the varying contexts in which nursing practice is delivered, complicating the clarity around
the professional identities of nurses. A research framework that highlights the contextual importance to social identity has particular relevance to nursing research. The relevance of a theory such as SIT is that the hypotheses that form this theory are testable, and able to be adapted to different contexts.

**Social Identity Theory Defined**

SIT is defined as an explanatory framework focusing on the psychological underpinnings of intergroup relations, and the distinctiveness of in-groups (Haslam, 2004, p. 281). There are some well-defined hypotheses, and concepts that afford this theory some distinction in comparison to other social psychology theories. What was new to social psychology was the development of research by Turner that suggested the “psychological field within the individual is socially structured” supporting the “interactionist approach of Kurt Lewin, Solomon Asch, and Muzífer Sherif” (Haslam, et al., 2012, p. 202). Up to this point, social psychology had viewed intergroup behaviour from two differing camps. The first being the individualistic psychologies that:

- have privileged the individual over society, and the role of the social group is merely to accentuate our individuality. On the other hand the idealist psychologies... have privileged the social over the individual, and treat people in collective settings as mere ciphers of societal belief systems... group minds separate from the minds of individuals. (Haslam, et al., 2012, p. 202).

The theorists, and researchers who have worked on this theory see it as a new vision “of human beings, and human minds: one that is rich, productive, and empirically, and theoretically coherent” (Postmes & Branscombe, 2010, p. 13). SIT is distanced from the individualistic conception of the human mind, and “argues that a defining feature is the social, and psychological interdependence of the individual, and the group. Human beings are neither merely individuals nor merely group members” (Postmes & Branscombe, 2010, p. 13).

The premise to SIT is that it acknowledges the importance of group belongingness as a consequence of the interpersonal-intragroup continuum as categorised by Tajfel (Haslam, 2004). As has previously been discussed, research into the significance of belongingness for nursing students has recently gained much attention with the work by Levett-Jones, and associates (Levett-Jones, Lathlean, et al., 2007b). They identified the importance of belongingness of nursing students within their clinical placements (Levett-Jones, Lathlean, et al., 2007b). As established by Levett-Jones et al. (2007b), research into belongingness has not been widely undertaken within the scholarship of nursing. The work done on belongingness goes on
to signify that belongingness plays a central part in a student's potential to develop clinical competence (Levett Jones & Lathlean, 2009). Belongingness within the context of Levett-Jones research included the cultural context of the nursing clinical unit/ward (Levett-Jones & Lathlean, 2009b; Levett-Jones, Lathlean, et al., 2007b; Levett Jones & Lathlean, 2009). While the importance of a nursing group within this unit, and belongingness, is a concern for nursing students, it is also likely to impact on qualified nurses who work within these clinical units. SIT acknowledges that the concept of belongingness is an important attribute in the development of social, and professional identity of nurses well after they finish their undergraduate training. SIT theorises social cognitive, and social conceptual perspectives with social interaction, and communication being fundamentally important (Hogg & Reid, 2006). Social identity is displayed in group membership, “supported, and sustained by group membership” (Hogg & Abrams, 2001, p. 256). Further, social identity makes group behaviour possible (Haslam, 2004, p. 29) There has been much research around the application of SIT to organisational contexts (Haslam, 2003, 2004; Hogg & Terry, 2001), and there is potential to apply these research designs to the group construct of professionalism within nursing contexts. This current research project focused on a specific cultural context of two clinical nursing units within an acute metropolitan hospital.

Further detailed explanation of the key concepts of SIT within the literature will now be explored. These principles are divided in to three core areas, group performance, social identities, and self-categorisation. (Haslam, 2003, pp. 57; 119-121; 243). These will be used to explore SIT throughout this thesis.

**Group Performance**

SIT has afforded significant research into group performance, particularly in relation to organisations (Ashforth & Mael, 1989; Haslam, 2003, 2004; Hogg & Knippenberg, 2003; Hogg & Terry, 2000, 2001; Moreland & Levine, 2002; V. Lloyd, Schneider, Scales, Bailey, & Jones, 2011). SIT takes the perspective that an organisation depends on its employees to “engage in spontaneous acts of cooperation, helping, and innovation”, and not the simple enactment of a job description (Haslam, 2003, p. 30). The development of group performance within work or organisational groups is based on this hypothesis, and is referred to throughout this thesis as organisational citizenship behaviours (Haslam, 2004, p. 76). Group performance is further divided into four significant categories; group motivation, group goals, group norms, and group efficacy (Haslam, 2003, pp. 29-42).

**Group Motivation**

SIT emphasises the importance of group motivation on "behalf of the collective" (Haslam, 2003, p. 31; Lewis, 2011; Turner, Oakes, Haslam, & McGarty, 1994). Therefore the argument is that
Higher group functioning occurs when there are motivated group members as opposed to motivated individuals within a group (Haslam, 2003, p. 31). The outcome of group motivation is ultimately performance goals or group effectiveness (Lewis, 2011). The more the individual identifies with the group, the more the individual is motivated to internalise the group norms, and performances, however this motivation is the result of a “pro-self rather than pro-social orientation” (Haslam, 2003, p. 33). Therefore, the collective interests are perceived by the individual as the individual’s collective self-interest (Haslam, 2003, p. 32; Van Knippenberg, 2000). To this point, this collective motivation appears like organisational behaviour (Van Knippenberg, 2000) but can be extended to what is commonly identified in nursing literature as enculturation (Chang, 2008; Duchscher, 2009). SIT is less interested in what motivates the individual per se; rather what motivates the individual to work on behalf of the collective (Haslam, 2003, p. 31). Hence, motivation to perform is intertwined with identification with the group such that the more the individual identifies with the group, the more motivated they are to work on behalf of the collective within that group (Van Knippenberg, 2000). This relationship between identification, and performance is not simple. In order for motivation within the group to enhance group performance, there is a need for volitional control (i.e. the conscious control of performance). This, according to Van Knippenberg (2000), will assist in ensuring motivation remains high enough to effect performance within the group (Van Knippenberg, 2000).

Group Goals, and Group Norms

Group norms, and goals in SIT move away from the traditional social psychology view that they exert external influences on the individual (Hogg & Terry, 1998; Terry, Hogg, & White, 1999). Instead, SIT sees group norms as standards that are “internalised through identification, and thus mainly affect group members attitudes, and behaviours to the extent that individuals identify with the group” (Haslam, 2003, p. 37). High performance is only a goal if it is a group goal or group normative (Hogg & Terry, 1998). In terms of an organisation, the relevance of group goals, and norms will be dependent on the salience of particular performance standards. In turn the salience of these standards will differ depending on the level of the organisational group. For example, the organisation may be focused on the performance of a KPI (Key Performance Indicator) that emphasises quantity, whereas within the clinical unit the focus will be more on the quality of professional performance (Haslam, 2003, p. 39).

Group Efficacy

There have been multiple studies using SIT (Haslam, 2003) to explore the concept of group efficacy, and the results have supported the hypothesis that “identification-induced motivation to perform well only results in actual attempts to perform well to the extent that high performance is perceived to be under volitional control” (Haslam, 2003, p. 39). This also
supports the view that tasks are more likely to be undertaken if performance success is expected either by the group or the individual. This has significance to nursing research in that a key attribute of a profession is autonomy within practice. Historically, nursing has been viewed as an oppressed group that was dominated, disciplined, and shaped by external but powerful ideologies such as medicine, and gender (Gray & Pratt, 1991, p. 430). It could be said that historically nurses have had limited volitional control of its work performances, and this has had an impact on group functioning both in relation to higher, and lower-order identities, which is further explained in the following section. More research is required to clarify this issue.

The complex nature of group performance in turn creates complexities for the researcher. This is simplified by dividing group performance into the areas of group motivation, group goals, group norms, and group efficacy. The identification of the individual to the collective remains essential in group performance (Haslam, 2003, p. 41). Although group performance does not always equate to high performance, there are some influences that impact on expectations of group performance, these include; identification with the group may be low, within the social setting the group may not be salient, group norms may not favour performance expectations achieving performance may not be seen as possible by either the group or its individuals (Haslam, 2003, p. 41).

### Social Identities

Social identities are the core underpinnings of SIT theory. The notion of social identities can be broken into further categories of *social identity salience*, *nested identities*, and *cross cutting identities*.

#### Social Identity Salience

The notion of identity salience is derived from identity theory, and has been further applied to the social identity framework, and identified as *social identity salience*. *Social identity salience* is in keeping with an individual’s identity (Hogg & Abrams, 2001). There is, however, the potential for multiple changing identities dependent on a given group situation. The salience of an individual’s given identity to a particular group will depend on the ranking given in a specific context thus producing the salient hierarchy (Hogg & Terry, 2001, p. 32). Identities, theoretically speaking are organised into a salience hierarchy dependent on context. Further to this, *social identity salience* can be flexible depending on a given social situation (Ickes & Knowles, 1982, p. 206). Identity Salience acknowledges the personalisation of social identities, and the idiosyncratic interpretation of a social identity is very much determined at an individual level (Hogg & Terry, 2001, p. 45). SIT emphasises that the salience of social identities will also be context dependent (Haslam, 2003, pp. 35-36). To further explain the contextual importance
of social identity salience, it must be recognised that an individual has multiple social identities, and which identity is salient in any given context is complicated.

The most important concepts in determining the salience of a given social identity, are the identity’s subjective importance, and situational relevance (Hogg & Terry, 2001, p. 32). The more subjectively important an identity is, the more the individual will seek to enact this identity. The subjectively important identity is central to the individual’s core sense of self (Hogg & Terry, 2001, p. 32). “A situational relevant identity is one that is socially appropriate for a given context” (Hogg & Terry, 2001, p. 32).

**Nested Identities**

Nested identities are those that are “attached to formal social categories” as in organisational structures, formal roles, and jobs, workgroups (Hogg & Terry, 2001, p. 41). Nested identities are then classified into higher-order identities, and lower-order identities (Hogg & Terry, 2001, p. 33). Higher order identities relate to strategic professional organisations, such as AHPRA (Australian Health Practitioner Regulation Agency). Lower order identities relate to the nursing staff within a given clinical unit. Both of these have significant impacts on social identities particularly in relation to organisational social categories. Hogg, and Terry (2001) argue that nested identities have three dimensions; inclusive/exclusive; abstract/concrete, and distal/proximal.

Higher order identities tend to be inclusive; for example, AHPRA could be seen as belonging to a higher-order category that is inclusive of all nursing roles, no matter the diversity of performance or context. Lower order identities are more exclusive as there are more specific criteria restricting membership. For example, the Australian College of Operating Room Nurses (ACORN) has the membership criterion for nurses that work in operating theatre. A still lower, and more exclusive nested identity may be the nurses who are employed in a particular theatre suite in a specific hospital (Hogg & Terry, 2001, p. 34). Likewise, higher order nested identities are more abstract in their identification criteria due to the need to involve multiple lower order nested identities. Lower order identities are then much more concrete in their categories (Hogg & Terry, 2001, p. 34). Therefore, the abstract identification of an individual as a nurse, but the more concrete category of a nurse within a specialty i.e. an operating room nurse, has expertise, and training to have concrete, specific clinical skills relating to managing cardiac patients. Further distinction depending on the specific clinical unit within a specific hospital would result in further categories that then result in even lower concrete identification. The result is that lower order nursing identities become more exclusive, and concrete the further that nurses
identity within a specific nursing context. The most obvious example of this would be the clinical unit within a large metropolitan hospital.

Proximal/distal identities refer to the impact the identities have on an individual. Higher order nested identities tend to have an indirect or delayed impact on an individual. Lower order nested identities tend to have a direct or immediate impact on an individual (Hogg & Terry, 2001, p. 34). An example of this is the delayed impact that senior management decisions may have on a nurse working at the bedside, as opposed to the direct impact the decisions the Nurse Unit Manager makes to the bedside nurses’ working context. The concept of nested identities helps in development of the social identity framework to describe, and identify the in-group characteristics of any given social group, particularly in relation to work. It can be assumed that usually identity salience is relatively stable in nested identities and the clinical unit is a good example of a nested group.

Cross Cutting Identities

Cross cutting identities is a concept usually applied to organisational contexts but is equally relevant to professional contexts. Cross cutting identities are “attached to social categories, and can be either formal or informal” (Hogg & Terry, 2001, p. 41). An example of a formal cross cutting social category might include membership of a committee while informal cross cutting social categories refers to friendship groups or cliques. Cross cutting identities are usually lower order identities, and therefore tend to be concrete, exclusive, and proximal (Hogg & Terry, 2001, p. 41). The impact of these groups will depend on the level of situational relevance, and subjective importance (Hogg & Terry, 2001, p. 41), and therefore their identity salience is usually fluctuating.

Self-categorisation

J.C Turner described self-categorisation in the 1980s (Turner & Hogg, 1987). This was a further extension to SIT, and expands on the understandings of self, and the collective self, which is considered a cognitive construct (Turner, et al., 1994). The individual is viewed in terms of “idiosyncratic personal attributes” whilst a group is viewed in terms of group attributes, shared by others who are perceived to be within the group (Haslam, 2004, p. 30). Therefore, the individual is afforded many categories at different levels of abstraction. The higher the category level, the more inclusive the abstraction is, and the lower the category the more exclusive the abstraction becomes (Haslam, 2004, p. 30). This self-categorisation concept within SIT has extended the explanation of self. It is perceived that self-categorisation has three levels; superordinate human level, Intermediate social level as an in-group member, at a subordinate personal level (Haslam, 2004, p. 30).
It is at the social level that SIT is most focused, and multifaceted, as there are many groups to which an individual can belong at any given time. This is a relative concept that is individual, equally real, and a reflection of a person’s true self (Haslam, 2004, p. 31). Like SIT, self-categorisation differs from the traditional psychological stance that focuses on the “person’s true self is identified by their individuality” (p. 31), instead defining individuals by intergroup and intragroup relations. It is in the differences between the intergroup, and intragroup that self-categorisation is helpful to research developments. This subtle emphasis in self-categorisation explains from the individual’s perspective the relationship to the social category (Hogg & Abrams, 2001, p. 207). Further to this, the importance of self-categorisation is explained as:

People are motivated to make sense of the world around them..., so they can cope more effectively with whatever problems occur. Categorisation is helpful because it allows people to respond rapidly to stimuli, without evaluating them exhaustively. Second, social as well as non-social stimuli can be categorised, and the categorisation of social stimuli involves the self as well as others (Hogg & Terry, 2001, p. 95).

Self-categorisation can be deconstructed further into two important social categories of organisational intergroup/intragroup relations; pride, and respect. Pride is attributed to intragroup relations (position of the group as a whole), and respect is attributed to intragroup relations (i.e. the position within the group) (Hogg & Abrams, 2001, p. 223). SIT espouses that an individual’s sense of self-worth is reflected in their evaluation of the groups to which they belong. In addition, evaluation of the individual’s level of respect within the group has an effect on the individual’s self-esteem rather than the evaluation of the group as a whole (Hogg & Abrams, 2001, p. 225).

Social Identity Theory, and its Relevance to Nurses’ Professional Identity

As was described in the previous section SIT has relevant concepts that can contribute to the understanding, and describing nurses’ professional identity. The literature reviewed in this chapter from the seminal nursing papers through to current literature, and research, highlight the potential for SIT to inform understanding of nurses’ professional identity. Concepts of profession, and professional identity, studied utilising the SIT concepts of social identities, group performance, and self-categorisation formed the underpinnings for this research project.
The contextual importance of social identities within groups can be applied to the nursing workplace by examining identity salience, nested identities, and cross cutting identities. The concept of social identities is important to nurses’ professional identity because it has the potential to inform, and describe the many, and varied contexts in which professional nurses undertake their work, and give voice to the diversity of identities within nursing. The identification of nursing work remains obscure, and often difficult to explain, and there is a risk that this lack of clarity devalues nurses’ work. Nurses have worked hard to obtain the classification of a profession but further work is required to justify, and clarify nurses’ professional position within healthcare. SIT may provide a language through which recognition can be given to the situated and multifaceted nature of nurses’ professional activity.

In relation to group performance, SIT emphasises the perspective that an organisation depends on its employees to “engage in spontaneous acts of cooperation, helping, and innovation”, and not the simple enacting of a job description (Haslam, 2003, p. 30). Likewise, a profession equally depends on its members to exhibit these attributes of co-operation, helping, and innovation. It can be argued that professional nurses certainly do hold such attributes, and these are clearly on display in any nursing context on any given work shift/day. Nursing work continually requires cooperation, helping, and innovation, as that is the nature of person-centred care. However, little research has been done to capture, and describe the group performances that help define the performance of nurses’ professional identity, particularly in relation to motivation, group performance goals, and norms, and efficacy. Lastly, the details of the intragroup attributes that have been described through self-categorisation also have significance to nurses’ stories. Applying SIT in future research will contribute further to the body of work on nurses’ professional identity.

There has been little focused research into the social identity that describes nurses, and its correlation to their professional identity. SIT has the potential to be applied to nurses within their working groups, and to shed light on the diversities, and similarities of nurses, and their professional identities. It can be hypothesised that there are fundamental similarities in nurses’ professional identities regardless of their work contexts but these have yet to be described.

**Handover and Multidisciplinary Meetings**

In the preceding aspects of the literature review the theoretical perspectives and research gaps which informed this project have been outlined. Because of the need to study SIT in relation to nurses’ professional identity, two easily identifiable professional activities were selected to
create a case. Literature related to these activities was then reviewed. These two activities were the nursing handover, and the ward MDM.

The handover literature afforded a plethora of commentary, and research papers. The handover meeting literature was then refined specifically targeted towards achieving identification of the essence, and controversies associated with this activity. Key literature included ritualistic practices, and current thinking around the efficiencies of group handover.

The literature around the MDM was not plentiful. Therefore, only the most contextually relevant papers were selected. The papers selected required a multidisciplinary focus, meaning more than one profession present within the meeting. Therefore papers that identified only one profession within the team meeting were excluded.

**Nurse Group Handover**

The nurse group handover is a group activity undertaken at the change of shift. This has been a ritual in nursing for many generations (Strange, 1996). Strange (1996) identified the significance of this ritual, and did not view the notion of ritual within a negative frame. The functions of handover were identified as both social to produce cohesion, and protective (Strange, 1996). This protective function of handover appears to involve concepts of both the uncertainty, and complexity of nurses’ work (Scott, Estabrooks, Allen, & Pollock, 2008; Weydt, 2009b). However, since the work of Strange (1996) there has been much change in acute healthcare organisations, and the increased need to continually rationalise the healthcare dollar both in terms of patient safety and efficiencies. The focus to change handover has come from several government initiatives to improve patient safety (Chaboyer, 2009; Chaboyer, McMurray, & Wallis, 2008; Chaboyer, McMurray, & Wallis, 2010; O’Connell, 2008; Wong, Yee, & Turner, 2008).

A literature review undertaken by the University of Tasmania for the Australian Commission on Safety, and Quality in HealthCare (ACSQHC) aimed to provide a comprehensive structured evidence based literature review regarding the effectiveness of improvement interventions in clinical handover covering Australian, and International published works (Wong, et al., 2008, p. 3). The main evidence gaps were identified as: patients’ perception, and involvement in clinical handover; morning report format; private hospital settings; professional anxiety, and handover; frameworks, and handover; Work process mapping, and design methods; education, and training of students; inter-Hospital, and patient transfer; electronic documentation, and medical records, and legal dimensions. Chaboyer, McMurray, and Wallis (2010) undertook a case study of six wards in two hospitals “to describe the structures, processes, and perceptions of outcomes of bedside handover in nursing” (Chaboyer, et al., 2010, p. 27). Their findings showed
that clinical communication was more effective if the handover was delivered at the patient bedside.

The project undertaken by O'Connell (2008) aimed to examine nurses' perceptions of handover, and to determine the strengths, and limitations of the handover process. A survey was undertaken in one hospital, and found that there were varied, and inconsistent handover processes. Therefore there has been a concerted move to disband the group activity of handover, and replace it entirely with bedside handover. The evidence strongly supports the improvement of clinical communication if bedside handover is implemented (Chaboyer, 2009; Chaboyer, et al., 2008; Chaboyer, et al., 2010; Clarke & Persaud, 2011; Kerr, Lu, McKinlay, & Fuller, 2011; Kerr, 2002; McMurray, 2010a, 2010b; O'Connell, 2008; Street, 2011).

The point of difference for this project is the focus on professional identity, and SIT. Therefore the methods to collect data focused on two significant professional activities that were consistent across the two clinical units' studies. Anecdotally the importance of both these meetings as professional activities within the construct of a nurse's working day led to them being a preferred method for data collection. Recent literature, and research into clinical handover does not acknowledge the social, and protective aspects of handover as identified by Strange (1996). Rather recent research focuses only on the efficiency, and safety of the clinical communication that occurs within the handover, and thus the move to more effective ways of undertaking this (Kerr, et al., 2011). It must, therefore, be emphasised here that this research project does not look at the clinical communication that occurs within the handover or the MDMs. Rather, the attention is around the professional activity of handover, and the social communications, and performances that afford aspects of professional identity.

**Multidisciplinary Meeting (MDM)**

Much of the literature on multidisciplinary team meetings refers to the MDM as being made up of doctors from differing specialties for example surgeons, radiologists, and physicians. There is not necessarily recognition of the larger healthcare team, and other disciplines involved in this team (Farrell, James, & Kirkbride, 2012; Kane, 2007; Loh, 2012). However, the common practice of the ward/unit multidisciplinary team meeting may not actually involve the medical doctor, who often chooses not to attend such meetings. The ward multidisciplinary team specifically used in the data collection for this project was made up of allied health, and at least one nurse. The MDM may also include students from the differing disciplines.

The literature on MDMs is varied (Boxer, Vinod, Shafiq, & Duggan, 2011; Deacon, 2013; Devitt, Philip, & McLachlan, 2010; Farrell, et al., 2012; Kane, 2007; Loh, 2012; Mazzaferro & Majno, 2011), and like the handover meeting the MDM is not always seen as time efficient (Farrell, et
al., 2012). However, Farrell et al. (2012) referred only to the medical use of time. The research study by Boxer et al. (2011) specifically looked at the outcomes of patients who had been diagnosed with lung cancer. This was a large quantitative study that identified MDM was associated with better treatment improving the quality of life for patients with lung cancer but not necessarily the outcomes. Kane (2007) identifies the time spent in MDM, and found that: “the process of preparation for meetings is having a positive influence on quality, but more resources are needed in pathology, and radiology to realise the full benefits of multidisciplinary team working”. However, many of these papers discuss the MDM in relation to the medical profession.

The intent of MDMs as used in this project is most clearly represented in the literature on breast care (Devitt, et al., 2010). Devitt et al. (2010) undertook a qualitative study of health professionals who attend MDMs, and the findings found that Health professionals endorse MDMs as a useful tool in treating patients with cancer. The MDM structure as represented in Devitt et al. (2010) paper is a common occurrence within the clinical unit of many if not most hospitals in Australia.

There is a lack of literature or research into the specific daily professional activity of the MDM, and a plethora of literature on the nursing handover. For the purpose of this current research project, the MDM is referred to as a daily professional activity involving usually the nurse in charge of the shift and the other health professionals involved with the patients of the specific clinical ward/unit.

**Conclusion**

Nurses’ professional identity is complicated. It has been identified that there are limited amounts of research studies specific to professional identity, and even fewer investigations within the context of nurses’ working environments. There is very little if any literature linking SIT, and professional identity specifically to nursing. SIT is postulated as suitable for investigation into the concepts of nurses’ professional identity. SIT recognises the contextual importance of organisational groups. Equally important are the contexts of professional groups. There is a need to develop new nursing knowledge about identity in varied nursing contexts. This includes understandings of group belongingness as a consequence of the interpersonal-intragroup continuum.
Chapter 3: Research Design

The aim of this chapter is to describe in detail the research design, and methodology that were foundations for developing a systematic qualitative research design, strengthening the research findings, and ensuring its rigour. The justification of the project is in the lack of clarity in understanding around how the workplace constructs nurses’ professional identity. Quite consciously, this core question arose from the researcher’s years of experience within the nursing profession, following the desire to understand the relationship between the social environments nurses work in, and the development of their professional identity.

The chosen methodology of organisational ethnography fits the workplace constructs, and SIT embedded in this study. Organisational ethnography, allows for an emphasis on the importance of context, and profession (Cunliffe, 2010).

**Overall Design Underpinnings**

There were key considerations underpinning the intent of the design, these are stated below.

1. Firstly the importance of qualitative design to understand SIT in relation to the construction of nurses’ professional identity within the work context.
2. That data collection would arise from a focused group of participants within a single organisational context.
3. The data would provide opportunity for understanding the human experiences of nurses within their working cultures/contexts.
4. The researcher, and the nurses would be able to give meaning in relation to observed, and intended practices
5. The data collection would be contained to two common nursing activities, these being nurses with nurses (nurse group handover), and nurses with others (MDM).

These five considerations led to decisions to choose the overarching methodology of organisational ethnography. The context of professional practice would be limited to the case context of a single site in acute care, and the activities of handover, and MDM would be the foci for the cultural investigation of identity in relation to SIT. The ethnographic methods of observation, interviews, and fieldnotes would be used to achieve the methodological congruence and the intent of the inquiry, as outlined in figure 3.
The time spent to develop the design was considered important to maximise the trustworthiness, and consistency of this project with the aim of contributing to the current evidence related to professional identity of nursing. In keeping with the ethnographic intent, this research connects both the researcher, and the researched (Cunliffe, 2010; Lecompte, 2002; LeCompte & Schensul, 1999a, 1999b, 2010; Spradley & McCurdy, 1972; Van Maanen, 2011; Wolcott, 1985).

The choice of topic arose out of years of working in the nursing profession within many healthcare organisations, predominantly in New South Wales, and Victoria, Australia. The 1980s was a time of great change in nursing with the move towards the professionalisation of nursing in Australia. Many practices within nursing are very different in the twenty first century including rapid development of health-care technologies, and increasing globalisation. However, the fundamental influences on professional identity that were anecdotally present in the 1980s still appear to be relevant today, including educational preparation, theory and practice development and nursing research. Based on SIT, it is likely that the social group that exists within a unit structure in any given hospital ward will influence the professional identity of the nurses exposed to it. In order to investigate this idea, the key questions for this research project were developed.

- What are the group dynamics within the ward that assist/impede the performance of professional identity within nursing work?
What constitutes the professional practice of the ward nurses within the hospital ward environments studied in this research project?

How are the professional positions of nurses within the hospital ward organised in practice in relation to each other, and to other health professionals?

In the following sections, the principles of ethnography as applied to organisational ethnography is explored, and details of the ethnographic case used for this project are discussed.

**Ethnographic Principles in Organisational Ethnography**

Ethnography is a relatively complex methodology that now has many constructions such as critical ethnography, organisational ethnography, ethnomethodology to name a few. It was important to understand the key concepts around ethnography generally and organisational ethnography specifically. Therefore key ethnographic researchers were used as sources to develop a sound knowledge of ethnographic research and design (Atkinson, 2004, 2007, 2008; Atkinson, Coffey, & Delamont, 1999; Atkinson & Pugsley, 2005; Emerson, 1987, 2004, 2009; Emerson & Shaw, 1984; Emmerson, Fretz, & Shaw, 2011; Spradley & McCurdy, 1972; Wolcott, 1985, 1990). What follows is a brief overview of ethnographic principles in conjunction with organisational ethnography as they apply to the context of the current research project.

By engaging in the same social processes, confronting the same organisational, technological, and administrative structures, and being implicated in the same relations of power, and control, ethnographic researchers have acquired a type of data that is simply unattainable using other modes of enquiry (Atkinson, 2007, p. 229).

Ethnography is considered a science of description (Spradley & McCurdy, 1972; Weppner, 1977), and Geertz (1973, p. 6) identifies this description as thick. Both Geertz (1973), and the founding father of ethnography Malinowski (2009), conceptualised the current approach of participant observer. Participant observation is the way thick, rich and complex description is obtained. This will be described in detail later in this chapter but from the perspective of the origins of ethnography.

Ethnography has its origins in anthropology, and is primarily focussed on culture rather than focussing on the physical, and biological paradigms (Gobo, 2008, p. 7). Culture is regarded as the knowledge, values, and beliefs that are shared by members of a group (Van Maanen, 2011, p. 3). Specifically, each bundle of knowledge, values, and beliefs (culture) is centred on that which
“informs, shapes, embeds, and accounts for the routine, and not so routine activities” of the group (Van Maanen, 2011, p. 3). Ethnography was first recognised as its own entity around the early twentieth century, prior to that it was considered part of anthropology (Gobo, 2008, p. 7). Key principles of ethnographic inquiry centre around understanding elements of cultural knowledge from the perspective of those within any specific culture (Spradley & McCurdy, 1972, p. 60). Ethnography is about understanding human experiences and this is done by "studying events, language, rituals, institutions, behaviours, artefacts, and interactions" (Cunliffe, 2010, p. 227).

Organisational ethnography emerged because of the need for understanding cultural dynamics within organisations. The principles of ethnography that include, culture immersion and detail to name a few all apply generally in organisational ethnography. In addition organisational ethnographers argue that the premise of studying people within their natural contexts allows for "grasping the complexity, intricacy, and mundaneity (commonplace activities) of organisational life" (Cunliffe, 2010, p. 229). Organisational ethnography allows for writings or "prose which is the cornerstone of ethnographic writing, a way of connecting readers to everyday experience of the research participants, and offering a credible interpretation of culture" (Cunliffe, 2010, p. 225). The organisational ethnographer brings a specific organisational ethnographic gaze. Organisational ethnography requires some understanding or knowledge of the complexities of the organisational context that is being studied (Cunliffe, 2010; Neyland, 2008; Yanow, 2009; Ybema, 2009). The principle aim of organisational ethnography is to “explicate the ways in which people in particular work settings come to understand, account for, take action, and otherwise manage their day-to-day situation” (Van Maanen, 1979, p. 540).

Context is fundamental to all ethnographies, but for organisational ethnography this context is more specific. Organisation has many definitions however, the focus remains on the notion of studying how people organise themselves within their work contexts (Cunliffe, 2010).

The clarity around the context within which the project was undertaken was imperative to ensure that it clearly fitted within the realm of organisational ethnography. The study where this project was undertaken was easily identifiable as a corporate healthcare organisation within the Australian publicly funded healthcare system. This organisation could be classified as a typical transactional bureaucratic structure, having clearly definable lines of authority, and management structures. A well-entrenched corporate culture existed possessing a shared meaning system in relation “to the social processes of organisation” (Rosen, 1991, p. 6). The context as defined conformed with the premise required for organisational ethnography.
The other relevant context in relation to the use of the methodology of organisational ethnography is the notion of profession. Many of the concepts that define the meaning of a profession are consistent with the definition of organisation, particularly in the construct of the concept of culture. This was very relevant to the current research design because the physical structure within which work was undertaken was that of a hospital organisation. The concept of profession does not have the structural boundaries of the physical setting of a hospital, but instead permeates across any physical setting, within which the profession is practised, influencing the corporate culture, and the individual accountabilities of a nurse. It is the universal shared body of knowledge, skills, and attitudes that exerts the considerable influence on the day-to-day work practices of nurses in any physical environment as well as the legislative codes of practice, no matter how varied the physical structures of work might be (W M. Sullivan, 2005). This research indicates the potential that organisational ethnography may highlight some of the contextual parallels between organisation, and profession. There is general agreement that organisational ethnographies are designed to inform knowledge of the organisations, and organisational social processes (Cunliffe, 2010; Neyland, 2008; Van Maanen, 1979; Yanow, 2009; Ybema, 2009). The notions of profession as applied in the study conformed to paradigmatic understandings within organisational ethnography.

This research project has focused specifically on the activities of nurse group handover, and the multidisciplinary team meeting, and the interactions that occur during these, and their impact as professional activities on professional identity. The language, behaviours, and artefacts are also significant to this project to the specific social construct of the nursing group. True to ethnography the researcher was significant as part of the research design for this project, as an insider with understandings of the activities to be studied.

Like ethnography generally, organisational ethnography aims to learn about the participants through first hand experiences of their daily routines (O’Reilly, 2009, p. 150). The primary source of information within an ethnographic methodology is through participant observation (Gobo, 2008, p. 12). It is the observation of culture as a lived experience that is of particular interest to the ethnographer. The use of SIT arguably strengthens the focus, and systematic structures for observation within the processes of organisational ethnography.

Ethnography is concerned with “similarities, and differences in human behaviour ...with the major goals being to describe, classify, compare, and explain these similarities, and differences” (Spradley & McCurdy, 1972, p. 6). Specifically, this knowledge is around that which “informs, shapes, embeds, and accounts for the routine, and not so routine activities” of the group (Van Maanen, 2011, p. 3). The routines of nurse group handover and the MDM are considered.
particularly routine, and mundane within the structure of the clinical unit. Ethnography has been used to uncover the tacit skills, decision rules, complexities, and look at social and historical construction (Atkinson, 2007, p. 221). Culture is not clearly tangible. Van Maanen (2011) sees culture as “a concept as stimulating, productive yet fuzzy to fieldworkers, and their readers as the notion of life is to biologists” (Van Maanen, 2011, p. 3).

There are of course criticisms of ethnography methodology. Quantitative researchers afford little importance to the methodology of ethnography due to its potential subjective forms of data collection (Brewer, 1994). The descriptions made by ethnographic researchers are personal interpretations, and this can be seen as problematic in research. The argument is that when the researcher employs reflexivity, the subjective nature of ethnographic data collection, and writing is made overt. Brewer (1994) identifies some clear guidelines to ensure good ethnographic practices:

- Include establishing the wider relevance of the setting, and the topic, and the grounds on which generalisations are made; identifying the relevances, and values which led to the choice of the research questions, and the omission of others; identification of the theoretical framework within which the study is conceived; establishing the author’s (and fieldworkers) integrity, and that of the data; and, discussion of the complexity of the data. (Brewer, 1994, p. 242)

What is particularly significant to any criticisms of ethnography is to ensure that the intent of ethnography is to drive theory development (Wilson & Chaddha, 2009), and that if this is relevant in answering of research questions, than the methodology is appropriate.

Participant observation is the most important method in ethnography (O’Reilly, 2009, p. 150). The methodology is premised on the concept that the researcher will learn about participants from firsthand experience of their daily routines (O’Reilly, 2009). There are two purposes to the observations of an ethnographer. The first is to blend into the culture without disturbing it, and second, to understand the culture from the native’s perspective (O’Reilly, 2009, p. 150). Therefore, in the tradition of ethnography the researcher is immersed as an insider, and then translates the data collected making it meaningful to the reader (Cunliffe, 2010).

The researcher was a native both to nursing as a profession, and to the organisation within which the research was being undertaken. The assumption of the researcher as participant observer acknowledged that there was already an understanding of the daily routines of both organisation, and the profession. The researcher has been immersed for over 30 years in the
cultures of nursing in the acute healthcare system in Australia. The challenge for the researcher was to develop the skill to step back, and hear the stories of nurses within the contexts under study, to see from an ethnographer’s perspective (Madden, 2010, p. 96).

Within ethnography it is appropriate for the researcher to be immersed within the fieldwork setting to facilitate continuous observations (Fetterman, 2010, p. 39). The researcher had been immersed directly, and indirectly with the staff of the clinical units (i.e. the field of study) over a seven year period leading up to the formal part of the research project. As a result, the researcher had an understanding of the language, and patterns of behaviour within this nursing environment. For this study the researcher was considered an instrument in the research as a participant observer with an insider perspective. As an insider the researcher experienced the emotions of being a nurse, of participating in the professional activities. Extending this there then became a need for the researcher to simultaneously also consider the outsider perspective, and reflect upon the social, and cultural. The notion of the researcher as an instrument was identified by Fetterman (2010). The sensitivity, and the perceptions of the researcher to gather data is a significant tool in ethnography.

There was a high likelihood of direct real time observations undertaken in the clinical setting by the researcher being disruptive to the functioning of the two professional activities. Because of this a mechanism to record the activities was needed so that they could be viewed using observation principles at a later time, and in a place independent of the setting. The researcher was then able to assume the role of participant nurse-researcher, reducing the feelings of intrusion or suspicion from the participants.

Throughout the analysis of the data for this project the researcher is acknowledged as a participant observer. These observations were of the specific video recordings of the daily professional activities of handover, and the MDM, and then the individual, and focus group interviews. What was unusual in this project was the consideration of the nurses who participated in both the video recordings, and were then interviewed whilst watching themselves in the video recordings, and asked to discuss these. In a way they too became participant observers of their own behaviour. For the researcher, the challenge was to find the “intersubjective embodied understandings” (Madden, 2010, p. 98) of what had been observed, and what the interviewed nurses then observed on viewing the taped video data. From the perspective of ethnography the researcher was required to develop her specific ethnographer’s gaze (Madden, 2010, p. 98). The theoretical concept of the ethnographer’s gaze elicits that each ethnographer develops their own gaze determined by the researcher’s “theoretical climate, the people, and questions that interest us, and our own experiences, predispositions, and foibles”
As a novice in using ethnography for this project, the development of this gaze was not without its own challenges. In particular, there was nervousness that structures, behaviours, or particular themes may be overlooked due to the nature of the immersion within this context. Therefore it became important to develop a systematic way of *gazing* within an ethnographic frame.

The literature emphasises the importance of systematic processes within ethnography (Madden, 2010; O'Reilly, 2009; Van Maanen, 2011). Madden (2010, p. 101) identifies that there are two domains to observation, “the structural elements, and the behavioural elements” (Madden, 2010, p. 101). These processes also fit the tenets of organisational ethnography. For this project the systematic process of looking at structural, and behavioural elements was developed using Madden’s work (2010, p. 102). These are depicted in table 1, and table 2 below.

**Table 1: Structural Elements of the Context**

<table>
<thead>
<tr>
<th>Place</th>
<th>Look at the surrounds</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What is seen in relation to other places or independently?</td>
</tr>
<tr>
<td>Appearance of this place</td>
<td>What are the qualities of this setting?</td>
</tr>
<tr>
<td></td>
<td>How do elements of the structure or setting relate to each other?</td>
</tr>
<tr>
<td></td>
<td>Are there any special features?</td>
</tr>
<tr>
<td>Social Aspects of this place</td>
<td>What sort of social place is this?</td>
</tr>
<tr>
<td></td>
<td>Is it mundane or ritual?</td>
</tr>
<tr>
<td></td>
<td>Will the structures affect social behaviour?</td>
</tr>
</tbody>
</table>

(Madden, 2010, pp. 102-103)

The concrete structures influence the behaviours of people in subtle ways, and therefore it is important that these were systematically observed, and reported.

**Table 2: Behavioural Elements of the Context**

<table>
<thead>
<tr>
<th>How do you characterise the human activity before you?</th>
<th>People standing, sitting, still, noisy, friendly, hostile.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Is it socially intense of diffuse?</td>
</tr>
<tr>
<td>How do the humans then group or align themselves?</td>
<td>Are social divisions or categories obvious?</td>
</tr>
<tr>
<td></td>
<td>Are you drawn to one character, if so what is ethnographically potent about this character?</td>
</tr>
<tr>
<td>Is it possible to observe intent, and impute purpose?</td>
<td>Are there tentative analytical insights?</td>
</tr>
<tr>
<td></td>
<td>Can effects of interactions be observed, any causal links?</td>
</tr>
</tbody>
</table>
See what is unfolding

<table>
<thead>
<tr>
<th>Are there observable codes of conduct?</th>
<th>Is there a normative framework that is shaping behaviours?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Is there an observable aberrant or unusual behaviour?</td>
</tr>
<tr>
<td></td>
<td>Is there any behaviour that stands uncomfortably against the observable norms?</td>
</tr>
<tr>
<td></td>
<td>Any unusual or distinctive events?</td>
</tr>
<tr>
<td></td>
<td>Is there any unusual collective behaviour that could be viewed as a special event?</td>
</tr>
</tbody>
</table>

(Madden, 2010, pp. 103-104)

Qualitative research designs aim to deliver “thick descriptive analyses” (Patton, 2002, p. 437) as is also a fundamental principle of ethnographic description (Geertz, 1973, pp. 3-30). According to Patton (2002) “description forms the bedrock of all qualitative reporting” (2002, p. 438). The importance of thick rich description allows the reader of the research to understand the phenomenon being researched while making their own interpretations, and conclusions from the analysis presented (Patton, 2002, p. 438). Rosen (1991) identifies that the thick description of ethnographic writing tells the “difference between a twitch, and a wink”. It consists in creating a “stratified hierarchy of meaningful structures” (Rosen, 1991). In ethnography it is not the distance but the closeness that the researcher has to the data collection that allows for a descriptive richness in analysis. This is very important. Within this current project, it was the personal interactions, and observations that the researcher had with nurses within their work contexts, and the engagement of the individuals involved, that contributed to the richness of the analysis.

Nursing is steeped in a tradition of storytelling, and the narratives of nurses, and their work is well-documented (Wolf, 2008). Therefore, in undertaking this research, the ability to tell the story of the data was not the challenge. The challenge came in the ability of the researcher to systematically write a rich thick description. It is interesting, and an irony, that most nurses develop their skills, and abilities to deliver patient stories during the group handover activity. So, by using Madden’s work (2010, pp. 157-161), the systematic process for recording ethnographic stories was,

- explaining the reason for being there,
- the description of being there,
- the analytic, and interpretive engagement, and
- substantiating the reason for being there.
As previously stated, this project has sought to examine a case of two groups (two units of analysis) of nurses within their cultural working groups. As identified by Neyland (2008), and Ybema (2009), there are some key criteria to organisational ethnographies that are relevant to this project which meant that an organisational ethnographic paradigm was most appropriate. As Ybema (2009, p. 254) identifies, the central substance of this criteria is akin to any ethnography in methods, writing, and sensibility. This notion of sensibility ensures that the results are clearly based on systematic scientific inquiry with a "specific orientation to the organisational world" (Ybema, 2009, p. 15). However, what really sets organisational ethnography apart from other ethnographies is the context within which the research is undertaken. If the research examines characteristics within work that is processes, human relations, or culture, it can be classified as organisational ethnography (Ybema, 2009, p. 255). This project clearly fits into the realm of organisational ethnography due to the context within which the research is placed. This research draws parallels between the notion of organisation, and the concept of profession. Many of the structures, and bureaucracies that exist for modern organisations also exist for the professions.

The Case Context of Acute Care

The next step was to define the context for the organisational ethnography in which this research project would be conducted. As revealed in Figure 3, a decision was taken to give theoretical focus to the organisational ethnographic process through the use of SIT, and sharpen the focus to one organisational context. For the purposes of this study, this has been called the case context of acute care. In this section the methodological principles, and application of case as they were designed to fit organisational ethnography are explicated.

Case studies are commonly used for research in health care, this includes both clinical, and biographical research (Yin, 2012, p. xix). This project used organisational ethnographic methodology, and the use of one organisation clearly enabled aspects of case study to be employed as a process in the methodology, and design of this study. Case study research is historically placed in the Chicago School of Sociology in the early 1900s (Yin, 2009, p. 17). Traditionally, case study research, and ethnography have been closely aligned (Yin, 2009, p. 17). Case study research is defined by Yin (2009, 2012) in two parts,

1. A Case Study is an empirical inquiry that
   - investigates a contemporary phenomenon in depth, and within it real-life context, especially when,
   - the boundaries between phenomenon, and context are not clearly evident.
2. The Case Study inquiry
   - copes with the technically distinctive situation in which there will be many more variables of interest than data points,
   - and as one result relies on multiple sources of evidence, with data needing to converge in a triangulating fashion,
   - and benefits from the prior development of theoretical propositions to guide data collection, and analysis.

(Yin, 2009, p. 18)

In applying these case study principles to the design of case in this project, a structured approach of organisational ethnography was strengthened. This was particularly advantageous in managing the data collected, and applying connections of the various data sources at the analysis phase.

Within the design, the case was chosen to ensure clarity of work context. The participant groups comprised a single case with two units of analysis. These two units of analysis were two separate clinical units within the same health service. This case was studied employing an underpinning organisational ethnographic methodology, and ethnographic methods (observation, interviews, and fieldnotes). In the following section the notion of the sample for the case is made more explicit. The researcher took care to ensure that the processes of case sampling as comparable to case study were made consistent with the tenets of organisational ethnography.

Ethnographic research is a form of naturalistic inquiry: ethnography fundamentally endeavours to study the real world as it unfolds naturally. Similar to naturalistic inquiry, ethnography uses a non-manipulative, and non-controlling approach (Patton, 2002, p. 39). Building on this organisational ethnography is also in keeping with a naturalist stance; that the human world is perceived differently by each individual, whilst still acknowledging the social construction of reality (Patton, 2002, p. 98). Capturing the stories of the individual nurses was of particular importance. The research design utilised a descriptive case study approach focusing on the “what” questions during the analysis. However, to complete the research process the use of interpretative ethnography within the findings explored the why questions. Taking the interpretive perspective allowed for emphases to be on the inter-subjectivity of interactions, and conversations between people, the meanings were seen as multiple, the “relational, intersubjective, and fluid sociality emerges ongoingly” (Cunliffe, 2010, p. 230). As such the systematic research process used can be summed up in three sections,

1. undertaking the methods of data collection using ethnographic methods,
2. analysing the data within a systematic case context that employs the social identity concepts of group performance; social identities, and self-categorisation, and
3. recording the findings, and discussion using an interpretive ethnographic line of inquiry.

**Clinical, and Environmental Contexts within their Organisational Structures**

At the inception of the research questions there was much deliberation about the sample logic for the constitution of the case while considering overall organisational ethnographic design principles. The context of acute care was set as the case sample with two units of analysis. These two units of analysis were two separate clinical units within the same health service. For Yin (2009, 2012) cases are set within real world contexts “especially when the boundaries between phenomenon, and context are not clearly defined” (Yin, 2009, p. 18). In this research project the phenomenon of professional identity of nurses in relation to SIT within the context of two clinical units (as case) constitutes the basis for the organisational ethnographic study.

**The Clinical Units**

The two clinical units used in the data collection were both similar and unique like many hospital wards across Australia. Both clinical units sat within the same healthcare network, and therefore governance and organisational structures were similar. It is a cultural irony that each unit in each work place is culturally distinctive whilst the social basis that creates the distinctiveness has a shared pattern. For this case it was important to have two units each carrying distinctive subcultures whilst at the same time conforming to usual social patterns of working, and cultural production.

Each clinical unit had its own micro-culture representative in some ways of the organisational culture, but also having differences pertaining only to that clinical unit (Van Maanen, 2011). This is because functionally, clinical units in any healthcare organisation have their own cultural microcosm. These are where subcultures of the organisation preside, and influence the distinctiveness of each unit. Each unit had a very different set of patient demographics. Unit A dealt with medical patients who were predominantly chronically ill. Readmission of these patients was commonplace due to their disease processes being protracted, and, therefore, many patients were quite well known to the nursing staff. Unit B was an acute surgical unit where patients came in for their surgery with a general plan of care to discharge or transfer patients for rehabilitation within five to seven days of admission. Unit A had fewer patient beds, and therefore there were less nursing staff on any given shift than Unit B. This meant that the number of nursing staff in the shift team was less for Unit A then Unit B. In both clinical units, there was a strong multidisciplinary team of allied health professionals working closely with the nursing staff, and patients to facilitate, and expedite the patient journey.
The physical design of the two units was also very different. Unit A was a relatively new unit, redesigned for the patient cohort it was caring for. The building was old but had been refurbished to specifically fit this cohort of patients. The space remained compromised as the refurbishment had been done within the old structure of the building. There was, however, a central nurses’ station with patient rooms located around it. The station was a hub of activity for all staff within the healthcare team, not just nurses, and was easily accessible for patients.

Unit B was one of the original units set up when the building was first built in the 1950s. This unit had three nurses’ stations, and patient rooms were divided in three distinct areas. The main nurses’ desk located in the middle of the unit had two corridors, one extending from the main desk, and the other located behind the main desk. A smaller desk was located in each of these corridors. The nurses construct their work, and patient allocation around these three areas. The remainder of the healthcare team tend to congregate at the main nurses’ desk, and the smaller desks were utilised almost exclusively by the nursing staff.

The aim of this brief description of the clinical environments is to situate the data collection, and recognise the contexts potential impact, complexity, and inter-subjectivity that the working environments may have on both data collection, and analysis. In recognising this complexity of environment there is also recognition of multifaceted considerations during the data collection. Ethnographic methods were used to capture the complexity, and richness of the data.

For this study the use of SIT as a theoretical framework in conjunction with organisational ethnography in a case context raises questions about qualitative transferability of findings. In keeping with qualitative traditions (Sandelowski & Barroso, 2007). It is the social patterning, and processes by which nurses professional identities are constructed which is the focus of the theoretical endeavour. Therefore at the end of the analysis it may well be reasonable to establish a logic that could be applicable to other nursing contexts. As Yin asserts, analytical generalisability can be appropriate when a single case is used, as is the situation for this project (Yin, 2009) the premise of analytical generalisability for transferability, therefore, is contained within the theoretical orientation.

**Data Collection: Defining the Case, and Contextualising the Practice Function**

**the Handover, and Multidisciplinary Meetings**

Within the case context of acute care two common professional activities were selected. Nursing group handover was selected because it is a typical forum for nurse, nurse interaction, and communication. The MDM was selected because it is a typical forum for nurse to other health
professional interaction, and communication. These were chosen because they were likely to provide a rich cultural environment in which to observe different or similar social mechanisms associated with the construction and performance of nurses' professional identity.

**Nursing Group Handover**

Within healthcare organisations across Australia, and the Western world, the ritual of shift-to-shift nursing handover is undertaken three times a day (Strange, 1996). The traditional structure of shift handover was for the oncoming nurses to sit in a room with one of the outgoing nurses who would outline each of the patients within the clinical unit, their plans of care, and an overview of happenings over the last shift. It has been identified that there are limitations to the effectiveness of the clinical communication that happens within this structure of the shift-to-shift handover (Clarke & Persaud, 2011; Randell, Wilson, & Woodward, 2011; Street, 2011). Furthermore, it has been identified that patient safety is significantly compromised if effective clinical communication does not occur within the shift-to-shift handover (ACSQHC, 2010, 2012; Clarke & Persaud, 2011).

Much research has been undertaken to focus specifically on issues of clinical communication, and review of the process of shift-to-shift handover (Chaboyer, 2009; Clarke & Persaud, 2011; Kerr, et al., 2011; McMurray, 2010a, 2010b; Randell, et al., 2011; Street, 2011). The current trend is to move the group process of shift handover to bedside delivery. Bedside handover continues to occur at the change of shift, the oncoming nurses with each of the outgoing nurses move from patient to patient receiving a verbal handover of the patients' care for that shift, and ongoing plans for each particular patient, with patients often actively involved in the process (McMurray, 2010a).

In this research process the focus was to observe, and describe social interactions that occur during the activity of group handover. The notion of shift-to-shift handover as a ritual is well accepted within nursing literature (Evans, Pereira, & Parker, 2008; Scovell, 2010; Strange, 1996). The definition of *ritual* as identified by Helman (2000, p. 192): "is a form of repetitive behaviour that does not have a direct overt technical effect". The notion of ritual is frequently viewed negatively, and yet many (not all) ritual behaviours in nursing have been shown to be culturally, and emotionally important (Strange, 1996). The shift-to-shift handover has been identified as an important ritual serving three functions (Kerr, 2002; Scovell, 2010). These functions are overt (for example communication), covert (for example psychological, and protective aspects), and ritualistic (for example routine practices, and professional language).
It was the notion of covert, and ritual functions that was of particular interest to the researcher. Evans et al. (2008) identified the importance of the shift handover in relation to some of these covert, and ritual functions, including the social, and emotional importance of the handover. These functions assisted in development of social cohesion, providing an opportunity to debrief, and the introduction of professional language. The short term management of nurses’ anxiety, and the preparation of the new shift by defining the lie of the land are also ritualistic functions undertaken within the shift-to-shift handover (Evans, et al., 2008). As observed, and noted by Evans et al. (2008) nurses’ behaviours are also modelled, and contained during the handover.

**Multidisciplinary Team Meeting**

Generally multidisciplinary team meetings have the overt function of communicating essential details “to enable care, and assist teaching” (Scovell, 2010, p. 36) for seamless care to be generated between health professionals. The essence of the meeting is discharge planning for each patient, rather than “information related to a moment in the patient’s life (the past shift)” (Evans, et al., 2008 p42). In selecting the two clinical units for this study it was important that there was a similar social, and functional structure to the MDM. The MDM construction identified for this study was that the meeting was a daily occurrence, led by the nurse, with allied health staff, exclusive of the medical staff.

**Analysis Framework and the Developments from Findings**

Having established the perspective of the ethnographic gaze within the case, the processes used for the analysis of the data are now discussed. There were two aspects to the analytic process. Using ethnographic principles, the case situation was explored, and analysed inductively by drawing questions, theming data, and exploring social constructions. The data was also examined analytically in relation to SIT, and thematic analysis was undertaken to test classification, and categorisation of the data. These two inductive and deductive processes were used to inform each other. The to and fro of analytical processes were designed to surface aspects of how the nurses’ professional identity was working, and being constructed during the studied activities. In table 3 the analytic framework for the SIT component is identified.

**Table 3: Thematic Analysis Framework for SIT**

<table>
<thead>
<tr>
<th>Group Performance</th>
<th>Social Identities:</th>
<th>Self-categorisation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group Motivation</strong></td>
<td><strong>Social Identity Salience</strong></td>
<td><strong>Prototype</strong></td>
</tr>
<tr>
<td>What motivates the individual to work on behalf of the</td>
<td>Identification with a group affects behaviour only to the</td>
<td>A “fuzzy set of attributes that define one group, and distinguish it from</td>
</tr>
</tbody>
</table>

collective extent that the group membership is salient other groups” (Hogg & Reid, 2006 p10). Prototypes are context dependent

**Group Goals, and Norms**

Standards that are internalised through identification, and thus mainly affect group members

**Cross cutting Identities**

a) inclusive/exclusive;
b) abstract/concrete
c) distal/proximal

higher-order identities, and lower-order identities

**Normative fit**

Perceived similarities, and differences between group members with group membership resulting in normative meanings for group members

**Group Efficacy**

high performance is perceived to be under volitional control

**Nested Identities**

Formal/informal

higher-order identities, and lower-order identities

**Comparative fit**

defining of oneself to a particular self-category when the differences of the in-group are perceived to be less than others within a given context

(Haslam, 2003, pp. 121 & 252-255)

It is argued that the use of deductive principles was not to test SIT but to assess the appropriateness of this theory to describing (Barratt, Choi, & Li, 2011) professional identity within nursing.

It was considered important to deliver findings that were thick in description, blending the interpretation of behaviour, and meaning, and structure within the true character of ethnography (Rosen, 1991). Attempts were made to explore evidence relevant to social identity, and professional identity of nurses, looking for divergent patterns in the analysis. The analysis attempted to then consider the framework of SIT drawing on professional identity, and describing any parallels, links, or associations.

In addition, aspects of Yin’s case study protocol were applied inductively to the data (Yin, 2012, pp. 13-14). The overall aim of a case study protocol is to increase the research design’s reliability (2009, p. 79). This particular case study protocol concentrated on the development of the line of inquiry, and challenges presented in setting up for the data collection. The end result was a clarification on the structure required to develop the methods to sufficiently answer the research questions. To develop the chosen line of inquiry, the steps of the case study protocol were used.

- Identify appropriate sources for data collection.
• Ensure the data collection was of an appropriate standard, and quality.
• Appropriately access the sites for data collection.
• Appropriately schedule the data collection.
• Be overt about the researcher as participant observer.
• Clearly identify the multiple sources of data collection.
• Develop the line of inquiry.
• Ensure the interviews are true to the line of inquiry.
• Consider any other general rules that needed to be taken into account before commencing the data collection.

**Conclusion**

Organisational ethnography and the methodological principles underlying the research design for this project have been outlined in this chapter. Key methodological concepts have been explained, drawing upon the works, and writings of some of the principal ethnographers. The specific context for the organisational ethnography in which this research was identified was the case context of acute care. The structured approach of organisational ethnography strengthened the research design to ensure the research questions were aligned with the methodology, and the data to be collected. The processes used for analysis have been developed from an established ethnographic perspective. The inductive plan involved drawing questions, theming data, and exploring social constructions. The deductive plan used SIT, and thematic analysis to categorise the data. These inductive and deductive processes are used to inform each other taking into consideration that the sequencing of ethnography is never a linear process, and therefore requires each phase to go on at the same time. The following chapter outlines the detail of the methods and how the research was essentially undertaken to achieve the principles of organisational ethnography, to appropriately answer the research questions.
Chapter 4: Methods

The research methodology has been outlined in the previous chapter, and in this chapter the research methods are described in detail. The methods chosen are appropriate for the methodology of organisational ethnography. The main methods were fieldwork (including participant observation, video recording, and fieldnotes), and interviews.

In Figure 4 the relationship of the methods to the ethnographic processes is depicted. Just as the five key considerations (identified in chapter 3) led to the choice of methodology they were also the basis for the design, and use of ethnographic methods for the collection, and analysis of the data. The fieldwork was the primary method for working inductively from the broad work context to the specific nursing activities, analysing aspects of interrelationships between professional culture, and SIT. After the fieldwork had been completed, interviews were conducted, and participants’ insights into their practices were probed inductively, and deductively, figure 4 shows the relationship of the methods to the ethnographic processes.

Fieldwork

Fieldwork is the main method used to collect information in organisational ethnography. Fieldwork is considered the “firsthand experience, and exploration of a particular cultural or social setting” (Atkinson, 2007, p. 4). For organisational ethnography this takes into consideration the complexities of organisational processes that dominate work (Ybema, 2009, p. 23). The aim is to spend time within the natural setting with the groups of people that are part of the research project. This allows the ethnographer to collect data about the informants/participants within their real world settings (Fetterman, 2010, p. 33). In traditional ethnographic practice, the researcher assigns an insider or outsider status, based on their knowledge of the context of the research, and their degree of influence in the natural setting. Insider status for the fieldwork component of the project was the most appropriate position for the ethnographic processes. Bonner, and Tolhurst (2002) identify the advantages of the insider perspective as not only having a greater understanding of the culture, but also being able to enter the environment without altering the social flow, enabling the quick establishment of an intimate relationship, and finally to enable the “process rather than the outcome of practice to be explored” (van der Riet, et al., 2011, p. 2).
Figure 4: Relationship of the Methods to the Ethnographic Processes
In the following sections different aspects of the fieldwork are discussed in detail, firstly the getting going is discussed including site selection, entry into the environment, sampling, and recruitment, and demographic information collection. Secondly, the methods of participant observation, and interviewing are outlined in detail.

**Site Selection**

In ethnography the selection of the participant group within the case commonly uses a concept called the "big-net approach" (Fetterman, 2010, p. 35). The researcher as participant observer, mingles with the larger population under study, and then focuses on specific groups that are representative of the larger population (Fetterman, 2010, p. 35).

The researcher had sufficient experience in nursing, and the institutions as an insider to appropriately identify the two units that formed the case as context, which informed the ethnography. The participant groups were comprised of a mixture of staff including Associate Unit Managers, Clinical Nurse Specialists, Registered Nurses, Enrolled Nurses, and newly graduated nurses completing their Graduate Nurse Program year.

**Entry into the Environment**

Once the site was selected mechanisms for entry into the environment were sought. At the inception of this project, the researcher had a pre-existing curiosity about how certain social activities within the nurses' shift impacted on the development of an individual nurse's professional identity. The clinical handover, and MDMs were chosen to be the main focus of this research project because they were seen to be the most appropriate arena for researching social elements within nursing (Kerr, et al., 2011).

Two participant observation processes were developed. The first was a traditional ethnographic method of the researcher being present in the setting as an instrument, observing note taking, and reflecting. The second process was a more innovative method whereby the participants' were video recorded during their nursing group handovers, and MDM. Later, in the study these nurses became participant observers of themselves when they watched these recordings, and discussed them during the interviews.

The use of video created some unease from the ethics committee when this project was first submitted for review. Some members of the committee were apprehensive that the clinical competency of the nurse participants might be exposed during filming, and that this would not be in the interest of participants. Once the researcher explained that clinical practice was not, and could not, be assessed within this arena, the ethics on the project was approved.
There were other practical concerns connected with the use of videorecording to collect data. It was imperative to obtain high quality video footage (for example, clear picture quality, and sound clarity). This issue was addressed when a technician from the supervisor’s unit was engaged to film the four handover sequences. This resulted in good quality video footage being obtained. There also needed to be acknowledgement of the possibility of the Hawthorne effect (Chiesa & Hobbs, 2008). This would almost certainly impact on the behaviour of the nurses, and allied health staff once they realised they were being videoed. This was, in fact, recognised by each of the videoed participant groups, some of who stated before filming that they felt embarrassed about being filmed. Others said that they would be “on their best behaviour during the filming”. Despite these concerns, the researcher felt that the videos gave a relatively true picture of social elements of the handover, and MDM within the two units of study.

The healthcare organisation was the researcher’s current place of work at the beginning of the project. As a result, the organisational structure, and communication processes were fully understood by the researcher. Nursing has a clear hierarchy of communication, and therefore, permission to collect the data was sought through the appropriate staff within the organisation. Initially the Director of Nursing was approached to gain permission to undertake the research project. This was granted, and then the researcher approached the relevant Nurse Unit Managers (NUMs) by arranging formal, one-to-one meetings. As the researcher was well known to both NUMs, they were keen for their staff to be involved in the research. The purposeful sampling frame was then defined after each NUMs identified the appropriate time when the nurse-to-nurse handover, and the MDM could be filmed. The scheduling identified that the nurse delivering the nurse-to-nurse handover would be the same nurse that would lead the MDM. Each NUM then reviewed the appropriateness of the skill-mix of staff that would be present for the video. The NUM or the nurse in charge discussed this with each of the staff that would be involved. At this stage the process of informed consent was discussed. Consent was obtained before the researcher was introduced to the staff. Each of the staff willing to participate then filled in an informed consent. Most of the staff knew the researcher, and it was identified from the beginning that the researcher would in some way be a participant observer due to her knowledge of the context, and the nursing profession. Valid consent forms were signed by all participants. There was a positive response to the request to consent with all the regular unit staff being keen to participate.

Ethics was successfully obtained through the University of Melbourne Human Research Ethics Committee. Ethics was also sought from the healthcare organisation although this process proved to be a little more difficult, due to the both the use of ethnography and the insider perspective of the researcher. Both of these were unusual to the research commonly done
within this clinical organisation. As a result entry into the research environment became a protracted process. Ethical approval from the healthcare network was finally obtained after twelve months. One of the concerns raised by the ethics committee was the issue of the insider of the researcher into the environment, and the small sample size. Much of the research in hospitals is driven by medical projects using scientific positivist methodologies, and so the members of these ethics committees are more familiar with this paradigm. This ethics proposal was relatively unusual particularly in its use of video recordings. It was viewed by the committee through the same prism as other scientific projects, and therefore took some time to be understood within its own paradigm. It was not until advice was sought from one of the Medical Professors who understood the qualitative paradigm that the research was finally approved. From here entry into the environment was relatively straightforward. Once ethics approval was obtained the practical entry to the environment was sought through talking to the Nurse Unit Manager. The nursing, and multidisciplinary staff were individually invited to voluntarily consent to participate by the researcher. The researcher was considered an insider, and well known, and the project was viewed by the participants as being relatively non-intrusive to the nurses’ daily schedules.

**Sampling and Recruitment**

Fourteen nurses were recruited as participants. Known technically in the ethnographically literature as key informants, in this thesis they are referred to as the participants. These participants completed a questionnaire about their demographic, and nursing work, participated in the nurses' group handover, and/or the MDM. In relation to observing the handover, and the MDM there were four groups -two handover groups, and two multidisciplinary groups. Ten of these participants were interviewed either individually or in focus groups. In addition, there were eight other qualified health professionals, and five students who consented to be video recorded during the group handover, and/or the MDM. These people were not recorded as participants rather they formed part of the cultural environment in which the research took place. These are depicted in Tables 4, and 5.

The ten participants who were interviewed either individually or in focus groups all looked at, and reviewed the video recordings of the meetings they had been involved in. Four nurses from the nursing group handover were involved in the individual interviews. Two of these nurses were additionally interviewed individually in relation to their MDM involvement. There were two focus groups. One group comprised of four nurses, and the other comprised of two these related to nursing group handover.
Table 4: Nurse Handover, and MDM Composition

<table>
<thead>
<tr>
<th></th>
<th>Unit A Handover</th>
<th>Unit B Handover</th>
<th>Unit A MDM</th>
<th>Unit B MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Presenter</strong></td>
<td>ANUM from morning shift</td>
<td>ANUM from morning shift</td>
<td>ANUM from morning shift</td>
<td>ANUM from morning shift</td>
</tr>
<tr>
<td><strong>Motivator</strong></td>
<td>Presenter &amp; ANUM for oncoming shift</td>
<td>Presenter &amp; ANUM from oncoming shift</td>
<td>No one motivator</td>
<td>No one motivator</td>
</tr>
<tr>
<td></td>
<td>ANUM presenter</td>
<td>ANUM presenter</td>
<td>ANUM</td>
<td>ANUM</td>
</tr>
<tr>
<td></td>
<td>ANUM for oncoming shift</td>
<td>ANUM for oncoming shift</td>
<td>Physio, pharmacist, OT, social worker</td>
<td>Physio x2</td>
</tr>
<tr>
<td></td>
<td>CNS x1</td>
<td>ANUM for oncoming shift</td>
<td>RN x5</td>
<td>OT x2</td>
</tr>
<tr>
<td></td>
<td>RN x1</td>
<td>ANUM for oncoming shift</td>
<td>EN x1</td>
<td>Physio students x 2</td>
</tr>
<tr>
<td></td>
<td>Graduate nurse (junior)</td>
<td>Graduate nurse (junior)</td>
<td>Nursing students x2</td>
<td>OT student x 1</td>
</tr>
</tbody>
</table>

Table 5: Summary of the Data Collection

<table>
<thead>
<tr>
<th>Method</th>
<th>Handover</th>
<th>Multidisciplinary team meetings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Method</strong></td>
<td><strong>Video recording meeting</strong></td>
<td><strong>Video recording meeting</strong></td>
</tr>
<tr>
<td><strong>Unit A</strong></td>
<td>Participant (1) delivering handover</td>
<td>Participant (1) participating in team meeting</td>
</tr>
<tr>
<td><strong>Unit B</strong></td>
<td>Participant (2) delivering handover</td>
<td>Participant (2) participating in team meeting</td>
</tr>
<tr>
<td><strong>Interviews</strong></td>
<td>Interview with participant (1) reviewing video recording of both handover, and multidisciplinary team meeting</td>
<td>Interview a nurse who attended the handover</td>
</tr>
<tr>
<td><strong>Unit A</strong></td>
<td>Interview a nurse who attended the handover</td>
<td></td>
</tr>
<tr>
<td><strong>Unit B</strong></td>
<td>Interview with participant (2) reviewing video recording of both handover, and multidisciplinary team meeting</td>
<td></td>
</tr>
<tr>
<td><strong>Unit B</strong></td>
<td>Interview a nurse who attended the handover</td>
<td></td>
</tr>
</tbody>
</table>

1. ANUM = Associate Unit Manager
2. CNS = Clinical Nurse specialist
3. RN = Registered Nurse
4. EN = Enrolled Nurse
5. OT = Occupational Therapist
<table>
<thead>
<tr>
<th>Method</th>
<th>Focus Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit A</td>
<td>Group from Unit A to undertake a focus group</td>
</tr>
<tr>
<td>Unit B</td>
<td>Group from Unit B to undertake a focus group</td>
</tr>
</tbody>
</table>

**Demographic Information**

A short preliminary questionnaire was used to collect demographic data from all the nurses who consented to participate in the research (see Appendix 1). The results are reported in the following chapter.

**Participant Observation**

Observation data was collected via video recordings of four independent occasions during the research period. Both the researcher, and participants (ten) acted as internal participant observers, and engaged in some analysis of the observation data. The participants’ contributions were achieved through recorded interviews which were undertaken by the researcher. In addition, the researcher undertook more traditional observation, and field note taking in relation to the video recordings, and the interviews. The researcher’s participant observations and subsequent fieldnotes arose from the data collected using video recording sessions. In addition the participants provided further participant observation from viewing the video recordings of their activities.

Aside from the general understandings arising from this insider knowledge the researcher applied the methodological frameworks. As stated in the previous chapter these included the inductive, and deductive processes of SIT, and the Madden framework (as shown in Tables 1, 2, and 3). In contrast, the participants provided innate professional understandings into the activities as they engaged in the participant observation of the video recordings.

**Fieldnotes**

The art of writing fieldnotes is an important part of ethnographic research. The development of a particular, individualised method to fieldnote taking was seen as important. It was necessary to minimise any intrusions into the natural setting during the handovers, and the MDM so the researcher’s observations of each activity were recorded in the form of fieldnotes constructed while watching the video recordings. A systematic structure for field note-taking is recommended for the researcher (Benner, 2001). Because of the use of video recordings fieldnotes were both inductive, and deductive, and written in the quiet of an office space. Madden (2010, p. 124) refers to this type of note taking as consolidated fieldnotes. The systematic structure was undertaken as planned methodologically (as detailed in Chapter 3).
The observations were documented by examining the structural elements (Table 1), and then the behavioural elements (Table 2) of the staff that were filmed.

**Video Recordings**

The collection of data using video recording was significant in this project. The videoing used a DDR (Digital Direct Recording) to take the images, and sounds of the real time handovers, and MDMs. This video data was then stored in the format of an mp4 recording, with the ability to be played on a computer with appropriate hardware.

The instrument of video recording was aimed at capturing the handover episodes in their entirety, and to ensure all observed behaviours could be documented. The use of filming is a well-recognised technique to capture events, and behaviours holistically (Murchison, 2010, p. 73). There were both technical, and ethical challenges that were resolved before videoing started. The ethical considerations were addressed during the ethics submission. Technical considerations were addressed through engaging a video technician from the research supervisor’s team. The videos were then used during the interviews where the participants then became participant observers of their own professional activities.

The video recordings provided a medium to initiate the interviews, and for the individual nurse interviewees, and nurse groups to reflect on the events of clinical handover, and MDM, to review their position, attitudes, and perceptions about the event of the handover, and MDM. Filming also allowed the researcher to review the events (collect data) in as complete a form as possible. This provided an important opportunity to revisit the events, by reengaging, and reviewing the handovers, and MDMs as wholes in order to extract relevant observations for later analysis. Each time the videos were viewed, insights into behaviours, and structures were developed, confirmed, and cross-analysed with the research supervisor.

Two types of professional activity were filmed using a DDR recorder (see below). They included the nursing change of shift group handover, and the multidisciplinary meeting (MDM). Both events are structurally similar, and commonly occur within the daily working life of nurses in the units. Both events were filmed in order to compare these two types of professional activities during the subsequent interviews, and to also facilitate discussions about the events as a separate entity. This allowed for analysis of the two professional activities to be undertaken for the purpose of comparison, and contrasting of the data obtained. The characteristics of these two events were as follows:

- MDM are unit team meetings (multidisciplinary). These meetings typically occur once a day to once a week, and include all health professionals involved in the care of patients.
excluding medical staff. In these meetings patient management is discussed from the
different professional perspectives

- Nurse group handover (nurse-to-nurse). The incoming shift team is briefed by a
  representative of the outgoing shift team. These meetings occur three times a day, typically
take between 20 to 30 minutes, and include all nurses of the in-coming shift, and one from
the completing shift. Discussion centre around what has happened to each patient in the
prior 8 hour shift, and any other relevant information.

The set up for these meetings was as follows; the video recordings consist of one nurse in each
of the units leading the multidisciplinary team meeting this nurse then lead the handover
meeting. This was purposively organised to allow for consistency in the process of the meetings.
This was also an important aspect in the interviews to ensure the same nurse that was engaged
in the handover meetings was also engaged in two individual interviews. These two nurses
were then interviewed individually with respect to their own meetings (multi-disciplinary, and
handovers). Nurses only viewed videos within which they participated in. Analysis occurred
during the interviews and focus groups when the research participants reviewed the videos
during the interview process. The video recordings were then analysed using Madden’s
framework, and documented in the fieldnotes (Madden, 2010).

**Interviews**

The use of interviews is another principal instrument for organisational ethnography. The
interviews were planned to be semi-structured, open ended (Fetterman, 2010; Madden, 2010;
Murchison, 2010; O’Reilly, 2009; Yin, 2009, p. 106 ). Within the structure of the case
interviewing was to follow the chosen process of case inquiry. The line of inquiry previously
discussed in Chapter 3, allowed the nurses to describe the activity of handover, and MDM. The
importance of the nurses’ interpretations was pivotal to the analysis, and is an appropriate
methodological approach in ethnography due to its emphasis on developing an understanding
of human experiences (Cunliffe, 2010).

As a result, the interviews were semi structured, and the interview protocols are outlined in
Appendixes B, C, and D. The interviews created valuable opportunities for conversations with
the nurses. These gave insights, not only to the handover, and MDM activity, but also to many
other aspects of professional work. Murchison (2010, p. 105) identifies three important
strategies the ethnographic researcher should engage in during the interview process

1. Be prepared to learn from the participants,
2. Be willing to cede some control of the process, and let the participants guide the
   research,
3. Be ready to adapt to circumstances as they present themselves (2010, p. 105). The prompts in the interview protocol were certainly helpful to the researcher but were used simply as prompts. However, there were occasions when the interviews took their own form, and the prompts became relatively insignificant. It is acknowledged that the process of interviewing does present a certain “degree of contamination” and may produce some staged responses (Fetterman, 2010, p. 41).

In order to ensure that the method of interviewing was true to ethnographic design, it was important that an established relationship was developed between the interviewer, and the interviewee (O’Reilly, 2009, p. 129). For this research project the researcher had in some cases already developed a contextual relationship, with some of the participants. For those not known to the researcher time was spent developing a relationship through informal nursing conversations with those to be interviewed. These included topics like; what was happening in the unit, how busy their day was what other pressures they were experiencing outside work, acknowledging their work experiences.

All interviews were audiotaped, and later transcribed. A further interview was then conducted after the analysis with an expert focus group to test emergent themes with the aim to ensure, and enhance the validity, and reliability of the emergent themes, as discussed in the research design chapter. Therefore there were six individual interviews; two focus groups, and one expert interview. Each interview, or focus group, took between twenty to forty minutes as is described as presented in Table 6.

**Table 6: The Structure of the Videoint, and Interviews during Data Collection**

<table>
<thead>
<tr>
<th>Method</th>
<th>Handover</th>
<th>Multidisciplinary team meetings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Video recording meeting</td>
<td>Video recording meeting</td>
</tr>
<tr>
<td>Unit A</td>
<td>Participant (1) delivering handover</td>
<td>Participant (1) participating in team meeting</td>
</tr>
<tr>
<td>Unit B</td>
<td>Participant (2) delivering handover</td>
<td>Participant (2) participating in team meeting</td>
</tr>
<tr>
<td>Method</td>
<td>Interviews</td>
<td>Interviews</td>
</tr>
<tr>
<td></td>
<td>Video recording meeting</td>
<td></td>
</tr>
<tr>
<td>Unit A</td>
<td>Interview with participant (1) reviewing video recording of handover</td>
<td>Interview with participant (1) reviewing video recording of MDM</td>
</tr>
<tr>
<td>Unit B</td>
<td>Interview a nurse who attended the handover</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Interview with participant (2) reviewing video recording of handover,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Interview a nurse who attended the handover</td>
<td></td>
</tr>
<tr>
<td>Method</td>
<td>Focus Group</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Group from Unit A to undertake a focus group</td>
<td></td>
</tr>
<tr>
<td>Unit B</td>
<td>Group from Unit B to undertake a focus group</td>
<td></td>
</tr>
</tbody>
</table>
Data Storage and Ethical Considerations

The research data was stored according to University of Melbourne policy, and kept in a locked facility. Data, and all identifying information were kept in a separate locked filing cabinet; access to computer files relating to the project was password protected, and only able to be accessed by the researchers.

Ethical considerations were managed according to the ethical principles of both the University, and the health care organisation. These included any potential participant risks. It was identified that all involvement in the project was completely voluntary, and the participants could withdraw at any stage during the data collection. This was then identified in the plain language statement (Appendix E). It was identified that there were no potential risks to participants. However, if an incident had occurred due to unexpected distress during the individual interviews, then it was planned that the interview would have been suspended, and appropriate counselling would occur through the organisations employee assistance program.

In consideration of ensuring patient anonymity, and confidentiality, patient names during the handover, and MDMs were replaced with patient bed numbers. This allowed for only the staff to be able to identify patients during the activities and not the researcher. Each member of the team was provided with the usual patient documentation that identified both patient name, and bed number. Prior to the video recording of the handover, and the MDM, the researcher checked that all relevant patient documentation aligned correct bed numbers with patient names, this ensured patient names were not spoken during the video recordings.

Methods of Analysis

The methods of analysis as previously identified use inductive, and deductive processes. Inductive processes followed the ethnographic principles of exploration, and investigation until a level of saturation in the social classification of the data was evident. A wide range of inductive processes were generally undertaken, for example, the use of Spradley’s inductive sequencing for observation, and interview data (Spradley, 1979). True to ethnographic sequencing the analysis required “constant feedback from one stage to another” (Spradley, 1979, p. 93). This was combined with the deductive framework of SIT. These inductive, and deductive processes were used interchangeably across the stages of the research, the stages were adapted from, and consistent with Spradley (1979, 1980) and Ybema (2009). These stages were

- selecting problems, and looking at the cultural meanings the participants used to structure their behaviours,
collecting the cultural data done through the descriptive questions of the interviews, the observations of the video recordings, and the fieldnote recordings,

- analysing cultural data, with constant reviewing in search of cultural symbols,
- formulating ethnographic hypotheses, and relationships to be tested, and
- writing the ethnography, which stimulates the need to generate new hypotheses, and further research studies.

The inductive phase of interview analysis involved the discovery of cultural themes in keeping with ethnographic interview processes (Fetterman, 2010; Spradley, 1979; Ybema, 2009). In order to develop a list of cultural domains interview data was explored open ended based loosely on a framework developed by Colaizzi (King & Valle, 1978, pp. 58-62). The framework used is outlined in Table 7.

Table 7: Interview, and Focus Group Analysis

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>All interview, and focus group transcripts were read, and compared to the audiotapes</td>
</tr>
<tr>
<td>2.</td>
<td>Extract phrases or sentences that pertain to the investigation were cut out, and put into a separate document</td>
</tr>
<tr>
<td>3.</td>
<td>Similar meanings from these sentences, and phrases were then grouped, developing themes were then identified.</td>
</tr>
</tbody>
</table>
| 4. | This process was repeated for each transcript, and then clustered into the emerging themes   
| a. | The themes were then referred back to the transcripts, and audiotapes in order to validate the emerging themes |
| b. | Discrepancies were noted. Ambiguity tolerated |
| c. | Themes were then identified across all interviews, and focus groups |
| 5. | Results were then integrated into description |
| 6. | An effort was made to formulate the exhaustive description into overall themes |

Cross checking of the analysis was provided through the research supervisor as an outsider. This enabled cross checking of the data from the non-nursing perspective. The overall aim of crosschecking was to develop "examples, and techniques that objectify, and standardise the researcher’s perceptions" (Fetterman, 2010, p. 34) ensuring important data was not missed, unrecorded or even unnoticed.

The deductive methods of analysis involved the use of the SIT framework as described in Chapter 3. This framework was applied to all data collected, including the interviews after the inductive process of cultural theming had been undertaken.
Reliability and Validity of the Analysis

It was of particular importance that the research process would be worthy, credible, and undertaken with integrity. Attempting to identify how to do this within the qualitative paradigm proved to be more complicated than first anticipated, and there remains no consensus on rigour in qualitative research amongst the experts, making this undertaking a challenging task. Further investigation of the literature was then undertaken to uncover the many meanings of rigour, reliability, and validity within the qualitative paradigm before making a decision on how to proceed.

The issue of rigour in research is about the reliability, and validity of the whole research process, and is most clearly considered in the quantitative paradigm, it is not always seen as appropriate for qualitative research (Golafshani, 2003; Long & Johnson, 2000; Morse, 2002). The objective, logical, positivist nature of quantitative research allows for these terms to have very distinct meanings within this paradigm (Long & Johnson, 2000). However, this has not been the case in the qualitative paradigm. In fact it is often seen as extremely problematic so much so that rigour, reliability, and validity is considered inappropriate by some for the qualitative paradigm (Long & Johnson, 2000). As a result, there has been a move to develop terminology that better suits qualitative methodologies with the aim to maintain the value of qualitative research.

Trustworthiness is often considered a more appropriate word than validity, making a link not to truth, and value but to persuasion due to the qualitative researcher making practices visible, and auditable (Sandelowski, 1993). In further discussion of terminology, credibility is also seen as the alternative to validity, and dependability the alternative to reliability (Rolfe, 2006). Credibility (Guba & Lincoln, 1989, p. 239) has been viewed as significant in qualitative paradigms for some decades, and has been given due consideration for this project, particularly in ensuring the analysis of the findings has demonstrated integrity. However, it is not the terminology, but rather the method of credibility, that Guba, and Lincoln (1989, p. 239) identified has implications for this project, specifically, the use of member checking to confirm credibility of findings. For this project the use of member checking was undertaken in the form of a peer checking process, whereby experts from nursing undertook a presentation of findings, with the expert focus group and an audiotaped discussion to ensure confirmability of findings. For many commentators of qualitative research reliability remains elusive, and is considered problematic to adequately demonstrate in qualitative methodologies (Long & Johnson, 2000). However, reliability can be considered in qualitative research by employing the method of “audit of the decision trail” (Long & Johnson, 2000, p. 33). The seminal work of Myrdal (1969, p.
43) explains that the intent of this method is to declare the origins of concepts, acknowledging values, and perspectives of the researcher.

Whether the decision is to use terminologies traditionally afforded, the qualitative paradigm or the quantitative paradigm, it was the aim of this project to contribute to the scholarship of nursing, and more specifically, the understanding of performance of nurses’ professional identity. As there appears to be considerable division between researchers, and their views on rigour, reliability, and validity in qualitative research a clear position for this project has been engaged. This position does come from an epistemological stance, rather than an ontological stance, but in essence is about ensuring that the data collection, and then subsequent analysis has been credible, undertaken with integrity, and remains open to further evaluation.

**Analysis Framework for Testing Emergent Themes: Validation of the Analysis**

The process for validation was developed to test the emergent hypotheses or themes from the data. The plausibility was undertaken with a community of nurse academics considered experts in qualitative research design, and nursing workforce issues. To begin with, a presentation about the research design included the acknowledgement of the researcher values, and perspectives. This was followed by another presentation of the research data using vignettes of the key findings. The community of nurse experts were then asked to comment, question, and seek any required verification (Table 8). The key question to the community was “Do you believe this account?” These presentations were audiotaped, and evaluated.

**Table 8: Interview for Testing Emergent Themes**

<table>
<thead>
<tr>
<th>Method</th>
<th>Expert Focus Group Audiotaped</th>
</tr>
</thead>
<tbody>
<tr>
<td>Four Nurse academics:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 2 qualitative research experts</td>
</tr>
<tr>
<td></td>
<td>• 2 nurse workforce experts</td>
</tr>
</tbody>
</table>

**Conclusion**

A detailed account of the methods undertaken during the research process has been explained in this chapter. The methods used were true to organisational ethnographic methodology. The multiple methods used for data collection, and analysis allowed for multidimensional understandings of the performance of nurses’ professional identity in the workplace. In the following chapter the findings from the study are presented in detail.
Chapter 5: Ethnographic Results

The results of the study are presented in this chapter. The overall aim of this project is to investigate elements that constitute the performance of nurses’ professional identity within a specific work environment. After presenting the demographic findings the ethnographic results are presented. The results are organised according to the SIT concepts of, group performance (group motivation, group goals, group norms, and group efficacy); social identities (salience, nested, cross cutting); self-categorisation (normative fit, and prototype).

The following abbreviations as presented in Table 9 are used throughout the chapter in relation to direct quotations (video recordings, interviews, and fieldnotes).

Table 9: Abbreviations Used in Relation to Quotations

<table>
<thead>
<tr>
<th>Data Method</th>
<th>Abbreviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Interviews</td>
<td></td>
</tr>
<tr>
<td>Multidisciplinary Individual interview 1</td>
<td>[MDII1]</td>
</tr>
<tr>
<td>Multidisciplinary Individual interview</td>
<td>[MDII2]</td>
</tr>
<tr>
<td>Individual interview Junior Nurse</td>
<td>[IIJN]</td>
</tr>
<tr>
<td>Individual Interview Senior Nurse</td>
<td>[IISN]</td>
</tr>
<tr>
<td>Individual Interview 1</td>
<td>[II1]</td>
</tr>
<tr>
<td>Individual Interview 2</td>
<td>[II2]</td>
</tr>
<tr>
<td>Focus Groups</td>
<td></td>
</tr>
<tr>
<td>Group Interview 1 Voice</td>
<td>[GI1V]</td>
</tr>
<tr>
<td>Group Interview 2 Voice</td>
<td>[GI2V]</td>
</tr>
<tr>
<td>Fieldnotes</td>
<td>Fieldnotes (Behaviour)</td>
</tr>
<tr>
<td></td>
<td>Fieldnotes (Structure)</td>
</tr>
</tbody>
</table>
A wide array of quotes from the different sources has been selected, and there has been considerable work done to ensure there has been even-handedness to the participants’ multiple voices. Some quotes are used more than once in the findings because they have meaning in more than one category of the findings. The complexities of the analysis against the SIT concepts often result in more than a single meaning.

From the analysis of the interviews, the key themes are, concept of team, tension between senior/junior nurses, what is experience, hierarchy of shift, communication in handover, and behaviours in handover. These themes became the foundation for insights into the construction of nursing practice within the clinical units/wards for these two nurse activities of handover, and the MDM. There are insights into the group dynamics, and the constructions of social identities that translate into the professional identity of these nurses, and will be explained in the discussion chapter. The video recordings are analysed using the ethnographic methods within the fieldnotes, and the interviews outlined in Chapter 4.

Demographic Information

The demographic data is presented below in Table 10. However, this data has not been reported on in any detail as it did not contribute anything further to the analysis. There is much data from the other methods that contributed significantly to the analysis.

<p>| Table 10: Demographic Information |</p>
<table>
<thead>
<tr>
<th>Age</th>
<th>Registered Nurse</th>
<th>Enrolled Nurse</th>
<th>Length in Current role</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-30</td>
<td>2</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>31-40</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>41-50</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Above 50</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Group Performance

Group performance is a key concept in SIT. The four categories from the framework of group performance are used to present the data. These categories are; motivation, group goals group
norms, and group efficacy. Results are then drawn from each of these categories from the data, and presented as interview, and video results.

**Group Motivation**

Motivation from a SIT position is founded on the concept to achieve, and maintain a positive self-identity (Haslam, 2003). This self-identity may or may not be linked closely to the group. Motivation is reported in relation to insights from interview about handover, and MDM, and insights from researcher observations, and fieldnotes.

**Insights from Interviews: Nurse Handover**

Within SIT it is argued that “organisational performance depends to a large extent on employees’ willingness to go beyond formal job prescription” (Haslam, 2003, p. 29). In relation to professional practice in nursing, the results show that the focus of the nurses always centres around the patient no matter what the context. This patient focus creates a motivation for group performance that differs from many other work or organisational situations. The findings identify that the nursing group has constant interaction with patients during a 24 hour period. This makes the nursing role unique in health care. All other health care roles have sporadic interactions with the patient during their hospital stay. Therefore, the motivation of the nurse group strongly advocates for patient needs. This group motivation is represented here in the interview data:

*To add a nursing perspective, and I think very much to add a patient perspective. [MDI1]*

*...well we spend a lot more time with the patients, and we probably have a better understanding of the medical issues going on with that patient, and usually the other person tends to accept that, and accept that they’re more of a consultative service rather than a full-time hands-on service. [MDI2]*

What constitutes motivation in the two handover episodes is the importance of patients as part of the nurses’ social world whilst they are in their working environment. The language used in nurse group handover is a social narrative, and not just medical clinical information. The descriptions of patients by the nurses in the interviews also demonstrate humanness, and a strong therapeutic relationship.

*Can I say that I don’t know how professional it is, but we do get difficult patients quite often, and it’s just to give a light-hearted version of how they’re behaving, especially if we feel it’s inappropriate or over the top, and*
I guess I find that really entertaining when people do that..., and you do that all the time in handover... [GI1V2]

I think if you can talk about a patient’s quirks.. personality quirks or what worked for a patient in handover freely without fear of I shouldn’t say that, that’s judging the patient, it does make your shift easier because you could get the heads up... often you’ll use that information to get the best outcome for your patient. [GI1V2]

...but you need to care for your patients so obviously you need to provide safe care – that should be any nurse’s number one priority [II2]

...well this patient’s in my care, and I’m the patient’s nurse, and my role is to advocate for this patient, and half the patients don’t know what’s going on, and I want to be able to explain to them why they’re having this medication or why they’re having this test. [IIJN]

Organisational commitment is not considered a motivating factor from this data, rather there is a level of underlying hostility to the organisation, and its new directive to change the handover process, and make it more time efficient, moving it from the group handover in the tearoom to a bedside handover only. In order for the nursing group to manage some of the forthcoming patient challenges, the handover presents an opportunity to identify these challenges, and offer strategies for management. Therefore, importance, and commitment is placed on the nurses’ handover. The notion of debriefing, and talking is seen as integral to this activity within Unit B.

For us handover is not just imparting information, even though we are encouraged to condense our handover time, and so forth, but it’s not just about that. [II1]

...there was big consensus that this was the only time that we get together as a group, and we didn’t want to get rid of that because we felt that although whatever I say in here can get told at the bedside, it was more about us – it was the only time that we get together as a group where we can debrief, and talk, and that’s the main reason why we kept it. [GI1V2]

Cooperating as a team is a strong motivator in group performance, and this is clearly demonstrated by quotes on the importance of team.
...and it’s a physically, and mentally exhausting job being a nurse, you know, and if you go into that, and you’re alone, and you just come, and you do your work, and you go home, that can drag you down pretty quickly. I wouldn’t imagine you’d want to stay in your job very long, so if you go into that job that does physically, and mentally exhaust you but you know Jane’s just as tired as me, and Mary’s done as many shifts as me, and that patient hit Julie just like she hit me, you know, like it does make you feel like you’re doing it together, and you’re not doing it by yourself. It’s not your shift just with your four patients, and you can rely upon them, I can go Joanne can I have a hand, and unless she’s stuck somewhere she’ll always say of course.

We just work very well together as a team, and I trust her. [II2]

Participants reveal how the motivation, and conversations that occur during the handover meetings allow for the development of the team.

You need that outlet because you can’t have that constant stress, stress, stress... high level pace constantly – you need to be able to step back, and I guess have a good laugh get it out of our system, and get back into it.

[GI1V3]

You feel you’re being supported, and you feel that you understand that if you need something you can go forward, and approach someone, and feel a bit comfortable, rather than just being isolated. [GI1V4]

Insights from Interviews: MDM

What constitutes motivation for the MDM differs from the nurse handover, and the group membership is also significantly different. Each member of the allied health care team had a very specific function in relation to patient care. The physiotherapist looks after the musculoskeletal, and respiratory issues of the patient, the occupational therapist focuses on the functional aspects of patient movement, the pharmacist focuses on ensuring medication management is appropriate, the social worker looks at the plans for discharge management, and the nurse’s role is dynamic as it involves all these areas, and day-to-day caring, and needs of the patient, and their family. Therefore the motivations of this meeting did not focus on a uniform group, but rather uniform outcomes. From the interview data the motivation around this meeting is the equal dissemination of patient information from each of the specific professions. The members are motivated by their need to offer their perspectives on patient information.
This is very different from the nurse handover where there appears to be a uniformity of perspectives i.e. the collective shaping of the nurse’s perspective.

...everyone you speak to has got a different idea, and that was the idea of starting these meetings so that we could all... knew where we were at, and where we were headed so that everyone wasn’t off doing their own thing, and potentially heading maybe in different directions with people. [MDII1]

We kind of thrash things out... making sure that we’re all on the same page to begin with so we know exactly where they’re at. [MDII1]

Insights from Researcher Participant Observations, and Fieldnotes: Group Motivation

The video data presents a different opportunity to explore motivation of the group in both meeting types. The video data demonstrates what has been spoken of in the interviews. Viewing the video recordings gives another angle of data with similar insights into what motivates the participants to contribute or participate in these meetings. These meetings are professional activities that are well embedded into the daily activities of these professional groups, and therefore the motivation to be part of the healthcare team appears to be driven by both an organisational, and professional motivation. The focus on the patient is a core aspect in the conversations that occur in all four meetings. On repeated viewing of the videos one of the key motivators is the creation of amicable groups. Each member of the groups demonstrates forms citizenship behaviour, these are identifiable in the quotes below.

Handover, and the MDMs clearly have a very informal tone in all the videos. However, this is not to say they are at all informal, their structures appear quite similar, and there is clearly a way of behaving, and a position for each player to play. There is also a lot of informal storytelling language, and some opportunities to unload difficult or unusual happenings of the patients with a common bond between the professionals. [Video 4: Nurse-to-nurse handover Unit B Fieldnotes (behaviour)].

There was a friendly informality in the discussions, and there was laughter throughout the meeting. In all the videos much humour is used to normalise situations around patient circumstances, and conditions that could be quite challenging. All 5 of the members sat amenably around the table interrupting, and chatting with each other. [Video 1: Multidisciplinary meeting Unit A Fieldnotes (behaviours)]
There is intenseness about the activity. The informal space I think is probably misconceiving as there is a very set way of doing, and behaving in handover. [Video 2: Nurse-to-nurse handover Unit A Fieldnotes (behaviour)]

The activities of all the health professionals in the videos are predominantly around the motivation to promote forms of humanness (Haslam, 2004, p. 61) or person-centeredness for those involved in the meetings, and handover. The concepts of nursing, and person centeredness, humanness, and caring are well identified in the literature (Lapum et al., 2012; Lehulante, Nilsson, & Edvardsson, 2012; Litchfield & Jonsdottir, 2008; McCormack, et al., 2011; Taylor, 1992). What is distinctive about the video data is the focus on person centeredness or citizenship behaviour in relation to aligning the group members. The binding factor of the demonstrated citizenship behaviours is the want to create a group that has the patients’ best interests as a primary concept.

...this meeting was socially intense but not in a formal way. More in the commitment to the patient, this is demonstrated by each of the members of the meeting, and their discussions, the way they all contribute to the information of the patient quite freely until a consensus around the next stage of management, and then the nurse initiates moving to the next patient. In each of the discussions each member appears very focused on their information, and this is recorded by the nurse before the plan of action is agreed upon. If one member does not think their perspective is adequately represented then they seem quite comfortable to speak up. There seems to be a shared equalness in the communication pathways. [Video 1:.Multidisciplinary meeting Unit A Fieldnotes (behaviour)]

The conversations focus around patient stories the activities that have occurred during the day, and the plans for the next shift. There are anecdotal suggestions on how to manage certain patients, and the completion of each handover there is discussion around patient allocations. [Video 2: Nurse-to-nurse handover Unit A Fieldnotes (behaviour)]

**Insights from Researcher Participant Observations, and Fieldnotes: Nurse Group Handover**

The motivation for the Unit A handover meeting from the observations of the videos seems to focus on delivering patient information in succinct manner. The desire to conform to the obvious structure of this activity can be seen in the active focus each member shows to the ANUM delivering the information. This can be seen in both the unit handover meetings.
Quietness, passive body language is clearly demonstrated. Yet the group identify in the interviews how important this meeting is to them as a group.

*The ANUM does most of the talking; there is not a lot of interaction just a few questions. However these questions are asked very predominantly by the nurse who will be in charge of the oncoming shift, and the second senior nurse. The other two nurses are quite obviously quiet, and only make comment on a very few occasions. [Video 2: Nurse-to-nurse handover Unit A Fieldnotes (behaviour)].*

The motivation at an individual level to be part of the group can be seen in one of the junior nurses attempting to interact on a level that is usually reserved for those considered to be senior.

*The other two nurses are quite obviously quiet, and only make comment on a very few occasions at the beginning of the handover. One of the junior nurses then begins to actively engage, without a lot of feedback from the ANUM. Although this appears to be congenial later in the interviews some tensions are revealed. [Video 2: Nurse-to-nurse handover Unit A Fieldnotes (behaviour)].*

What is evident in the Unit B handover meeting is that the time allocated for this meeting is not supported by the organisation (superordinate level), but is very much supported at the team, and individual nurse level (intermediate, and subordinate levels). The motivation for undertaking this activity advances the motivation to continue this activity as it currently exists. In the video, this group employs a lot of humour in the delivery of the handover, and there is elaborate storytelling around patients with complexities either socially or clinically.

*There is a lot of friendly banter throughout the handover, and although the conversation is very much monopolised by the nurse giving handover for me it is clear who the in-charge nurse will be for the oncoming shift due to her confidence in process, and information when she speaks. There is also quite a lot of input from a number of the other nurses, and there is clearly lack of input by certain other nurses who I know are the less junior nurses. [Video 4: Nurse-to-nurse Handover Unit B Fieldnotes (behaviour)].*

Motivating behaviours from the video appear to be good citizenship behaviours. The group appears motivated to stay focused on the ANUM delivering the handover. Group members
interact only when they are given cues by the leading staff that this is appropriate. Members are involved in humour when instigated by the ANUM giving handover or the ANUM coming on to take charge of the next shift. The group appear to be motivated to behave appropriately, and conform to the hierarchical structure of the activity. There is only one deviation from this, and that is displayed by the junior nurse in Unit A who does not conform to the apparent salient citizenship behaviours, and speaks relatively freely throughout the handover. This is perceived negatively during the interviews.

*Insights from Researcher Participant Observations, and Fieldnotes MDM*

The motivation to function together demonstrating organisational citizenship behaviours (Haslam, 2003, p. 30) is obvious also in Video 1: Multidisciplinary meeting Unit A.

*There were 5 people in this video. All were women which is common in nursing, and allied health groups. There was a friendly informality in the discussions, and there was laughter throughout the meeting...All 5 of the members sat amenably around the table interrupting, and chatting with each other. [Video 1 Multidisciplinary meeting Unit A Fieldnotes (behaviour)].*

Eye contact, and close proximity to each group member give insights into the possibilities that a willingness to work together may be present. Body language, and non-verbal cues indicate a keenness to create an amicable group. This can be seen in Figure 5 in the way the group are attentively engaging as a close knit friendly group.

**Figure 5: Video 1:Unit A MDM**

The MDM in Unit B (Figure 6) does not reflect the same congeniality as Unit A. The motivation for undertaking this activity is not performed with the same keenness or interest by the individual participants as is in Unit A. Yet, there remains a commitment to creating a congenial
MDM group on the surface, and the tensions appear to be between one particular professional group, for the sake of the meeting this is contained, and only demonstrated in the body language. This further reinforces the motivation to appropriate citizenship behaviour within the MDM.

Figure 6: Video 2: Unit B MDM

...the allied health staff were not as interactive as in the previous ward, and I wonder if this is because of the way the room is set up. Does it take away from the friendlier approachable atmosphere all sitting around a table having a chat? The information given around the patients is similar to Unit A but the conversations are not as equally distributed. The nurse seemed to deliver most of the information, and the allied health staff seem to receive this more passively. The shared, and equally distributed conversations are not as defined in this meeting. [Video 3. Multidisciplinary meeting Unit B Fieldnotes (behaviour)].

The motivations of this group appear to be driven by information, and communications between individuals. The motivations appear to focus on the patient, and not the group as such.

The results in relation to motivation have been presented in this section. The key findings are that there are central motivators around the patient for both the professional activities, and a commitment to good citizenship behaviours. The motivator for the nursing group handover is patient advocacy, and the development of the team through social conformity during the handover process. The motivator for the MDM is to ensure the voice, and patient perspective of the individual professional is heard.
Group Goals

Activities of the MDM, and the handover are organisational goal setting activities. Goals are reported under three headings. These are insights from interviews: nurse handover; insights from interviews: MDM; and insights from researcher participant observations, and fieldnotes. Important examples of daily group goal setting within the health care organisation are presented. The focus of goal setting centres on the coordination of patient care by the healthcare team. The MDM focuses on the plan of care for each patient in the unit with input from other healthcare professionals who are involved in the patient’s care planning. The handover is an activity where the group of shift nurses organise the priorities, plan, and structure for that shift through the feedback received from the nurse in charge of the previous shift.

As well as a motivator, citizenship behaviour is also often an important collective goal in organisations (Haslam, 2003, p. 30). This offers insights into the way professional practice plays out in the case context.

Insights from Interviews: Nurse Handover

The SIT approach emphasises the importance of involving group members in goal setting. The interviews reveal that one of the significant outcomes of the handover activity is to set the scene for the shift. This is done through the allocation of staff to patients dependent on the skill mix of staff available for the shift.

At the beginning of the four individual interviews to discuss the handover video, the nurse to be interviewed is given names of those in the team in the video of the oncoming shift. They are asked to sort these names in groups. Initially this is all the information that is given. Two of the nurses ask for clarification, but overall it is assumed this means working groups. Each of the groupings is different but all identify the groups as like teams. One saw this as a linear senior to junior, the others saw the groupings as mixing of senior, and junior with one or two as leads. However all saw the handover as an opportunity to allocate, and organise the team for the oncoming shift.

The forming of the staff names into groups identifies a number of factors. One of these is that in order to achieve the goals for the shift the group needs to organise itself in a workable manner to meet the outcomes of the shift. The four groupings offered by the participants during their interviews are revealed through the pictures in Figure 7.
Aspects around skill mix, and insight into how this is managed in handover are revealed by the quote below.

...so if your skill mix is quite low, so you might have a couple of very junior staff members, and a senior staff member who isn’t very good at actually support her staff, and someone else who isn’t a real team player, then your skill mix is pretty important because you can’t carry everyone. So you need to know that.... I think, being in charge you need to know that there’s two or three people that are under you that are competent, and that they can be your “go to” people as well, and that’s a safe skill mix in case something goes wrong. [II2]
The overarching goal of the nurse group handover is to be prepared for the coordination of patient care; the complexities embedded in this care are explored in more detail as the results from the ethnography unfolds during this chapter.

**Insights from Interviews: MDM**

For the MDM the discussions during the individual interviews whilst watching the MDM video gave insight, and understanding on the goals of this group activity, and the goal setting that arises during these meetings.

*I guess it’s to get them out of here, but it really is to determine I guess what the optimal outcome will be for that particular patient, and hopefully, ideally it’s based on the patient goals as well. So together we can try, and achieve that. [MDII1]*

The above quote identifies the organisational goal of patient discharge, the unity of this group to strive towards this is seen as important, this nurse also acknowledges that the patient goals should also be considered.

*What’s important is what the patient wants – what we might think might be the best thing to happen, and the best goal, may not be what they want... you know sometimes what the patient wants is very unrealistic, and it’s not obtainable, so you know with everyone’s input we can determine that –, and you know the physio can go, look this person’s not walking, they’re not going to be able to go home, they have to go to rehab, so you know we can adjust or change goals through that. [MDII1]*

These goals are very much focus on the individual professional’s specific goals for patient care. The nurse leading the MDM brings these goals together as a consensus on a holistic plan of care. These positions are consistent across the MDM interviews.

**Insights from Researcher Participant Observations, and Fieldnotes: Group Goals**

Observations of the video data gave insights that each of the four videos presents a similar sequential structure to their respective activity with a process of going through each patient according to their bed number, and then delivering specific patient information. The developments of goals of the handover are socially driven to develop a group dynamic which is led by the senior nurses. The goals of this activity centre on the preparation of the nursing group to function together in the following shift as an organised productive unit in order to
maximise patient care. The goals of the MDM are far more patient-centred, and focus more on the patient plans, and management, then the development of the group.

**Insights from Researcher Participant Observations, and Fieldnotes: Nurse Group Handover**

The setting of goals in the handover meeting is subtle. Interactions that occur are limited to key people. This gives the impression that it is these people who are setting the goals or at least leading the goal setting. The conversations in this activity focus on happenings of the previous shift, and possibilities for the next shift. Information is around immediacy of patient management, and although include long term patient care goals, are focused on the imminent shift. The goals are specific but are steadfast to the group participating in the handover activity, and there is a strong use of storytelling which appears to unify the group.

> The conversations focus around patient stories there activities that have occurred during the day, and the plans for the next shift. There are anecdotal suggestions on how to manage certain patients, and the completion of each handover there is discussion around patient allocations clearly the aim of this activity is preparation of the forthcoming shift. [Video 2 Unit A fieldnotes].

**Insights from Researcher Participant Observations, and Fieldnotes: MDM**

What is identified from the videos is that these goals revolve around procedures that have been done, and need to be done for each of the patients. The goals here are around overall patient management. Each member of the group has their own specific pieces of information, and focus on their specific areas. The physiotherapist, and OT are very focused on the mobility, and self-management of the patient. The pharmacist focuses on medication management, and interactions. The social worker focuses on how the patient will cope, and what referrals or processes or support structures need to be organised for discharge. The nurse is not specific or focused on areas of patient care. Rather, the nurse holds the overall story of each patient, fills in gaps, and answers questions around patient information. The nurse is also the person who is identified each time something needs to be followed up or clarified. In the first video, the nurse is asked on a couple of occasions to follow-up on doctors to clarify patient care issues. Notes are made in these meetings by each of the group members identifying tasks they will need to do on completion of the meeting. Each person has their own list of “to do” items. At the completion of Video 3, the allied health team set out goals with their students as a list of tasks before they leave the room.

The meeting ends with general acceptance or consensus that aspects of patient planning have been adequately addressed. The insights are that the goals made during this activity are
consistent, and realistic, and specific to this healthcare group whilst also being consistent, realistic, and specific to the to the individual patient care goals.

These meetings are very different in their goal setting to that of the handover where the focus is not only on patient management but also on creating a team for the forthcoming shift.

The group goals for both professional activities demonstrate differing perspectives. The intent of the group goals for the handover is to develop the social group of the nurses. The intent of the group goals for the MDM is to ensure each professional group is provided an opportunity to present their professional perspective on patient care. Both groups also establish goals for patient care.

**Group Norms**

The notion of group norms in SIT is that the group leads the individual to internalise group norms (Haslam, 2003). Group members will adopt these norms if they are aligned to the group. For the professional activities of nursing group handover, and MDM these group norms are quite different. The foundational principles evident in the motivations, and goal setting (revealed above) for each of these activities result in differences in group norms. These findings are discussed in this section of the chapter.

There is a commonality in the case context in that the same nurse led the nurse group handover, and the MDM in their respective clinical units. The nurses who led each of the nurse group handovers are identified by their nursing groups as leaders. They both held formal organisational positions as an Associate Unit Manager, and this reinforces this leadership role. The nurses who led the MDM are also recognised by this group as being nurse leaders. The SIT concepts identify that a leader must embody the norms, and values of the intragroup. The results of this project demonstrate that each of the nurses who led the meetings/handovers demonstrate intergroup norms, and values of the nurse handover over the MDM, and identify closely with the values of the intergroup of nurses in their unit.

**Insights from Interviews: Nurse Handover**

The expression of the group norms in handover is visible in the inductive, and deductive analysis of the interviews. There is a strong emphasis on the concept of communication particularly its significance in the nursing group handover. The degree of saturation of the data in relation to the nurse group handover is strongly consistent. The strength of the data enables aspects of the communication in handover to be explored more deeply. Four aspects of communication are consistently present in the data, and analysis. From the theme communication in handover further aspects highlight some of the norms of the handover
activity. These include, acceptance of the complexity of nursing work; nurses informal knowledge of patients; patient advocacy, and team (team is also one of the main emergent themes but is repeatedly evident within all the emergent themes). The following quotes have been selected for what they reveal about these aspects of communication.

Acceptance of the complexity of nursing work is central to the communications in handover. The group demonstrate normalisation of the complexity by their taken for granted messages, and communication strategies.

*Well it’s a common goal of taking care of your patients, and you know, by the same token, keeping the powers that be happy as well – getting people out so you can get people in, and it just makes it work a whole lot better – it works.* [II2]

*Nursing staff have this big hat, and they do all the jobs that other people say it isn’t my job to do this, and I think it’s very rare that you’ll find a nurse that says that’s not my job, so I think it’s generally accepted by all other staff, like medical staff, that they can interrupt you whenever they feel they need to interrupt you, and tell you what they feel you need to know, so for a nurse… I think it’s generally accepted that you can be interrupted, and you can…, and meetings don’t have that high level of, I guess, importance by other disciplines.* [MDII2]

The normalising of the complexity of nursing work plays out across the SIT categories in the findings. The normalising of the complexity of nursing work influence not only group performance but also play a significant part in the development of group efficacy, and in the self-categorisation of the nurses to the salient nursing group.

Nurses’ informal knowledge of patients is another normative aspect of communication. Nurses are aware of personal, and often sensitive information on patients that may not be recorded in any patient notes. This is identified as the informal knowledge of nurses about patients. This informal knowledge in part contributes to the complexities of nursing work.

*…there’s just that verbal thing that goes around, and that’s often the social kind of things are more verbally passed over than documented, you know. You’ll often hear someone say, you know, their wife’s an alcoholic, and it’s never documented anywhere but everyone knows it somehow.* [GI1V1]
This acceptance of the unusual or socially unaccepted is a norm that reinforces patient advocacy. Patient advocacy another aspect of normative communications in handover, at the centre of the development of these nursing norms is loyalty to the patient. This is played out as patient advocacy.

...well this patient’s in my care, and I’m the patient’s nurse, and my role is to advocate for this patient, and half the patients don’t know what’s going on, and I want to be able to explain to them why they’re having this medication or why they’re having this test. [IIJN]

It is evident in all handovers that this norm is repeatedly reinforced by the lead nurses, and is assumed, and sustained by the other nurses in the team.

Team is an important aspect of communication. The conversations within the interviews on the nurse group handover continuously reinforced this notion of the nursing team. Team is seen as essential in order to achieve the work successfully throughout the oncoming shift. This norm is consistently significant to group performance. Later in this chapter it is also revealed that social understanding of team within the nursing group is also central to social identity.

...as nurses, and we have shared experiences, and we have terrible days together, and we have great days together, and we know more about each other’s lives as a rule, so I think it’s different because it’s a bit more disengaged (with the allied health team). [MDII2]

The development of the group norms contributed the organisation, and coordination of the nurses’ work. It is identified that the close proximity of the nurses to each other during the working shift requires the conformity to the group norms in order for the work to be achieved.

**Insights from Interviews: MDM**

Norms from the MDM are quite different to the nursing group handover. These norms are limited to the immediate behaviours within the MDM without any expectation that there is a requirement for internalising the group norms beyond the activity of the MDM. The commitment to appropriate citizenship behaviours are important during the meeting but the expectation is that these norms are performed only during group activity of the MDM, and are not a preparation of the group to continue to work together. Therefore the norms focus on the meeting structure alone.

*We do it at 8:45 every day, which is after I’ve done the ward round, after I’ve handed over to the Unit manager, and then either myself or the Unit*
manager will do this meeting [MDM], and it depends on the staffing, but there’s always a physiotherapist present regardless, an occupational therapist unless they have something else on that day, and a social worker if one’s allocated to the ward. So when one’s allocated to the ward they also attend. [MDII2]

There is a norm or routine to the timing of this meeting. It is identified that it occurs after there has been dissemination of patient information to nursing staff, and then there is a meeting with the multidisciplinary team for their input, and consideration of patient management.

*I give them a handover on the medical condition of the patients first so they know whether it’s appropriate that they actually go in, and speak to that patient that day or if they’re really not medically well enough to be seen, and where they’re at mentally, and if they require any... like discharge planning, so we’ll talk about who’s expected to go home today or who’s expected to go home tomorrow, and what they may or may not need, and then I’ll also get feedback from the physios, and OTs, and people they have seen the previous day, and they can let me know where they’re at with their work with any aids, and whether they feel they’ll require rehab or whether the aim is straight home, and that’s pretty much the stream of it, so it’s just to have a discussion about what needs to happen that day to facilitate discharge planning. [MDII2]*

*It’s about getting input from the different perspectives, the different allied health perspectives with the view to moving ahead so that everyone’s on the same page so that we’ve got all the different areas of input, and we know where we’re at, and from there work out together where we’re heading. [MDII1]*

The practice regarding this meeting focuses on the opportunity for each of the occupations or professions from the health care team to offer their perspective.

*...the other disciplines tend to be a little bit more stuck up – if that’s to be honest, and they think that their role’s a lot more valuable than say a nursing role, some of them, and that is reflected in the way that they talk to nursing staff often, and the way that the relationship is.[MDII2]*
There are also some tensions present for the nurses as they believe, and feel that the other professionals who attend this meeting do not view the nurse as a health professional equal.

*We kind of thrash things out, like I’ll often run through the list, and say this person, this is what we’re doing, and then someone else might say, well I thought this was what was happening, and I think part of it is straightening out what that interaction is just making sure that we’re all on the same page to begin with so we know exactly where they’re at.* [MDII1]

The overall norms around this meeting are to present an opportunity for each discipline representative to give input into the patient care, management, and outcome from their particular professional perspective. The norms are to behave as a collegial group during the meeting but this group did not extend beyond the MDM.

**Insights from Researcher Participant Observations, and Fieldnotes**
The video data from the researcher’s observations reinforced what is identified from the interviews. The norms for the nursing group handover are multidimensional, and create a platform for the internalisation of group norms to enable the nurses to perform as a group after the handover is finished. The MDM in contrast has norms for behaviour during the meeting, the translation of the group norms are not expected after the MDM finishes. When analysing the four videos, there is clearly a normative influence that creates conformity to the behaviours in all the meetings. There are, some insights into the different norms that exist between the MDM, and the handover meetings.

**Insights from Researcher Participant Observations, and Fieldnotes: Nurse Group Handover**
The normative influences in the handover meeting appear to have a very hierarchical structure. All participants in Video 4 conform to the ANUM leading the activity, and the oncoming ANUM contributing some commentary with minimal interaction from other team members unless invited during storytelling episodes. In Video 2, one of the junior nurses interacts quite frequently. Although the ANUM is polite, her interactions do not appear to be validated by the other members of the group who do not make eye contact with her. Otherwise, Video 2 also demonstrates a normative hierarchical structure to the activity.

*...I am also drawn to the most junior nurse who seems to be actively attempting to engage, and she appears to be actively engaging in this activity but the ANUM although politely responding does not return this engagement I suspect there is no expectation that she talks during this*
activity... Although this appears to be congenial later in the interviews some tensions are revealed. [Video 2 Handover Unit B fieldnotes, (behaviour)]

The complexity of work, and the use of humour is also seen in the video recordings.

There is intensity in the social interactions; the stories demonstrate the complexities of managing the patients. Also there are discussions about interactions, and issues with other members of the healthcare team or patient relatives but there is also a lot of humour. The complexity of the work is managed through the frequently funny interesting bits about patients are shared, and the intensity of the previous shift is diffused by telling these stories of the shift with lots of humour. The description of the woman, who has come from another state to be looked after by family, had a fall, and is now in the unit. This patient’s complicated social situation is discussed, and suggestions, and strategies to manage not only the patient but also the main carer are considered. [Video 4 Unit B fieldnotes]

In Table 11 an example from the interviews depicts the normalisation of the unusual by using humour to manage both complexity, and informal patient information. This is observed during Video observations frequently.

2Table 11: Nurse Group Handover 1

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Activity</th>
<th>Participants</th>
<th>Purpose</th>
</tr>
</thead>
</table>
| Minute 7 | Question asked of ANUM giving handover: “How was patient bitten?” This creates conversation around patient including humour. These interactions occur mainly between the ANUMs, and the EN nurse. | Interesting patient creates interactions. Some interaction between ANUM2, and EN this is slightly unusual during this handover most interactions involve ANUM1. | ANUM1
ANUM2
EN | Other staff remain quiet. As a group there is an acknowledgment that there may be challenges to nursing this patient. |
| Minute 12 | Discuss a very fit patient interaction between ANUMs. | Gives social information around the patient who was identified by ANUM1 as a very interesting fit | ANUM1, and again only ANUM2 interact. Other staff members make eye contact with ANUM 1, and | Demonstrates information that is interesting but may not be included in patient notes. Humanises patient. |

2ANUM= Associate Unit Manager; EN= Enrolled Nurse; RN=Registered Nurse
The development of group norms is observed as an extremely multidimensional process during the nurse group handover. The formal hierarchical structure of the meeting is contrasted by the use of humour, and the normalising storytelling conversations around the patients many, and varied unusual social, and personal situations. Profoundly the reinforcement by the senior nurses to normalise nurses’ complicated work is an overarching group norm.

**Insights from Researcher Participant Observations, and Fieldnotes MDM**

When observing the normative influences in the two videos of the MDM it would appear that although the nurse leads the discussions, and directs the structure of the meetings, there is not an expectation that she actually leads the meeting. The normative behaviours allow for the sharing of information between all members during this activity. In Video 3, the conversations are not as florid as in Video 1. However, in both of these meetings there is active engagement, and many occasions where team members are prompted by each other to interact.

The contrasting group norms between the Nursing Group Handover, and the MDM demonstrate very different meanings in group norms. The nurse who leads the nursing group handover is seen to embody the group norms, and reinforces these by her communications during the handover. More than this the group norms are identified as important to the ongoing group performance of the nursing group. This is in direct contrast to the MDM where the group norms are behaviours only required for the performance of the MDM activity, and not beyond. The group norms are presented as organisational citizenship behaviours that allow for a collegial performance during the MDM.
**Group Efficacy**

The notion of efficacy is relevant to both groups, and individuals. Conscious control of performance plays a significant part in developing efficacy if attitudes are to translate into behaviours (Haslam, 2003, p. 39). Citizenship behaviours are seen as far more significant to efficacy than task or job descriptions (Haslam, 2003, p. 39). The understandings of group efficacy identify that group performance increases if the group member identifies strongly with the group (Haslam, 2003, p. 40). The analysis of the group goals, norms, and motivations show how the nurses identify more strongly with the activity, and the members of the nurse handover than with the members of the multidisciplinary group. The reinforcement of this group performance is strengthened through group efficacy, and examples of this are demonstrated in the data.

The video data then provides insights into the concept of group efficacy through revealing the actions, and behaviours that underpin, and support the volitional control of these groups.

**Insights from Interviews: Nurse Handover**

In the results from the interviews examples of group efficacy are noticeably demonstrated particularly in the explanation of what is considered *experience*, and discussions around the two junior nurses who show some wayward behaviour that may translate into their inexperience in group performance.

The following quotes identify that the junior nurses have not as yet fully embodied the nursing group behaviours, and structures. As a result they do not always demonstrate or understand the group efficacy, and appropriate group performance is still developing.

*Absolutely, it’s paramount. You need to know that you can rely on your nurse in charge, and staff around you if you get into trouble. You need to be able to feel comfortable in saying look, I’m having trouble or I’m not coping, I need some help. There’s nothing worse than having that sinking, drowning feeling...I guess over time like anyone you get worn down, and you sometimes conform to what’s around you...I find there’s a wall sometimes. [IIJN]*

*...but not to argue with somebody who’s... like with somebody who knows more... Senior in a way that they are higher in years, but lesser in knowledge. [IIJSN]*
The emergent theme of experience is particularly evident in light of group efficacy, and is demonstrated here in these results. Experience underpins the concept of group efficacy as the experienced nurse is considered to be successful as a nurse. The experienced nurse is considered to have considerable volitional control. The following quotes highlight the importance of the nurse who is considered experienced, and the attributes that attribute to this.

*People that showed leadership, reliability, accountability is a big one for me... someone who will follow through, and someone who I have the confidence that I can also learn from them, and will treat me as an equal.* [IIJN]

*I think a senior nurse is someone who has a bit of knowledge, and experience, and I guess a certain personality type that makes a good senior nurse who can be a “go to” person, and can prioritise, and can make judgement calls in hard situations, so I guess people who have all those attributes I would classify as senior, but by the same token there are junior nurses that I think are more senior than people that have more experience than them because they have those qualities.* [II2]

The quiet nurse who does not ask questions is viewed with suspicion. This quiet behaviour is not normative, and therefore viewed as potentially less effective, and may be damaging to the group efficacy.

*[About a graduate nurse]...but there are others who don’t like to ask too many questions. They feel as if they should know it because they’re, you know out in the workforce... I like that behaviour of question asking because at least then I know where they’re at, you know, as opposed to them going off doing it, and making a mistake. I would rather them acknowledge that they’re needing help, and then we can you know do it together, and then hopefully avoid any complications down the track.* [II1]

*Because he wouldn’t listen to me... I remember being junior, and running things past my senior nurses, and taking their directions, and suggestions onboard with a lot of – I had a lot of confidence in them so I was happy to go, okay, that’s a good idea, I’ll try that, and that wouldn’t be well received with that particular nurse, and as awful as it is, it was much easier just not
to go in there, not even into the room when he was on – it’s just going to be
a fight the whole way. [II2]

The loud nurse is viewed similarly to the quiet nurse. The loud nurse is also a junior nurse, and therefore she broke the hierarchical structure of the nursing group handover by asking questions. This is also seen to threaten the group efficacy.

...the dos, and don’ts sometimes they don’t have that – they just keep going
without even thinking, and I don’t like working with people like that. [II1SN1]

but not to argue with somebody who’s... like with somebody who knows
more... Senior in a way that they are higher in years, but lesser in
knowledge. [II1SN1]

Group efficacy in the nursing group handover is epitomised by the experienced nurse. The junior nurse struggles to identify with the group efficacy, and this is recognised by the group. Any threat to volitional control is taken seriously, and this is commented on in the interviews.

Insights from Interviews: MDM

Where group efficacy appears fundamental in the nursing group handover it is not evident to any significance in the MDM. There is not a belief in the MDM as a group that will achieve together. Rather the nurse who leads the MDM continues to align with the nursing group whilst performing in the MDM.

In nursing, and in our team, but you know I think it’s a lot to do with
personality but it’s also I had to pick out how many people I trust in that
group, and how many I kind of trust in the nursing group.[MDII2]

There is a clear distinction here between the meeting members as a group. Their performance is seen on an individual level rather than on a group level. This is demonstrated in the lower level of trust of the members of the MDM to the members in the nurse handover group.

I think it does you give you a little insight into what they do, and the kind of
things regarding what their expertise is. [MDII1]

The performances of the individual professions are seen as often working in isolation, one of the benefits of this meeting is to understand what each person does. There is individual efficacy demonstrated but group efficacy is not a focus for this meeting or this group.
...everyone you speak to has got a different idea, and that was the idea of starting these meetings so that we could all... knew where we were at, and where we were headed so that everyone wasn’t off doing their own thing, and potentially heading maybe in different directions with people. [MDII1]

The interviews reveal that group efficacy is important in the nursing group handover but not in the MDM. The MDM promotes a sense of individual efficacy whilst each member presents with good organisational citizenship behaviours. The members of the nursing group handover passionately advocate for group efficacy.

**Insights from Researcher Participant Observations, and Fieldnotes**

From the observations of the video the physical space of the meetings is interesting. Each of the meetings occurs in similar spaces. These are informal small rooms as shown in Figure 8. The physical space of the professional activities contributes differently in each of the meetings. Group efficacy is promoted by these spaces in the nursing group handover these spaces are considered nursing spaces. For the MDM the health professional other than the nurses look to be invited into this space.

**Figure 8: The Handover Space in Unit B**

The space sets the scene for the performance of the professional activities, and it is observed that the nurses have a distinct volitional control over the space that reinforces the group efficacy of the nurses during the professional activities video recorded.

**Insights from Researcher Participant Observations, and Fieldnotes: Nurse Group Handover**

When the videos are analysed there is obvious the conscious control of performance of this activity by the handover group. The behaviours in the handover meetings depict a clear structure to this activity. The nursing group handover is nursing business, and in Unit B the
The door is actually locked so that the nurse presenter (who site by the door) has control over who enters, and leaves the room during the activity. The handover then follows a very specific structure, and this is true of both the nurse group handover meetings. There is a particular seat in each of the handover meetings where the presenter (ANUM) sits. The remaining group members sit around this presenter in Unit A at a table in Unit B a semicircle of chairs. At all times the nurse presenter is the central focus of the meeting, and determines the undertakings during the handover. There is a structure to the conversations that occur. In both units, the presenter (ANUM) reads through the patient list starting at the patient in Bed 1, and methodically in a numerical order reports on each patient. The information disseminated is not just clinical information, there is storytelling about patients with challenging social behaviours or situations, advice about how to deal with situations that may be unexpected or challenging; review of shift, and passing on or unfinished tasks. At the close of each of the handovers, there is a very quick ritual where the ANUM or presenter then verbally passes over the leadership to the oncoming ANUM who then proceeds to check the allocations of nurses to patients, and hear any other issues before leaving the handover space. In both handovers, the presenter demonstrates a considerable amount of effort in the delivery of the handover, making the conversation interesting, through humour, and storytelling techniques. The remaining group member show considerable regard to listening quietly, and engaging in conversation in a limited way. They actively take notes, and give positive nonverbal cues like head nodding, overall giving an impression of being genuinely focused on the activity of handover. This formal structure is conformed to by all except the junior nurse in Unit A who is identified by the more experienced nurses as not having a strong understanding of normative group behaviour.

This activity is undertaken in isolation with only the in-group being present. This allows for group efficacy to be reinforced throughout the activity. As is identified in the interviews, there is a level of trust between the members of this group, and their goals, norms, and motivations lean to establishing the group performance. The individuals appear to identify very strongly with the group, and aim to behave appropriately within the structure of the handover, and homogeneity is evident.

*Insights from Researcher Participant Observations, and Fieldnotes: MDM*

The group undertaking the MDM demonstrate collegiality, and the behaviours within this group are socially polite. Analysing the videos, there appears to be a genuine friendliness, and the activity gives the impression of a pleasant social activity. The structure of each of the MDM is slightly different, and the groups do not appear to be particularly homogenous. The nurse commences the meeting, and initiates the dissemination of information in each of the meetings. In Unit A all members of the team equally contribute information. In Unit B this information
contribution is dominated by the nurse, and one of the physiotherapists with the other two members contributing less, and the students remaining silent but using positive nonverbal cues. The ANUM in Unit A does not sit at the head as she does in the handover meeting. In Unit B the ANUM resumes her position in the same chair as in the handover meeting (the chair near the locked door). The MDM is presented in a similar order to the nursing group handover. Patient information is presented using a numerical bed order format.

Volitional control is present at an individual level but group efficacy is not clearly reinforced as in the nurse handover. The videos of the MDM show the equal sharing of communication interactions in a very friendly manner. There is a lack of obvious hierarchy, and with each member of this meeting attempting to have an equal opportunity to share their particular information. With the results demonstrated in motivations, goals, norms the performance of this meeting group is not focused on group performance but rather to achieve the outcome of coordinating patient care. Therefore the notion of group efficacy is not strongly demonstrated but there are certainly self-efficacy behaviours, and acceptable social behaviours within this meeting.

In this section of the chapter the ethnographic results associated with group performance in relation to the nursing group handover, and the MDM have been presented. The four categories which collectively signal behavioural, and structural qualities identify that the professional activity of nursing group handover is significant in the development of group performance. This performance extends beyond the activity of handover to the preparation of the group for the oncoming shift. The leaders direct social voice, and processes in the meeting to sustain the group efficacy. In contrast the MDM does not contribute to group performance except as appropriate organisational citizenship behaviours during the undertaking of the MDM.

**Explanation of Social Identities**

The second concept from SIT used in the inductive, and deductive analysis of the data is *social identities*. From the premise of SIT, the notion of social order is considered to alter depending on the intergroup, and intragroup that an individual is in at any given time. Therefore, context is a significant contributor to social identities. From this perspective, group stereotypes reflect situated forms of social organisation being able to shift from situation to situation “as a function of the varying forms of social organisation”(Haslam, et al., 2012, p. 207). The findings about social identity are discussed in relation to three categories, *social identity salience*, *nested identities*, and *cross cutting identities*. 
Social Identity Salience

Social identity salience is central to SIT, and it is considered that “organisational identifications is context dependent” (Haslam, 2003, p. 36), and therefore salience differs depending on the organisational group. The presumption for SIT is that salience increases social identity (Hogg & Abrams, 2001, p. 256). Nurses in hospitals work closely together for periods of eight or more hours. The nature of their work requires them to form social groups for these periods of time. These groups change or vary each shift so there is never a completely stable work group. There are different members coming in, and out of these work groups depending on their differing shift allocations. The multidisciplinary team frequently has quite a stable membership, and routine hours of work (Monday-Friday 8am-4.30pm). However, the multidisciplinary group only spends minimal amounts of time together as a group. The context of an acute hospital means that work is physically and mentally demanding for both nurses, and the multidisciplinary groups.

Overwhelmingly the findings are consistent with the nurses’ salient identities being closely aligned to the nursing group. This identity prevails as salient regardless of the groups they move in, and out of during their working context.

Insights from Interviews: Nurse Handover

Many examples of the importance of the nursing group emerge from the interviews, and that the individual nurses align strongly with their nurse group. There are also examples of negative communications focusing on individuals not considered in the group, this reinforces the salience of the in-group (Haslam, 2003, p. 89). As has been discussed in the group performance section, the communications that occur between the in-group of the nurses in the handover enables planned coordinated action (Haslam, 2003, p. 92) for the oncoming shift.

There is much evidence Social Identity salience. The themes arising from the interviews reflect what is important to the group, and are evident of concepts found in SIT.

As already identified in the group performance section the concept of team is essential in the establishment of group norms. This theme of team underlies the commitment of the salient identity of nursing whilst the nurses are working within the acute case context. This use of team assists in mobilising effective strategies to manage all aspects of professional practice during a shift as a nursing group. The salience of the nurses’ identity to the team is outlined in the quotes below.
You feel you’re being supported, and you feel that you understand that if you need something you can go forward, and approach someone, and feel a bit comfortable, rather than just being isolated. [GI2V4]

Well it’s a common goal of taking care of your patients, and you know, by the same token, keeping the powers that be happy as well – getting people out so you can get people in, and it just makes it work a whole lot better – it works. [II2]

They’re like the wheels on the bike, like I mean, you know I see it like having them around – two people, the kind of “go to” people in a circular motion that it’s one fluid team, and they all work together to create a fluid ward, and without one person being a team player, then the circle’s just not going to roll, and it’s not going to work. So that’s how I see the ward being – one big team where all the players work together. [II2]

A theme that emerged from the data, demonstrates some tensions between senior, and junior nurses. These tensions result from what is perceived by the senior or more experienced nurses as a lack of commitment to the nursing team, and therefore a threat to the group efficacy in group performance. This also has implications to identity salience as the junior nurses in their lack of identification with the nursing group are perceived to be not as strongly aligned to the nursing group.

These tensions between senior, and junior nurses appear particularly interesting as the two junior nurses identified in this project are not displaying expected behaviours. Their lack of conformity to salient behaviours raises questions around their in-group dependability. One particular junior nurse in the interviews discusses that her membership to the Unit, and to nursing overall is not something she values as much since commencing clinical practice.

*How dare you ask me that?, and I said well I have every right … well this patient’s in my care, and I’m the patient’s nurse, and my role is to advocate for this patient, and half the patients don’t know what’s going on, and I want to be able to explain to them why they’re having this medication or why they’re having this test, but sometimes medical staff, and senior management are a bit resistant to giving us any information, and that knowledge. I find there’s a wall sometimes.* [IIJN]
I have very firm beliefs, and values, and how I go about things, and how I’ve been taught, and trained, and I will continue to do that, and the more, and more people I guess the voice of the people that are trained in the way I have hopefully, I really hope it will change. [IIJN]

This nurse is having trouble identifying with the group, and this is recognised by other group members, she is the junior, and all others in the group are considered more senior, and/or more experienced.

...the do’s, and dont’s sometimes they don’t have that – they just keep going without even thinking, and I don’t like working with people like that. [IISN1]

but not to argue with somebody who’s... like with somebody who knows more.... Senior in a way that they are higher in years, but lesser in knowledge. [IISN1]

For this junior nurse her behaviours are not representative of the intragroup salient behaviours, and are interpreted negatively by the other staff who identify strongly with existing social identities (Haslam, 2003, p. 92). This supports the premise that salience then becomes about self-definition, and current context (Hogg & Abrams, 2001, p. 255). This is demonstrated in the observations of the video from the fieldnotes.

I am drawn to the person giving the handover, and this is because she is obviously the leader, and so does most of the talking. I am also drawn to the most junior nurse who seems to be actively attempting to engage, and she appears to be actively engaging in this activity but the ANUM although politely responding does not return this engagement I suspect there is no expectation that she talks during this activity. [Video 2: Nurse-to-nurse handover Unit A. Fieldnotes (behaviour)]

Experience is a theme that emerges frequently in the interviews. Experience is identified as particularly important in the group but recognition of experience must be earned, and then identified by the senior staff before it can be legitimised by the group. The in-group show that they very much value the notion of experience and this is considered an important salient behaviour that strengthens the in group. There are many differing characteristics that made up the notion of experience. The participants offer insights into the many different characteristics
that make up the notion of experience in nursing. The quotes below identify these characteristics.

People that showed leadership, reliability, accountability is a big one for me... someone who will follow through, and someone who I have the confidence that I can also learn from them, and will treat me as an equal. [IIJN]

Talking about what experience is: more likely to sort of take on more of a holistic approach to the patient care rather than just sort of task orientated. You know, if they sort of look at the big picture, and when they’re sort of organising their care. [II1]

I think you can’t get flustered as a nurse because otherwise you’re going to be useless because you need to do ten things at once, and you need to help four people at the same time. [II2]

...confidence to be able to know that you’re in control of yourself, and you can still make decisions even if it’s busy, and stressful, and overwhelming at times. [II2]

I think a senior nurse is someone who has a bit of knowledge, and experience, and I guess a certain personality type that makes a good senior nurse who can be a “go to” person, and can prioritise, and can make judgement calls in hard situations, so I guess people who have all those attributes I would classify as senior, but by the same token there are junior nurses that I think are more senior than people that have more experience than them because they have those qualities. [II2]

Applying their knowledge would mean that they know what they’re doing, and they don’t just do because doctors are telling them to do these thing. [IISN1]

The presiding hierarchy of the nursing handover is identified in group efficacy; it has implications also to salient identities. This theme that emerged from the interview data serves to strengthen the embedding of the salient identity of nursing by ensuring conformity. In analysis the quotes from the theme around hierarchy of shift, the hierarchy of the handover
activity reinforces social validity, and social structure, creation, and maintenance (Haslam, 2003, p. 92).

...and it’s become the ANUM chair. I actually prefer not to sit there; I prefer to sit somewhere else. (this nurse was an ANUM). [GI2V1]

I’ve done my part, and handed to my nurse in charge, and I’ll expect her to take the next stage of follow up, but I also like to know, and like to be kept in the loop of what’s going on because ultimately it’s still my responsibility. [IIJN]

...but when you’re in charge after worrying that there are four other nurses or six other nurses doing their job well, and make sure that I keep my seniors informed, and think a bit more broader I guess in terms of strategic plans, and patient flow, and budgets – it’s a slightly different focus, but at the end of the day, I’m happy if I go home, and I know that all of the patients are well, and safe. [II2]

In this theme, the responsibility of the patient lay with the nurse in charge of the shift, reinforcing the salience of experience through the conformity to the nursing hierarchy is considered a necessary assert for each group on each shift.

The subjective importance, and situational relevance (Hogg & Terry, 2001, p. 32) of handover renders it salient as an intragroup activity in both the nurse handovers studied. The communications, and behaviours that are developed, and enacted during this professional activity ensure it is a salient significant activity that is valued by the nursing group. The quotes below demonstrate how important this activity is perceived to be to the nursing group.

Handover’s a good debriefing time, particularly if you get to a patient who’s been difficult or I don’t know, their family’s been painful or causing problems. [GI1V1]

Talking about the process of handover: it’s just a forum where we can do that in a confidential, private way, you know, that’s sort of what handover is to us. It’s a team building exercise each day that we have from early to late shift. [II1]

We kind of thrash things out.... making sure that we’re all on the same page to begin with so we know exactly where they’re at. [MDII1]
Yeah, and over time there are lots of different behaviours like some people can be very intimidating during handover. [GI1V1]

About who talks in handover: I think the more senior you are perhaps the more aware you are of what questions to ask, while if you’re a bit more junior you kind of sit there more blankly not too sure so you just keep quiet. [GI1V1]

Handover is seen as a forum to debrief to develop a community amongst the nurses. It is seen to provide a private forum for nurses to interact as a homogenous group.

There was big consensus that this was the only time that we get together as a group, and we didn’t want to get rid of that because we felt that although whatever I say in here can get told at the bedside, it was more about us – it was the only time that we get together as a group where we can debrief, and talk, and that’s the main reason why we kept it. [GI2V2]

You need that outlet because you can’t have that constant stress, stress, stress... high level pace constantly – you need to be able to step back, and I guess have a good laugh get it out of our system, and get back into it. [GI2V3]

...and knowing that it’s contained within this room which it wasn’t on that day because there were cameras there, we were on our best behaviour [laugh]. [GI2V1]

...and identifying problems I suppose that are current, as a heads up for the next shift. I think for us it’s debrief, like it’s the only time we get together as a team, and can talk, and it’s all confidential, and we can say how we feel, and you never get judged for what you say in here in our particular room, and I think that’s a big element here. [GI2V2]

The handover activity is a complicated process, so much so there are two distinct, but overlapping, themes one focussing on specific behaviours in handover, and the other on the ways of communication in handover. It is also of significance that the analysis of the handover activity from the researcher’s observations uncovered a very concrete inflexible delivery, and structure to this activity. However, when asked about the presence of a structure, the nurses interviewed did not see a structure in this activity as identified from this quote.
...we just do it in the numerical because it’s the easiest kind to follow because that’s how we do our handover sheets so that’s our structure I think. [G21V1]

A conjecture to this might be the lack of recognition of the structure of this activity may render it invisible to those who align closely to the intragroup.

**Insights from Interviews: MDM**

The MDM does not demonstrate the same social identity salience. There are examples of individual salient behaviours an example of quotes that illustrate this are offered below.

*Discussing resolving differences between disciplines: It’s never something that’s really spoken about but usually just standing your ground – well we spend a lot more time with the patients, and we probably have a better understanding of the medical issues going on with that patient, and usually the other person tends to accept that, and accept that they’re more of a consultative service rather than a full-time hands-on service.* [MDII2]

*I think there is a difference in personality that the other disciplines ... they think that their role’s a lot more valuable than say a nursing role, some of them, and that reflected in the way that they talk to nursing staff often... there’d be no banter in that handover.* [MDII2]

*Nursing purpose of their presence in the meeting: To add a nursing perspective, and I think very much to add a patient perspective.* [MDII1]

From the analysis of the interviews there is particular allegiance of the MDM members to a group identity. Therefore it is assumed by the nurses that this group do not have a strong social identity.

**Insights from Researcher Participant Observations, and Fieldnotes**

The observations of videos afford interesting insights into the commitment the nurses appear to have to the nursing group, and more specifically to the structure of the handover. The MDM appears as a much less formal entity, and a much more social entity. The participants of the MDM are friendly, and collegial but do not expect to appropriate organisational citizenship behaviour as salient identity.
Insights from Researcher Participant Observations, and Fieldnotes: Nurse Group Handover

The salient identity of the nurse handover in both the units videoed focuses on affirming the social structure, and function of the nurse team for the given shift. The communications that occur in both these meetings incorporate clinical information. Handover meetings of this form have traditionally been identified as the arena or activity where the nurse hands clinical information, and needs, requirements for the patients for the staff in the oncoming shift. However, the salient communications in these handover meetings focus on the storytelling of the experiences that the nursing group of the outgoing shift have gone through. The focus is not simply the handover of clinical information but rather the preparation of what to expect of each of the patients, and some advice on how to manage these challenges. The communications also involve much humour, and anecdotal advice for handling certain situations. Although humour, and storytelling occurs in the MDM, the focus is not on preparation of the group but rather dissemination of information in an interesting, and engaging way.

If you dare suggest she didn’t weight bear, watch out. [Video 2: Nurse-to-nurse handover Unit A minute 5. Discussion then reflecting on the patient from a previous shift, there is laughter, and confirmation from members in the team.]

Comments are made during the handover about how the patient likes to be spoken to or what name they would like to be called [Video 2: Nurse-to-nurse handover Unit A minute 6.18].

Comments are made if patients are nice or unusual, difficult, if they have good or bad days, social challenges, and then there is limited discussion usually between the ANUM giving the handover, and one or two of the senior staff on how to manage if a difficult situation arises. The more junior members of the group tend to be quite, and obediently listen to this advice.

...and I think if you can talk about a patient’s quirks... personality quirks or what worked for a patient in handover freely without fear of I shouldn’t say that, that’s judging the patient, it does make your shift easier because you could get the heads up... often you’ll use that information to get the best outcome for your patient. [GI2V2]

There is also conformity to the structure of the handover, and a clear acceptance to conform during this activity; this is clearly demonstrated from the fieldnotes.

This room is quite centrally located in the ward/unit but remains quiet when the door is closed, during the meetings. The informality of this room is
reinforced at the beginning of the handover when someone outside the handover enters the room. This does not stop the handover just temporarily stalls the process. This person was later identified as a support staff member from the unit, it was considered quite reasonable for her to enter the room during this activity. She did not participate just retrieved something, and left, and later re-entered took something else, and left again without interacting with the handover team. Overall this remains a quiet area where the nursing staff appear quite relaxed. They are writing notes on the patients on to their handover sheets throughout the handover, there are no patient notes referred to in this meeting just their handover sheets. These sheets are brief lists of the patient with minimal information, each nurse then notes down specific activities that will need to be undertaken or followed up for the patient during the oncoming shift. [Video 2: Nurse-to-nurse handover Unit A. Fieldnotes (structures)]

The salient communication style of the handover is that of storytelling. The focus is not simply the handover of clinical information, but rather the preparation of what to expect of each of the patients, and some advice on how to manage these challenges. The communications also involves much humour, and anecdotal advice for handling certain situations.

*The nurses engage in humour, and laugh about difficult or uncertain situations throughout the handover. In this handover everyone was sitting with the nurse (ANUM) giving the handover sitting at the head of the table. The ANUM does most of the talking; there is not a lot of interaction just a few questions. However these questions are asked predominantly by the nurse who will be in charge of the oncoming shift, and the second senior nurse. The other two nurses are quite obviously quiet, and only make comment on a very few occasions at the beginning of the handover. One of the junior nurses then begins to actively engage, without a lot of feedback from the ANUM. Although this appears to be congenial, later in the interviews some tensions are revealed. [Video 2: Nurse-to-nurse handover Unit A. Fieldnotes (behaviour)]*

*There is much humour used in this ward, and the staff are very friendly, appear quite extraverted, and relaxed about being videoed. They make comment that they must use professional language, and will have to tone*
down some of their conversations they have in the handover meeting.

[Video 4: Nurse-to-nurse handover Unit B. Fieldnotes (structure)]

This video is clearly the most informal, everyone is sitting, and there is a clear structure to the sitting arrangements with the nurse giving handover sitting in the same place as she did for the multidisciplinary meeting. There is a lot of friendly banter throughout the handover, and although the conversation is very much monopolised by the nurse giving handover, for me it is clear who the in charge nurse will be for the oncoming shift due to her confidence in process, and information when she speaks. There is also quite a lot of input from a number of the other nurses, and there is clearly lack of input by certain other nurses who I know are the less junior nurses.

[Video 4: Nurse-to-nurse handover Unit B. Fieldnotes (behaviour)]

There is intensity in the social interactions; the stories demonstrate the complexities of managing the patients. Also there are discussions about interactions, and issues with other members of the healthcare team or patient relatives but there is also a lot of humour. The complexity of the work is managed through the frequently funny interesting bits about patients are shared, and the intensity of the previous shift is diffused by telling these stories of the shift with lots of humour. The description of the woman, who has come from another state to be looked after by family, had a fall, and is now in the unit. This patient’s complicated social situation is discussed, and suggestions, and strategies to manage not only the patient but also the main carer are considered. [Video 4: Nurse-to-nurse handover Unit B. Fieldnotes (behaviour)]

The salience of identity to the nursing group, and the salience of certain communication characteristics are observed, and obvious throughout the nursing group handover videos. There is a tempering of the clinical communication aspects to handover with salience attributed to other forms of communication particularly storytelling, and humour. This is attributed particular significance in Chapter 6.

**Insights from Researcher Participant Observations, and Fieldnotes: MDM**

The performance of this group activity is rich with salient group behaviours. If this recording had been repeated in the same unit, comparisons would have been enormously valuable.
However, with the data that has been collected there remains rich detail in the salient behaviours that are similar, and different in between the two MDMs.

This activity is highly coordinated, orderly group interaction. The salience of compliance to social norms of equality of interactions, and politeness in listening, and responding is demonstrated across both the multidisciplinary team meeting videos. The communication styles that are salient show a collegiality, friendliness, and politeness amongst group members. Each person listens to what the other person contributes, and there is a lot of affirmation through non-verbal, and verbal cues for example. head nodding "hmm, I agree". Sitting in a circle or semi-circle, at either a table or in the small room in chairs, contributes to the focus each group member appears to award this activity.

*I would have said that this meeting was socially intense but not in a formal way. More in the commitment to the patient, this is demonstrated by each of the members of the meeting, and their discussions, the way they all contribute to the information of the patient quite freely until a consensus around the next stage of management, and then the nurse initiates moving to the next patient.

In each of the discussions each member appears very focused on their information, and this is recorded by the nurse before the plan of action is agreed upon. If one member does not think their perspective is adequately represented then they seem quite comfortable to speak up. There seems to be a shared equalness in the communication pathways. [Video 1: Multidisciplinary meeting Unit A Fieldnotes (behaviour)]

The expressions seemed intense but the words were diffuse, there was a lot of storytelling techniques in this meeting however the allied health staff were not as interactive as in the previous ward, and I wonder if this is because of the way the room is set up. Does it take away from the friendlier approachable atmosphere all sitting around a table having a chat? The information given around the patients is similar to Unit A but the conversations are not as equally distributed. The nurse seemed to deliver most of the information, and the allied health staff seem to receive this more passively. The shared, and equally distributed conversations are not as defined in this meeting. [Video 3: Multidisciplinary meeting Unit B Fieldnotes (behaviour)].
Social Identity has both a cognitive, and motivational basis to intragroup, and intergroup behaviours (Haslam, 2004, p. 21). The multidisciplinary motivations as mentioned above appear to ensure salient behaviours promote organisational citizenship behaviours. However, where this differs from the group handover is the subtle organisations of goals for the oncoming group to work together are not clearly demonstrated in MDM. Each person from these two videos identifies personal or discipline specific plans for the patients. Therefore, the salient behaviours do not appear to promote group efficacy.

This ethnography has provided some important insights into the social identity salience of the nursing group handover; in contrast social identity within the MDM was not significantly demonstrated. Rather, the salience of the individuals is evident. The nursing group handover as an activity is important to the groups salience. As an activity it has specific behaviours that contribute to the further development of the nursing group, and it’s salient identity within the particular case context within which this study is undertaken.

**Nested Identities**

Nested Identities are formal organisational specific group identities. These can be higher order nested identities such as being a nurse or lower order nested identities: I am a nurse in this particular hospital on this particular ward on this specific shift. The data collected identifies that structurally the social identities of both the handover group, and the multidisciplinary group are different. The significance of the nested identity is that lower order nested identities are seen to reinforce social identity salience. The lower order nested social identities are seen as one’s primary group they are perceived as concrete with commonality between members (Hogg & Terry, 2001, p. 35). In this section the interview data, and the researcher observations are combined.

The nested identity of the nursing group can be attributed to a lower order group. The nursing clinical unit is a primary working group, and members are known to each other. The case context was a particularly concrete nested group, and therefore certain attributes are obvious in the analysis of the findings. The first is that nested identities can be either inclusive or exclusive. In the case of the nursing group handover the nested group is particularly exclusive; this is in keeping with a lower order nested group.

The clinical units are part of the bigger hospital, and therefore have elements of inclusiveness. However, they show strong characteristics of an exclusive group. The languages they use to describe themselves very much around being a tightly knit social group demonstrate their exclusiveness.
...but I’d stay for my colleagues, I love my colleagues. We all get along. For me I couldn’t work where I couldn’t have a laugh, where I couldn’t joke, I couldn’t do it, and I think from my standpoint that’s one of the main things, we like working together, and we have fun. [GI1V2]

...and it’s a physically, and mentally exhausting job being a nurse, you know, and if you go into that, and you’re alone, and you just come, and you do your work, and you go home, that can drag you down pretty quickly. I wouldn’t imagine you’d want to stay in your job very long, so if you go into that job that does physically, and mentally exhaust you but you know Jane’s just as tired as me, and Mary’s done as many shifts as me, and that patient hit Julie just like she hit me, you know, like it does make you feel like you’re doing it together, and you’re not doing it by yourself. It’s not your shift just with your four patients, and you can rely upon them, I can go Joanne can I have a hand, and unless she’s stuck somewhere she’ll always say of course. [GI1V2]

In contrast the MDM did not demonstrate the same inclusive characteristics. The multidisciplinary group is more inclusive at the same time there is not the emphasis on being unified team.

...everyone you speak to has got a different idea, and that was the idea of starting these meetings so that we could all… knew where we were at, and where we were headed so that everyone wasn’t off doing their own thing, and potentially heading maybe in different directions with people. [MDII1]

I think there is a difference in personality that the other disciplines … they think that their role’s a lot more valuable than say a nursing role, some of them, and that is reflected in the way that they talk to nursing staff often… there’d be no banter in that handover. [MDII2]

A further characteristic of a nest identity is the concrete identity of the group. The higher the nested identity order, the more abstract the social identity is. The notion of profession is more abstract but the notion of a specific unit, even a specific shift is very concrete in group identity. The behaviours, and discussions from the data analysis identify very concrete structures, and functions within the handover activity. As demonstrated by the rigid communication interactions. Conformity in these interactions is insisted upon in the handover but this is not so
in the MDM. An example of this is criticism the junior nurse attracts when she chooses to speak out in the handover given this interaction is not considered normative behaviour for a junior member of the group. These communication interactions are not so concrete in the multidisciplinary group where even junior student physios engage in conversations in this meeting.

The third attribute of nested identities is that of proximity or distance. This is showcased when the proximal nested group of the clinical unit decide to go against the organisational directive to disband the nursing group handover. Because of the distance of the organisational management, and the inability to influence the group efficacy of the proximal nursing group on Unit B the nursing group handover is continued. Organisational management although acknowledged as a nested identity is seen as too distal understand the significance of the handover. The clinical unit represents a proximal lower order social category, and is the primary group for these nurses, and therefore their behaviours are determined at this level (Hogg & Terry, 2001, p. 35).

People were saying what’s the importance of having handover here, and we actually talked about not having it because we get a bedside handover anyway, and there was big consensus that this was the only time that we get together as a group, and we didn’t want to get rid of that. [GI2V2]

...there was big consensus that this was the only time that we get together as a group, and we didn’t want to get rid of that because we felt that although whatever I say in here can get told at the bedside, it was more about us – it was the only time that we get together as a group where we can debrief, and talk, and that’s the main reason why we kept it. [GI2V2]

The clinical units are exclusive lower ordered nested groups with concrete criteria restricting membership to certain individuals. It is at the unit level that the organisation’s goals (decreasing handover time) must be enacted. As is commonly identified the nurses are at the coalface when it comes to patient care, and practices. This then translates to the proximal nature of the lower order group, in this case the nurses who deliver the core business of the organisation being patient care. Due to homogeneity of lower order groups they are also identified as more salient. The nurses within each of the units are representative of lower order identities, and examples to support this are their use of language, particularly identifying themselves as the nurse collective “we”.

...well we spend a lot more time with the patients, and we probably have a better understanding. [MDII2]
I think there is a difference in personality that the other disciplines... they think that their role’s a lot more valuable than say a nursing role, some of them, and that is reflected in the way that they talk to nursing staff often... there’d be no banter in that handover. [MDII2]

...but I’d stay for my colleagues, I love my colleagues. We all get along. For me I couldn’t work where I couldn’t have a laugh, where I couldn’t joke, I couldn’t do it, and I think from my standpoint that’s one of the main things, we like working together, and we have fun. [GI2V2]

The language used amongst the nurses within the handover activity is often emotive, and sometimes quite personal. This creates the impression that this group of nurses is bound together through experiences that they share only within their group. Their experiences are inclusive only of those within the group. There are also examples of exclusive behaviours towards those individuals who did not demonstrate appropriate intragroup behaviours. This is expressed during the interview during the viewing of the multidisciplinary team meeting video recording, and the use of an “us, and them” attitude. There is not the homogeneity that is exhibited in the nurse-to-nurse handover.

It’s a good environment to swap things that, because some things that I know can be quite different to what the OTs found out when they’ve spoken to their partner or their place of residence or whatever, so often it can be a way of straightening out the facts that we know about people. Sorting out the chinese whispers. [MDII1]

The expectations of the MDM are more abstract. Concrete expectations of work between the allied health workers are not identified, rather it is up to each individual allied health worker to set their own expectations, and work practices that may not necessarily involve consultation with other multidisciplinary team members.

The development of a homogenous work environment, and the forming of the shift group are very much identified as happening in the nurse-to-nurse handover as seen below the organisational directive is to reduce this time as it is seen as inefficient.

It’s taken away from that group dynamic that we had every day, like we still have it to some extent, but it has reduced because of time constraints, yeah, so ... you know we don’t have the half hour that we used to have,
although sometimes we do get it because you know we’re a bit cheeky, and we do have our chats, and so forth. [GI2V1]

At the ward level or lower order group level handover is seen as a very significant activity that meets all the criteria of lower order groups. The professional activity of the nursing handover is a group that is proximal, concrete, and exclusive, meeting all the characteristics of a nested identity. In contrast the MDM although proximal is not exclusive or concrete in its identity.

**Cross Cutting Identities**

The concept of cross cutting identities relate to more informal social groups. These are not so prevalent to this study. The results reflect much more evidence in relation to the concept of nested identities. However there is evidence to suggest that the MDM met some of the criteria of a cross cutting group. Each of the nurses who is involved in the MDM identify closely with this group in a proximal, concrete, and exclusive way but what made their identity with this group different is that their membership fluctuates. They are only part of the MDM for a short period of time, and whilst they are partaking in the MDM they remain closely bound to their nursing identity. This reinforces the characteristic of the MDM as a membership group that fluctuates, and is transient, therefore fitting the criteria of a cross cutting group.

> Well I think it’s important – for me it makes the day flow. It’s good to start the day when everybody knows what’s expected of them, and what has to be achieved today, and you can delegate tasks or they can delegate tasks back to me. [MDII2]

> Yeah I think it’s good. We kind of thrash things out, like I’ll often run through the list, and say this person, this is what we’re doing, and then someone else might say, well I thought this was what was happening, and I think part of it is straightening out what that interaction is just making sure that we’re all on the same page to begin with so we know exactly where they’re at. [MDII1]

However their participation is always as a nurse, and they saw themselves as representing the nurses’ perspective.

> ...well we spend a lot more time with the patients, and we probably have a better understanding of the medical issues going on with that patient, and usually the other person tends to accept that, and accept that they’re more of a consultative service rather than a full-time hands-on service. [MDII2]
To add a nursing perspective, and I think very much to add a patient perspective. [MDI1]

Many insights into the social identities of the nursing group as they are constructed, and sustained by the nursing group handover, and the MDM have been presented. The social identity salience is demonstrated by the nurses’ commitment to the nursing group even when participating in the MDM. The identification of the nursing group as a well formed nested group is demonstrated in the use of language that reinforces the exclusiveness of the nursing group. This is contrasted by the MDM where salient identities are based on individuals, and not groups. This demonstrates the inclusiveness of the MDM, and the cross cutting characteristics of this group.

**Self-Categorisation**

The ethnographic results from this study have revealed much about the construction of nurses’ professional identities. The findings in relation to the SIT concepts of group performance, and social identities have been presented in the previous two sections. The findings in relation to the third, and final concept of self-categorisation are presented in this section of the Chapter.

Self-Categorisation was developed from the SIT work by Turner and Hogg (1987). There are three key insights of self-categorisation. The first is that group activity occurs because of social identity, and this is a cognitive mechanism. The second is that the self-system of the categorisation process is context sensitive, people either see themselves as “sharing category membership with others or not” (Haslam, et al., 2012, p. 206). The last insight is that mutual social influence is based on shared social identity.

The results demonstrate the significance of the cognitive construction of self, particularly to the salient nursing group. The cognitive development of salient in-group membership is of interest in developing insights into the professional identities of nurses. Examples of this will be considered by stimuli at an inclusive level, these promote assimilation of self into the prototype (Hogg & Terry, 2000).

**Insights from Interviews**

This section of the ethnography draws upon the previous analysis, and further extending the findings to recognise the cognitive processes that occur in SIT to develop a specific professional nurse prototype. The senior/experienced nurses are recognised as the aspired prototype. They then reinforce the prototype, question it, when it is threatened, and promote the attributes that reinforce the prototype. This is demonstrated in the themes arising from the interviews. From
the interviews there are suggestions that certain attributes make co-workers suitable to work with within the intragroup. The below quotes outline these specific attributes reinforcing the attributes of the espoused prototype.

...next I would go to Jane because we get along very well personality wise as well, and we work very well together. [II2]

We just work very well together as a team, and I trust her. [II2]

...so you know if you work with someone say like Jane, you know that you can actually go, hey can I have a hand to roll this patient or can I give you a hand with this? Let’s go, and do this together, and you just generally – there’s a fluidity about the way you work. [II2]

The attributes here that are seen as positive are willingness to help each other, having a personality that is seen as positive, and being able to trust the co-worker to help. Cooperation is an important attribute. There is a concept of the “go to” person or resource person II2, and the use of the term “fluid team” II2

One big team where all the players work together. [II2]

Helping, and relying...to achieve your goal. [II2]

This goal is then identified as taking care of patients... keeping the powers that be happy. [II2]

Attributes of the prototype include team members being responsive, and willing to assist other team members, trusted to seek their opinion, willing to be available to debrief. Part of the normative fit appears to include the ability to “be there for the team” [II2].

Another attribute is the ability to communicate issues, and ask questions.

I like that behaviour of question asking because at least then I know where they’re at, you know, as opposed to them going off doing it, and making a mistake. [II1]

The attributes of the prototype appear to very much rely on behaviours that bind the staff together as a close social unit for the eight hours of a shift. The team is seen as being successful if there is fluidity to the work.
Three of the nurses interviewed individually categorise themselves very normatively with the nursing clinical unit. The one nurse who did not align closely with the unit group is the junior nurse.

When you’re new, you always feel that you have to prove yourself, and you need to show that you’re competent, and that you can manage, but I guess you need to be realistic, and say there are times that I’m just not. [IIJN]

...and I’ve found since coming into the real world of nursing, and questioning the “why” factor like a young child – why this? why that? some people felt threatened I think, and they were very different in their approach, and their answer would be because that’s just the way we do it. [IIJN]

There is a contradiction in that the nurses who categorise themselves closely with the normative fit of the nurse unit espouse their want for questioning as a positive attribute, and yet the experience of the junior nurse is that questioning is not welcomed. It would appear there is a much more complicated process to understand the actual normative fit.

**Insights from Researcher Participant Observations, and Fieldnotes**

The focus here is the observations of the development of the nursing prototype. This is observed most profoundly in the nursing group handovers. The concept of context is particularly important within self-categorisation (Haslam, et al., 2012, p. 206). However, what is emerging from the results is the importance of the professional context as a structural, and behavioural context. Given the professional context, and construct of the two activities video recorded there appears to be a developing prototype for each of these groups that had similarities between the two regardless of their different clinical unit contexts. The SIT concepts identify that “context in which they find themselves is defined along group-based lines” (Haslam, 2004, p. 23), however the results indicate that there may be an influence at the higher order identity that has an impact on self-categorisation.

The professional context where the group activities occurs determined the type of interactions, and reinforced the prototype relevant for this activity to occur (see Figure 8: The Handover Space in Unit B). However, the specific space also contributes to the interactions. Self-categorisation is influenced by the professional context but would also be attributed to the structural context.
The results in this section focus on the structural space where the activities occur, and their influence on the self-categorisation of the individual to the group. The two activities video recorded in Unit A are in the same room, and the two activities in Unit B are in the same room. Therefore there is a consistency in the space used for the two varying activities.

Some of the key aspects to the contextual spaces include that they are private, and away from patients, relatives, and other team members. In Unit B a key is needed to open the door during the handover activity. There is a homely aspect to both the spaces, sitting, and talking is the main activity undertaken in these spaces. Both the spaces are small which reinforce the closeness, and therefore the opportunities to interact in conversations. Both the spaces are seen as the nurses’ domains, and therefore the allied health staff are invited in.

_The meeting occurred in the nurses’ tea room. The space was quite small, and although there was room as the team was small what struck me was that this was a room designed for storing food for both patients, and staff, with a table that was really set up as dining table. There was no formality to the surrounds that you might expect for a unit meeting Video 1:. Multidisciplinary meeting. [Unit A & Video 2: Nurse-to-nurse handover Unit A fieldnotes (structure)]_

These spaces are not formal meeting rooms, and they are used for informal gatherings as well as these two professional activities. These spaces are nurses’ spaces.

_This part of the ward is a hub of informal activity where nurses, and other staff congregate frequently for informal conversations. What is seen is a small space that conjures up feelings of safety, and inclusion. This is different to other areas of the ward where there is a feeling of business, and often high levels of stress.[Video 1: Multidisciplinary meeting Unit A & Video 2: Nurse-to-nurse handover Unit A fieldnotes (structure)]_

_The qualities of this setting seemed to be the informalness, it was a bit like sitting in a kitchen, particularly once the meeting had commenced. It was not particularly tidy almost a dishevelled little room. This is generally considered a private space away from the normal work environment, where patients, and family are do not normally enter. [Video 1: Multidisciplinary meeting Unit A & Video 2: Nurse-to-nurse handover Unit A fieldnotes (structure)]_
This room is used as an important informal social space. Staff congregate at their meal breaks in this space, meetings such as handover, and the multidisciplinary meeting happen here. Nursing staff use the space for informal conversations. Speaking with patients, and relatives does not occur in this room. Food for patients is sometimes stored in the fridge but it is unusual for patients to access this room. [Video 1: Multidisciplinary meeting Unit A & Video 2: Nurse-to-nurse handover Unit A fieldnotes (structure)]

The pictures of the spaces reinforce the informality. In relation to the cognitive perspective of self-categorisation the reinforcement of the nursing identity as salient is profound given the identity of these spaces are entirely the nurses. The concept that contexts play an important part in self-categorisation is identified in these quotes, and pictures.

Figure 9: Unit A MDM

This space is quite different from the previous ward. The multidisciplinary meeting is held in the room that is used by the nurses as a tea room. However it’s set up is very different from Unit A. This is an oddly shaped room with insufficient space for a table (see picture). Instead there are chairs scattered around the edge of the almost triangle shaped room. There are lockers squashed on one wall two coffee tables in the middle of the room strewn with old magazines, and an old patient locker to one side that is used as an extra side table. People have to keep excusing themselves to pass others to reach the empty seats in order to sit. The nurse leading the
meeting positions herself near the door, and is quite distant from the allied health staff who sit towards the other end of the room. [Video 3: multidisciplinary meeting Unit B fieldnotes (structure)]

This room is situated in the corner of the ward, and is away from the noise of the ward. There is a window that looks out onto the street, overall it remains a nurse’s space that is not questioned, and the door is closed, and locked, and only the nurses have the pass code. This security is due to staff leaving valuables in this room, and its location in relation to the rest of the ward/unit. This however creates a very definite nurse ownership of this space as no one can enter unless allowed by a nurse from the current shift. Therefore outsiders would need to be invited in. [Video 3: multidisciplinary meeting Unit B fieldnotes (structure)]

The MDM members are invited into these spaces.

The room is a quite compromised space, and the qualities of this space are more crammed than on the previous ward, particularly as there are more staff on any given shift on this ward so more staff will need to access this room, and attend the meetings. The nature of locking the door allows for complete isolation during any activities that might occur in this room. This is very clearly a defined nursing space. There are lots of artefacts on the spare walls including notices, and information not all relating to the organisation. The lack of a large table makes this room look more like a living room than a kitchen. [Video 3: multidisciplinary meeting Unit B fieldnotes (structure)]

This space does not seem to include elements that are related. There is no sense of the warm homely kitchen of the other ward. There is no microwave or fridge no table to amiably have a conversation at. The elements here are mainly chairs with padding making them more comfortable to sit in. This room could be likened to a living room. Again there are lockers for nurses to store their valuables in. [Video 3: multidisciplinary meeting Unit B fieldnotes (structure)]

See Figure 6 Unit B MDM
Again the space where the video is filmed is the tea room, and the cramped slightly dishevelled room is the same as the space used in the multidisciplinary meeting. There are 10 nursing staff, and 2 nursing students in this handover. By far this is the biggest group videoed. The setting appears even more compromised with so many in this space. The staff do seem quite comfortable sitting in this space, their writing papers are either on their laps or resting on the coffee table or the patient bedside table. Again this space is locked when the door is shut, and the position of the person giving handover (ANUM) is close to the door so she is able to open it if there are any interruptions. [Video 4: Nurse-to-nurse handover Unit B fieldnotes (structure)]

These spaces have artefacts that belong to the nurses. The nurses undertake many of their informal daily activities that are away from the patients in this space.

The social aspects of this place are very similar to the previous ward. It is the informal gathering area for this unit used for eating meals in, storing valuables in lockers, and beginning, and ending the shift from this room. The use of this space clearly affects the social behaviour. This was spoken about before the video was commenced. The nurses very much feel the set up, and structure of this room allows for confidentiality, and comfort in conversation. Here the nurses of this ward identify they do not always use completely professional language away from the patients, and other staff. This space is very much owned by the nurses, and regarded as a safe place to off load some of the uncertainties that their work brings. [Video 4: Nurse-to-nurse handover Unit B fieldnotes (behaviours)]

The prototype is influenced by the social identities, and group performances of a given group, however this is context dependent. This section of the ethnography has given extensive examples of the context, and the emerging insights identify that the behaviours, and alignment to the social identity of the nurses to the nursing group is influenced by the context in which these professional activities are undertaken.
Having given consideration to the influence the context has on the development of self-categorisation, the other presiding influence on the acceptance of the prototype is the recognition of the senior or experienced nurse as espousing the prototype. Examples of this include the designated seat where the senior nurse presenting the handover assumes her position; the dominance of the interactions between the two senior nurses to reinforce their place in the group. Another example is when the senior nurse takes the lead role in the communications, and most questions are focused towards the other senior nurse who will take over, and run the following shift. There is a compliance of the remaining group to remain quiet unless they are seen as being well embedded in the group through length of time on the unit (this is referred to in the interviews around experience). Social discussion, storytelling, and humour are led by the senior nurses, and this is then a trigger for others to interact. There is an orderly way the meeting is concluded led by the nurse who will be in charge of the oncoming shift who reinforces the staff patient allocations, and affirms that the shift may now commence.

In comparison to the MDM there is not an obvious focus on group cohesion but rather group interaction. Although the nurse led the meetings in both the units, looks to the other members of the team in the MDM for information, and active participation. The perception of self in this meeting is not as obviously aligned with the need to be part of this group but rather to ensure their individual information about the patients is shared, and used to plan further patient management. Clear examples of this are in the way there is an equal distribution of communication interactions; in the types of communication where each person representing their own profession puts their perspective on patient needs forward. Further examples are the focus on the patient plan, and discharge rather than the focus on the oncoming group goals for the shift, and the dissemination of actions to individuals depending on their actual role.
Therefore, what is interesting in the results is not that the multidisciplinary group is not a group but the differing normative behaviour between the two groups identifies clearly that the nurse handover is a group activity of interplay between nurses that demonstrates a prototype that sets up potential nurses to nurse interactions for the next shift. This has potential to greatly influence the self-categorisation of each nurse member in this shift group. Given the purpose of this research is to examine the professional interplay of the nurse activity, and its potential influence on professional identity comparison between these two differing groups’ offers probable insights into the differing identities of these two groups.

Shared identities in the nursing activity reinforce their identity in the nursing group, and there is significance to this as they will need to work closely as a team to achieve the overall goals of patient care that must be met in the next eight hours. The prototype of teamwork, and fun is reinforced in the nurse handover. This is seen in the video as each person behaves as is expected of them in an orderly quiet way interacting, and laughing, and being involved in storytelling only when prompted by the nurse leading the handover. This theme of teamwork, and fun is identified in the literature (Morris Thompson, et al., 2011), and also throughout the interviews. There are also suggestions that the need to belong, and therefore behave, is also evident in the videos by the way the handover is built on forming the team for the oncoming shift. The need, and necessity of belongingness has been described in relation to nursing students in the literature (Levett-Jones & Lathlean, 2009a), and this has possible implications for self-categorisation, and normative behaviours of the nursing group as a whole. If what the senior nurses identify as important behaviours within the group are seen as the prototype for each of these units, then the behaviours that are demonstrated by each of the nurse groups reinforce these in the videos.

**Conclusion**

The ethnography has been undertaken in accordance with the methodological plan. The findings revealed significant aspects of nurses identity, and there construction, and maintenance within nurse group handover, and MDM. In this chapter the group performance, social identities, and self-categorisation are identified as concepts. The concepts are applied deductively, and confirmed inductively through the ethnographic processes.

The motivations of group performances for the handover focus on developing the group for the oncoming shift, whereas the MDM motivation is around promoting individual professional roles. Goals for the handover are around developing appropriate citizenship behaviours, normalising the complexity of nurse’s work, and appropriate allocation of patients. The goals for the MDM
are to ensure each professional group has a voice in the management of the patient. The norms for group performance in the handover include the internalisation of the formal structure of handover, the acceptance that nurses are available to all, at any time, and accept interruptions as normative practice when undertaking specific activities. The dissemination of non-clinical information is an accepted norm in both the MDM, and the handover, but this is much more extensively undertaken in the handover. The normative use of humour is present across both professional activities, and is very much valued by the nurses as a coping mechanism of their complex work environments. Group efficacy is reinforced through the nurses who are considered experienced or senior in the handover. Those who do not conform to the group performances are challenged, and potentially viewed as a threat. These are specifically the junior nurse who is considered too quiet, and the junior nurse who is considered too loud. The MDM did not overtly promote group efficacy, rather there seems to be reinforcement of individual efficacy.

The results on social identities demonstrate some interesting emerging themes. Within the concept of social identity salience within the nursing group these include concept of team; tensions between senior, and junior nurses, explanation of experience; hierarchy of the shift, communication in handover, and behaviours in handover. The clinical nursing group demonstrate all the characteristics of a nested group, and the handover process promotes the development of nested identities of those coming on to the shift, therefore creating a transient nested group. The MDM represents a cross cutting group, and the nurse presenting at the MDM promotes the salient nursing identity when functioning within this group.

Self-categorisation is a cognitive construct of individuals into their social groups. The nurses categorised themselves at all times when in their professional contexts as nurses. Their prototype is that of the experienced nurse, and this is reinforced by both the experienced or senior nurse, and others interviewed. Those who did not align as strongly with the nursing group are seen to not have the attributes of the espoused prototype.

In Chapter 6 implication of these results will be discussed.
Chapter 6: Discussion

The overall aim of this project was to investigate the construction Nurses’ Professional Identity, and the elements that constitute the performance of nurses’ professional identity within a specific work environment. It has been demonstrated that investigation into these aspects of nurses’ professional identity has not attracted much research attention. Nurses are the largest professional group in healthcare, and understanding how nurses’ professional identity is constructed, and sustained in the workplace will have implications across the healthcare sector. Organisational ethnography was used as the overarching methodology for the investigation, and SIT was used theoretically focus the research inquiry. In this chapter, connections will be made between the ethnographic results of this project, and existing theory, and research.

It is well-documented that nursing has long struggled with its identity (Fights, 2007; Gordon, 2005; Healy, 2004; Kalisch, 1982). Therefore, this study sought to understand professional identity for groups of ward nurses within a typical Australian acute healthcare setting. Overall, the investigation looked at the professional interactions of nurses with other nurses in the context of their work environment. The use of ethnographic methods was a contemporary addition to the usual quantitative research methods more commonly used in SIT studies. The purpose of an ethnographic design was to capture nurses undertaking activities within their normal environments without any research manipulation, and for them to then explain their experiences of nursing. The addition of the researcher’s fieldnotes allowed the researcher to exploit her position as an insider to the profession. These fieldnotes (see chapter 5) used a specific framework based on Madden (2010, p. 101), looking at the structural, and behavioural elements of the video data. The fieldnotes then became part of the video analysis, contributing to the capture of elements of the natural working context of nurses. These methods have, therefore, offered different, and potentially new opportunities for insights, and understandings of nursing professional practice, emphasising its importance as a social activity, and the contribution that this makes to professional identity. These nursing practices have not previously been studied through the lens of SIT, and this research, therefore, contributes a new, and different view of nurses’ professional identity.

There were two aspects to the analytic process. Using ethnographic principles the case situation was explored, and analysed inductively by drawing questions, theming data, and exploring social constructions. The data was also examined analytically in relation to SIT, and thematic analysis was undertaken to test classification, and categorisation of the data. These inductive, and deductive processes were used to inform each other. The to, and fro of analytical processes
were designed to surface aspects of how the nurses’ professional identity was working, and being constructed during the studied activities. In table 3 the analytic framework for the SIT component is identified.

The insights gained from this project were based on the experiences of nursing groups in two differing clinical environments. The data was purposively collected within their working environments, and specifically drew upon the professional interactions of nurses with other nurses, and other health care professionals.

The use of two very specific but differing nursing activities in two different clinical units (a surgical unit, and a medical unit) has resulted in a large amount of qualitative data. Each of the two clinical units undertook the activities of nursing group handover, and multidisciplinary team meeting (MDM). The two activities have comparable structures, and organisation, but with different individual players, and differing contexts. Parallels can be drawn between each of the clinical units in relation to the corresponding activities, and comparison of the different nursing groups undertaking the same two activities. This assists in recognition of the underlying culture of nursing that potentially prevails across this particular organisation, and potentially even more widely across the profession. This research does not endeavour to address this culture in a definitive or generalisable sense, but rather reports the recurrent patterns of interaction and activities as potential for further investigation.

The nursing group handover involved members of two nursing units, and consisted of at least two senior nurses, and at least one junior nurse. The MDM were led by the same senior nurse that ran the relevant handover meeting, and the makeup of each MDM included representation from the key unit health professional team excluding medicine (as discussed in chapter 5). The continuity of the same nurse leading the two meetings for the same clinical unit allowed for consistent comparisons between the two types of clinical unit meetings.

*What are the group dynamics within the ward that assist/impede the performance of professional identity within nursing work?* This main research question required investigation of the group dynamics among the professional staff working within a clinical unit during specific professional activities, and the identification of elements within the social contexts that appeared to assist or impede the performance of the nurse.

These key aspects of a nurse’s daily practice could then be connected to the construction, and performance of their professional identity. The remainder of this chapter will discuss the findings in detail, and relate them to appropriate current literature where it exists. The sequential order of this chapter will be based on the overall project aims. These aims will be
enacted through the main concepts of SIT. Firstly, the aim to investigate the professional interactions of nurses with nurses, and nurses with other health professionals (the multidisciplinary team meeting) will be discussed under the heading of Group Performances. The identification of elements that constitute performances of professional identity will then be discussed under the heading of Social Identities. The identification of elements that shape performance will be discussed under the heading of Self categorisation, with particular emphasis on the in-group influences. The chapter will conclude with the development of a theoretical framework constructed on the basis of the current research.

What has ensued from the results of this study has been that the professional activity of handover presented an opportunity for nurses to form their professional identity. This was in comparison to the multidisciplinary team meeting (MDM) which presented the nurses contributing to this meeting an opportunity to perform their professional identity. This differentiation between forming, and performing was an unexpected but interesting result, and is dealt with in detail in this chapter. However, in brief it would appear that the rigid structure of the handover appears to contribute significantly to the forming of professional identity in contrast with the lack of structure of the MDM appears to have no significant impact on forming professional identity of nurses. Instead the MDM presents an ideal opportunity for nurses to perform their professional identity.

**Group Performance**

SIT takes the viewpoint that an organisation depends on its employees to “engage in spontaneous acts of cooperation, helping, and innovation”, and not the simple enaction of a job description (Haslam, 2003, p. 30). These spontaneous acts were played out in the group performances during the two activities. There were distinct differences in the group motivations, goals, norms, and efficacy in the nursing group nurse handover, and the MDM.

Group motivation for the nursing group handover was led by the senior/experienced nurses to prepare the nurse collective for the oncoming shift. Two very clear social strategies to enable this were the development of a *group think*, and the use of humour to engage the team. The establishment of a shared knowledge base reaffirmed the nurses' group identity before commencement of the shift. The motivations for the MDM were significantly different centing around the opportunity of different professional groups to present their perspectives on patient care. Humour was also used as a motivating factor in the MDM, again a strategy to engage members, and provide a collegial atmosphere.
The group goals of the handover activity were to organise the team appropriately to manage the complexities of patient care for the oncoming shift. The goals for the MDM were to provide a forum for the multidisciplinary team members to be heard amongst their professional peers. Group norms of the activities were significantly influenced by the motivators, and goals of the two activities. The group norms of the handover activity were enacted by the experienced nurses within the handover meeting; they controlled, and shaped the normative behaviours. The group norms of the MDM were quite different. The focus here was not to set up the group for immediate professional activity, but rather the MDM was focused on appropriate citizenship behaviours that allowed the maintenance of individual professional perspectives.

As a final platform for group performance, discussion of group efficacy reinforced the significance of the handover meeting as an important activity in developing the collective to manage the work ahead. The intention of the organisational initiative to discontinue the group handover process, as reported by one of the clinical units, highlighted a direct threat to group efficacy.

This discussion on group performance is extended by comment on group motivation, group goals, group norms, and group efficacy.

**Group Motivation**

SIT emphasises the importance of motivation on “behalf of the collective” (Haslam, 2003, p. 31). The suggestion is that higher group functioning occurs when there are motivated group members as opposed to motivated individuals within a group (Haslam, 2003, p. 31). The motivators were different in each of the professional activities. What was clear was that the MDM was a group of motivated individuals, whereas the handover comprises a motivated group.

The MDM interactions occurred amongst all members within the multidisciplinary team meeting equally. Everyone in the meeting was attributed the opportunity to speak. In the nurse group handover, there was a clearly defined communication hierarchy. When questioned about the differing meetings, the senior nurses that ran the meetings agreed that the MDM was about the health professions having an opportunity to come together, and share their professional perspective on each patient, thus developing an overall management plan. In contrast to the MDM, the handover meeting was identified as an opportunity to debrief, and to get together. The interviews with nurses reviewing the videos highlighted that the handover was the only time the nursing group could safely debrief amongst themselves as a professional group.
The very obvious hierarchical structure of the handover meeting, where only the seniors, or perceived seniors were free to speak, was quite different to that of the MDM, where everyone appears to have equal voice. The apparent lack of hierarchy within the MDM appears to be the result of a keenness of all the individuals to display appropriate citizenship behaviour whilst still being true to the intent of representing their particular health care professional community. The in-group behaviours of this meeting appeared to reinforce the opportunity for each profession to demonstrate their position in patient care delivery. This emphasises the distinctive contribution of each, reinforcing the individuality of participants rather than their potential of connectedness. This was in direct contrast to the intent of the handover where the citizenship behaviours reinforce the expectation that members were motivated to function as a group, which was reinforced by the clear hierarchical structure. The result observed was that in the MDM, the motivations appear to function on an individual basis, and not as a unified group. This was consistent with the SIT literature (Haslam, 2003, p. 31).

The literature on nursing handover (McMurray, 2010a; O’Connell, 2008; Randell, et al., 2011), gives little consideration to the idea that this activity was motivated by anything other than the dissemination of clinical communication. This project has provided insights into the nursing group handover activity as a professional activity that was predominantly motivated by communications other than clinical. The evidence that emerged from the research demonstrated that the motivations for the handover activity rest in the development of the nurse collective; this was a new insight into the motivations of handover. The current literature emphasises how poorly clinical communication was demonstrated in group handover (Mayor, 2012; McMurray, 2010a; O’Connell, 2008), and as a result there was a movement towards bedside handover rather than group handover (as discussed in the literature review in Chapter 2). Importantly, there appears to have been little consideration that the ritual of handover has motivations that lie more in the development of group performances of the oncoming shift than in the dissemination of clinical information.

The nurses identify closely with the nursing group but not with the multidisciplinary group, and therefore, group membership of the nurse community was a powerful motivator to nurses. An example of this was when one nurse describes why the MDM was created, as an opportunity to offer the multidisciplinary team a forum to voice their perspectives on patient care. In contrast, the conversations in the nurse group handover were identified as light-hearted and often entertaining even though they were controlled by two key members. This was interesting as the strict hierarchical structure of the handover would be expected to suppress group motivation, and light-hearted interactions, however, this was not the case. Instead the willingness of the individuals to conform as a group ensured the handover was perceived positively.
Both the handover, and the MDM were led by the same nurse in each of the units. The nurses that led the handovers were identified as being at the top of the hierarchy on the basis of the activity of sort these names in groups, and the basis of the hierarchy correlated with level of experience. These nurses employed key strategies to motivate the group during the group handover, whilst in the MDM these nurses used strategies to promote a shared opportunity for members to talk. In the nursing group handover there were specific strategies which included the reinforcement of group think, and the use of humour to motivate the group. The purpose of the motivator in the handover was to pull the group together in preparation for their shift ahead. Although the presenter, who was also the motivator, will not be part of the group for the oncoming shift, they were identifying the lie of the land, and then handing the leadership of the group over to the most experienced nurse for the oncoming shift. In the MDM the same nurse also acted as the informal chair, however, in this meeting she became a spokesperson for the professional community of nursing. Her role in this meeting was to represent the nursing perspective of patient care. Those interviewed indicated that the nursing voice that was advocating for the patient was not always respected by the others participating in the MDM. These nurses were identified by the other nurses as appropriate to be the nursing representative in the MDM meetings. When asked to identify the experienced staff, the nurses unanimously identified the presenters of the meetings, and those who were to be in charge of the oncoming shift.

**Group Think**

The handover meetings promoted the development of group think in the preparation for the oncoming shift, and this was further supported by the hierarchical structure of the handover. The observations of the videos show the group behaving in a very conformist way, and the information being given to prepare the nurses for what to expect of the patients for the next shift. The nurses at interview identified the support, and understanding that occurred during the handover, that protected them from feeling isolated during the shift.

The conformity of the handover was not as visible in the MDM, and, although the meetings demonstrate appropriate citizenship behaviours (Haslam, 2003, p. 30), there was a focus on working as individuals within their own professional identities, and not as a unified professional group, therefore there was no suggestion of developing a group think in the MDM. In some of the older literature, there was a focus on the ritual in nursing as playing an important role in valuing the social, and psychological knowledge of nursing (Strange, 1996). This has given way to the recent focus on developing efficiencies in clinical communication, and improving the handover disbanding the group handover for a bedside handover structure (Chaboyer, 2009; Chaboyer, et al, 2010; Clarke & Persaud, 2011; Kerr, et al, 2011; McMurray,
The ethnographic results show that clinical communication was only one aspect of the nursing group handover. The motivations for this activity as indicated previously that the nurse presenting the handover identifies the lay of the land for the group who was taking over. This was different to the motivation of the MDM, where there were discussions on interesting, and challenging patients but the suggestions, and advice on handling these situations were given as if from peer to peer. Nursing group handover emphasised a more definite hierarchy, where the nurse giving handover was seen as the leader imparting wisdom in preparation for the shift to come. This was not dissimilar to the hierarchical structure of the clinical ward round but with a much more congenial atmosphere (O’Hare, 2008).

From the ethnographic results the nursing group handover activity within the case context plays provides an opportunity for the nurses to motivate their working group to set the scene for the shift ahead this professional activity contributes to the development of a group identity.

The centrality of the patient was paramount in the development of group identity. The challenges of patient care was the focus of the professional activities, and there was more detail provided for patients that were seen as more challenging (this may be on clinical, social or psychological levels). The Group handover was motivated by dealing with these patient challenges as a group, in contrast the MDM focus was on the siloing of the tasks specific to each health professional, and representing their specific perspectives in relation to their priorities for each patient. For example the physiotherapist was concerned with mobilisation, and breathing; the social worker was concerned about the social home environment the patient was from, and the plan for their safe return. The pharmacist was concerned with all things pertaining to the patient’s medications, and the nurse was concerned with the patient as a whole, this encompasses every other professions roles, and the coordination of nursing care. These characteristics of the MDM, and the handover gave insight into the professional identities of the nursing group through the performances during these activities. The determination of the nurses in the MDM to represent the nursing community, and the promotion of group think in the handover were representative of the endorsement, and protection of their professional identity respectively.

The Use of Humour

Humour was present in all the activities, and was observed across all the data collected, it was evident throughout all the videos, and was also present during the taped interviews. Humour was used to capture the attention of the listeners (those present at the meetings). The literature refers to the use of humour by nurses as a way of managing the unpredictability of their work (Scott, et al., 2008), and the need to normalise it to the group in order that their work will still
be manageable, even in the face of adversity (Cameron & Brownie, 2010; Chinery, 2007; McCreaddie & Wiggins, 2008; Smyth, 2011).

The study has revealed that the nurses use of humour was a necessary outlet when working with unpredictability. This was specifically identified in relation to the handover where they see this space as an outlet through humour discourses to make light of their stress, work complexity, and hectic work pace. The literature strongly supports the use of humour to manage crises, and stress, and it was substantially recognised in the literature that nurses use humour with this intent (Cameron & Brownie, 2010; Chinery, 2007; McCreaddie & Wiggins, 2008; Smyth, 2011). The nurses identified in their interviews that their specific humour could be seen as unprofessional, and they recognised this use of humour would not be used if the activities of handover, and the MDM were held anywhere but in a private room away from patients, and others.

The use of humour also appears to be a group unifying behaviour, and was seen by nurses as necessary to motivate, and support each other throughout the shift. For the MDM, it again promotes a form of citizenship behaviour, and all members of the MDM group seem to interact easily, and engage in this humour. There were differences between motivations of humour for each of the activities, and the structure of the humour was interesting. In the MDM, all the members of this activity seem able to interact in telling stories that encourage laughter. In the handover, the stories are told mainly by the senior nurses: the one presenting the handover, and the nurse who will be in charge of the oncoming shift. Occasionally, another member of staff may tell a humorous story, but this was not so freely enacted as it was in the MDM. There appears to be compliance by the other handover members to allow specific nurses to direct the handover meeting, and this includes the humour, however, in the MDM all participants appear to have equal entitlements to voice humorous discourses.

**Ethnographic Hypothesis Development for Motivation**

It is hypothesised that the motivation of the professional activities for group handover, and the MDM were quite different. The purpose of the group handover can be directly attributed to developing a nursing group identity for the oncoming shift. This motivation is aimed directly at developing a group think (i.e. promoting the group collective), and the use of humour is used to engage the oncoming nurses, and the participants in the MDM.

**Group Goals**

As described in the results chapter (Chapter 5) the goals for the particular activities that were studied provided insight into the goals of the collective of nurses within the case context. Goal setting as a component of group performance in the activities was demonstrated by the focus
being on the organisation of patient care by the healthcare team. The MDM focuses on the plan of care for each patient in the unit with input from other healthcare professionals that were involved in the patient’s care planning. The handover was an activity where the group of shift nurses organise their priorities, plan, and structure for the forthcoming shift, and this was done specifically through the feedback received from the nurse in charge of the previous shift.

In the handover, goal setting was structured in a formal way by one of the senior nurses, either the nurse giving the handover or the nurse who was in charge of the oncoming shift. In the MDM, each member of this meeting set their own individual goals, and this was not undertaken as a group activity.

Patient allocation for the oncoming shift was obvious as a goal setting task during the handover with the overall aim that patients were managed by appropriately skilled nurses within the limitations of who had been rostered on the shift. The complexities of this goal were demonstrated during the interviews when those interviewed were asked to sort these names in groups. Each of the nurses interviewed, when asked to group the names of the nurses in the handover, considered the safest grouping of the nurses. By safest, this means the most appropriate skill mix of staff matched to the complexities of the patient needs, and therefore the staff abilities to adequately care for their patients within the constraints of who was actually rostered for that shift. What was interesting was that each nurse sorted the names differently producing different groups. This grouping related directly to the allocation of nurses to patients.

Although the pictures shown in Chapter 5 indicate differing structures there was a clear identification of the senior to junior staff, and the ranking or pairing of nurses with differing levels of experience. This affirms the importance of clinical experience for establishing, and meeting the goals of the group for the oncoming shift to provide safe patient care. All the interviewed nurses identified that it would not be appropriate to put two experienced nurses together, and leave two inexperienced nurses to work together. There was a strong belief that the planning of the goals i.e priorities, plans, and structure of the work practices for the oncoming shift relied on the mixing of skill levels. The pictures demonstrated that this could be achieved in a number of ways but was determined by only one nurse, either the nurse presenting the handover or the most senior nurse of the forthcoming shift. Although this appears to be an individual, and not a collective task, it was the collective ingroup that decided who should make these decisions, and this responsibility was allocated on the basis of experience.

The other significant goal of the handover was to provide support, and strategies to the oncoming shift in the management of uncertain situations. This was done by discussing what
had happened on the previous shift, and providing strategies or possibilities to manage situations for the next shift. Again the use of humour was paramount in unifying the group, and was a normative behaviour, and consistently initiated by the senior nurses. The use of storytelling was another normative behaviour for unifying the group, and managing uncertain situations. This was very different for the multidisciplinary team where the goals focused mainly on patient-centred plans of management, rather than management of uncertain situations.

**Ethnographic Hypothesis Development for Group Goals**

The nursing goals of the handover were different to those of the MDM. The principal goal of the handover is to use this activity to form a collective of nurses that will work together as a group for the oncoming shift. The MDM goal for the nurse is to promote the position of nursing amongst the other healthcare professions.

**Group Norms**

Group norms were established through the group performance social processes, and the developed through the unified group motivators, and goals. The normative behaviours can be grouped into key areas, and the interviews, and the observations of the videos demonstrated the importance of these key areas. As identified in the results chapter, there were distinct normative behaviours on which the organisation, and implementation of actions for practice were developed. These normative behaviours were more explicitly evident during the handover due to the clear development of the collective. This was not nearly as visible in the MDM. Themes, and concepts around nurses' professional identity were evident in the norms of the nurse collective. The evidence of normative behaviours was classified into four categories. These were listed, and discussed below.

- Recognition of the attributes that the group identified with experience.
- Recognition by nurses of the complexity of nursing work.
- Dissemination of non-clinical patient information occurs at the handover.
- Reinforcement of patient advocacy.

**Recognition of the Attributes that the Group Identified with Experience**

The underlying themes of experience strongly connected all the norms. This theme arose time, and time again throughout the interviews, and focus groups. Experience was an embedded concept that was clearly understood by those interviewed. The same nurses were identified by all interviewees as either having experience or not having experience. The concept of
experience requires certain behaviours to be valued by the group. Valued behaviours were evident in both groups but there were variations in what normative behaviours constituted experience. There has been previous research done identifying the worth nurses place on experience or expertise. Most notably, the work of Scott et al. (2008) identifies that nurses tend to depend on those whom they see as having expertise, and experience, rather than using research to inform practice. Although the paper by Scott et al. (2008) focuses on research utilisation, its acknowledgment that nurses depend on experience to make clinical decisions rather than resorting to current research findings reinforces the importance of experience for nurses’ professional identity. The presence of the experienced nurse ensured that the collective felt secure during the shift.

The nurses that led the handover, and MDM were considered by the other nurses, and by themselves as experienced. They demonstrated a confidence in their nursing identity, and a willingness to champion, and advocate their role to other nurses as evidenced by the comments made in relation to the attributes of an experienced nurse. This sense of experience was reflected in the notion of seniority. There was normative acceptance of the role of the senior nurse. The group normed experience by aligning this with the concept of expertise; in every day working terms this leadership equated to professional competence, and confidence.

Recognition by Nurses of the Complexity of Nursing Work

There is much literature identifying the complexity of nursing work, and the uncertainties this brings to each nurse’s working day/shift (Burger et al., 2010; Fairchild, 2010; Fitzgerald, Pearson, Walsh, Long, & Heinrich, 2003; Gamlen, 2012; Hughes & Clancy, 2009; Krichbaum et al., 2007; Rice, 2010; Shirey, 2010; Solomon, 2011; Weydt, 2009a, 2009b). Much of the recent literature focuses on the concept of complexity compression, “the exponential increase in the pace of change confronted by nurses” (Weydt, 2009b). This literature also identifies the difficulty nurses have in identifying, and describing nursing work (Weydt, 2009a, 2009b). This complexity is considered to be the result of the ever increasing complexity of systems, and patient acuity within healthcare, particularly the acute sector (Burger, et al., 2010; Krichbaum, et al., 2007; Solomon, 2011).

This complexity of work was compellingly identified by the nurses in this study. The group norms promoted the discourse that the nurses needed to do the jobs others don’t want to do. This acceptance of nurses’ availability to everyone was a powerful normative behaviour. It not only reinforces the acceptance of the complex work environment of the nurse but also that the in-group promotes this availability, and this was an important, and normative attribute. This was exemplified in the videos by the constant interruptions by other staff members in the
handovers, and MDM. This was viewed by the nurses as quite reasonable. The nurse was then expected to move quickly from one focus to another. The general acceptance of constant interruptions, and availability of nurses as a normative occurrence needs further investigation.

Handover was an important activity, where nurses discuss the complexities of their work. During this process normalisation of this process was reinforced by the experienced nurses. The social processes most commonly used to normalise the complexity of work were storytelling, and humour. These helped the nurses of the oncoming shift to help with the foreshadowed situations.

**Dissemination of Non-clinical Patient Information at the Handover**

Much time was spent in all the videoed activities sharing information that may not be seen strictly as clinical communication. In the MDM this was kept to a minimum but was certainly still present. However, it was interesting that in the handover there was meaningful time committed to sharing this non-clinical information. Most of this was around social situations or personality traits of patients that were viewed as either challenging or unusual.

There was some literature on non-clinical communication in handover. Hopkinson (2002) identifies the significance of information exchange that occurs during handover, and Evans et al. (2008) identifies the significance handover plays in decreasing anxiety, and allowing nurses to commence practice. Hopkinson (2002) identifies the importance of the handover activity to discuss opinions, and express feelings, and then develop actions, and make decisions.

In this study on professional identity the use of non-clinical communication as a normative behaviour during handover was important. To a member of a given group, normative behaviour was what we do around here. Normative behaviour within the handover that includes such things as storytelling, and making fun of difficult patient situations ensures that work appears manageable. This dissemination of non-clinical patient information was an essential social aspect of handover.

**Reinforcement of Patient Advocacy**

The final normative behaviour that was valued by the nurse collective of these units was patient advocacy. Patient advocacy is considered as core to nursing work, and is extensively represented in the literature (Baldwin, 2003; Cameron, 1996; Cook, 2011; Mahlin, 2010; Segesten, 1993; Smith, 2004; Ulrich, 2011; Woodward, 2011).

Patient advocacy as a social norm was reinforced during the patient handover. Patient situations that would be viewed as challenging if encountered outside of nursing work were normalised, and made acceptable during the handover process. The use of acceptable in this
context means that the nurse can still view the patient in a person-centred way even though their behaviours may sit outside the nurse’s own values, and belief system. This is an attribute that is developed, and given considerable time to in undergraduate nursing programs. Storytelling that used humour, and made the story interesting were techniques which often normalised the patient as well as the situation. Senior nurses used this technique to sustain patient advocacy as a cultural process.

**Ethnographic Hypothesis Development for Group Norms**

The development of group norms within the handover activity highlights essential professional attributes; these mostly include behaviours that bind the staff together as a close social unit, and the ability to cope with work complexity. It is therefore hypothesised that those who were considered experienced were the most accomplished at demonstrating, and utilising these process for norming the group. In order to demonstrate these norms, there is an intrinsic normalising of the complexity of nursing work.

It can also be hypothesised that the handover serves as an opportunity to disseminate non-clinical patient information that is important for patient care, and for the nurse to develop strategies to manage the complexity of care whilst still advocating for the patient.

It is hypothesised that in relation to group norms experience is aligned with the concept of *expertise*; and results in leadership being equated with *professional competence, and confidence*.

**Group Efficacy**

Group efficacy is as significant as group motivation, group goals, and group norms in achieving group performance. The discussion around group efficacy centres on the conscious degree of control within the activities of the MDM, and the handover meeting. The literature (Boxer, et al., 2011; Devitt, et al., 2010; Farrell, et al., 2012; Mazzaferro & Majno, 2011) discusses the effectiveness of the MDM, and the necessity to allow time for this meeting. The literature also discusses the ineffectiveness, and considerable time group nursing handover takes, and questions the necessity for this meeting (Chaboyer, 2009; Clarke & Persaud, 2011; Kerr, et al., 2011; O’Connell, 2008).

The views of the literature were reflected in the organisational directive which recommends that nursing group handover be disbanded, and replaced with a handover that occurs at the patient’s bedside. It was curious that the structure of the handover, and the MDM activities were similar, held in similar rooms over similar time frames. The importance of the MDM was not questioned, and the nurses also consider this to be the case. However, the threat to the change
in the handover, and the disbanding of it as a group activity was seen by the nurses in Unit B as a direct threat to their group efficacy.

The findings in this study reveal the importance of the nursing group handover for group performance, and the social construction of professional identity. Intuitively nurses recognise the significance of the group handover activity, and they found ways to engaging in responsible subversion (Hutchinson, 1990). In that, in Unit A, and Unit B the nurses had implemented bedside handover as the directive, and still engaged in the nursing group handover activities behind closed doors. While other theoretical frameworks recognise responsible subversion as a patient oriented activity, it was clear from this study that it was also used to sustain group efficacy.

What was noteworthy from this research was the feeling of loss, and the importance the nursing handover was accorded by the nurses that were researched. There was a sense of loss in the move to change the group handover to a bedside handover in entirety. This would result in the inability of nurses to gather formally in privacy before the shift commences. The reinforcing of self-efficacy, and the development of group performance that was identified in the data to occur during the handover was seen to be threatened.

Even though there had been a clear directive to change the handover structure to a bedside handover, from the higher order nested groups (organisational management), there was a resistance to completely conform to the organisational requests. This was justified by the nurses due to what they perceive as a significant activity in preparing the group identity for the oncoming shift, which may otherwise be fraught with uncertainties (Mayor, 2012). Therefore the continuation of this meeting even in a shorter time frame was still within the volitional control of the nurses in Unit B, and its continuation maintained the group efficacy around this activity.

If the recent initiatives to improve clinical communication through bedside handover were to be supported this should not be at the expense of dismantling the group handover activity. There a need to redefine the handover, and sustain it as a group building activity which provides an opportunity to develop professional identity.

**Ethnographic Hypothesis Development for Group Efficacy**

Three ethnographic hypotheses related to group efficacy have been developed. These are stated below.

- Group efficacy is highly valued, and group performance strategies ensure this is social, and functionally sustained.
• If there is a threat to a professional activity (in this case group handover) in which group efficacy is normally maintained than the nurse collective is likely to use responsible subversion to continue the activity.
• It is hypothesised that the loss of group handover would compromise the forming of nurse professional identity.

Conclusions on Group Performance
Group performance has a direct impact on the construction of nurses’ professional identity. In undertaking the activities of handover, and the MDM there were important characteristics that influence, and shape group performance. The group goals of the handover were directed towards achieving a safe allocation of staff to care for patients, and developing a collective that will provide functional support, and direction for the nurses during the shift. The nursing work was complex, and the activity of handover was used to normalise this, and to reduce the threat of uncertainty. The MDM also highlighted normative behaviours such as humour, and storytelling but to ensure citizenship behaviour, and not to develop the collective group. Experience was a valued attribute, and was identified throughout the categories of group performance. The performance in handover ensured, and reinforced that nurses understood, accepted, and normalised the complexities of their work, including their often multifaceted non-clinical knowledge of the patient. Patient advocacy was also reinforced in the normative behaviours.

Social Identities
The importance of social identity to professional identity was a central concept in the development of this research project. These social identities are determined by the work situations an individual is in at any given time. However, salience is defined as the “probability that a given identity be invoked” (Hogg & Terry, 2001, p. 32). SIT emphasises the importance of salience in determining social identities. It came as no surprise that the nurses’ social identity salience aligned with the nursing clinical unit group. What was interesting was that regardless of the groups the nurses moved amongst there was always a commitment to the salience of the nursing group as the key determinant of the individual’s identity. This may have been due to their salient alignment with their professional identity to nursing. The identification of what this salient identity looked like from the results of this project aligns closely with the concept of group performance, but the results here focus on the key concepts that were characteristic of salient social identities. These include the strong commitment to the nurse as a collective self. This was demonstrated through the individual nurses’ connection to the nursing team, and the prevailing, and internalised commitment to the handover activity. This commitment was then
reinforced through specific communication techniques. These will be discussed in detail in the following section.

**Social Identity Salience**

In this study handover rather than the MDM was the most powerful activity that influenced social identity salience in the construction, and maintenance of professional identity. Because of this, in this section the findings from handover are emphasised, and discussed. As outlined in the SIT literature, salience relates to a type of identity hierarchy (Hogg & Terry, 2001, p. 32). The concept is somewhat convoluted as any one individual can have multiple salient group identities that are invoked, depending on the group with which the individual is involved with, at any given time, and then, there is the potential for multiple identities to be ranked. This then produces the salient hierarchy (Hogg & Terry, 2001, p. 32). What was very much apparent from this research was that when the nurses were functioning within their working environment the salience of the nursing group to individual nurse identity was always dominant, this was regardless of whether their working group was a nursing group or not. The nurses maintain their salience to their nursing identity even when they were functioning in other groups, this was witnessed when the nurses were participating in the MDM. They maintained strong commitments to the professional identities as a nurse. The characteristics of social identity salience from the results of this research were demonstrated through four specific, but broad behaviours. The four behaviours are listed, and discussed below.

- Identification with the collective self (Haslam, 2003, p. 31).
- The emphasis on team.
- The expectation of conformity to the handover process.
- The reinforcement of group identity salience (i.e. the dominant group the individual identifies with) through the communications that occur within the handover.

**Identification with the Collective Self**

The collective self (Haslam, 2003, p. 31) is an underlying descriptor in SIT, and had particular significance to the analysis of this project. There were clear indications that identification of the nurses as a collective was internalised by each individual nurse. The use of language referring to the nursing group was particularly exclusive. Frequently the terms *us*, and *we* indicated that the nurses saw themselves in terms of a collective self. Another example of this was in the internalisation of the handover as a meeting that had no structure but rather was seen as a natural and accepted event. During handover there was a clear hierarchical structure which was relatively inflexible. An example of this was the positioning of the nurse presenting the handover; she had a specific chair in which to sit, either at the head of the table or near the door.
of the meeting room. The hierarchical, very specific communication approach where only specific participants spoke was another example of the formal construct of the meeting. The regular regimented time and place of the handover was also an example of the structure, right down to the presenter sitting in the “ANUM chair” close to the door, and locking the door during the handover process. This activity was a routine, structured ritual that was unconditionally adhered to by all staff within the nursing team of the oncoming shift. The MDM was a much more flexible process, and although the location was always the same, the time sometimes was known to vary, the participants varied depending on who were available for the meeting. All these factors appear to contribute to the nurses the nurses performing within the MDM as a representative of the nursing profession. The internalisation and normative acceptance of the handover structure suggests there was a strong connection between the handover activity, and the development of the collective self.

The handover meeting again supported the notion that this activity was significant to the group. It was seen as an important time to debrief, to discuss patient information in private, and develop solidarity amongst the group. The information given about patients was not just clinical information, but rather an opportunity to debrief around difficult real scenarios that were encountered by patients, and other staff.

Evans et al. (2008), identify that the purpose of handover assisted in reducing nurse anxiety in patient management. Evans et al. (2008) finding was confirmed, and extended in this research. The findings from this study identify that the development of the group and of the collective self for the oncoming shift was a significant determinant of the handover. This had not been previously reported. The significance of this to the development of group identity, and therefore identity salience was a new insight, and the results suggest there was much to be learned from these collective nursing activities. Particularly, the influences the handover had on the forming of professional identities. This was particularly so when reflecting on the contrasting findings related to the MDM. The MDM was not to develop a collective self, but rather to a social process that ensured that the individual participants communicated their individual positions on the patient, and sustained their referent professional identity in performance. A further hypothesis would be that this then contributes to the development or formation of the individual nurses’ professional self, and the salience of the professional self was very much reinforced during the group activity of handover.

**The Emphasis on Team**

The development of the collective self was progressed through the reoccurring theme of the importance of the team, specifically the nursing team. This theme of team was not to be
confused with the current move within nursing towards team-based models of nursing practice (Cioffi & Ferguson, 2009; Fairbrother, Jones, & Rivas, 2010), and the research in nursing that has been undertaken to evaluate this model of practice.

The concept of team for the nurses in this project was centred on the development of a group identity, and not a patient allocation system. Their nursing professional identities were strongly aligned to their work groups. The results demonstrate this alignment. The handover activity was viewed as essential to prepare the social group as a team before the shift commences. The overwhelming concept of team was seen as fundamental by the nurses to authenticate their professional practice. Through the interviews, and the videos there were many examples of how important the concept of being a team was, and of getting on with the team. There has been much research done on the nurse, and team (Fraser, 2011; Spiva & Johnson, 2012; Sullivan & Godfrey, 2012; Timmermans, Van, Van, Van, & Denekens, 2012), and much of the recent literature focuses on the nurse, and their position within the multidisciplinary or interprofessional team. What this project has focused on, was the nurse within their nurse team, and its influence on the social, and professional identity of the nurse. The interviews categorically supported the notion of the importance of having a nursing team that was unified. The concepts around trust, fun, and approachability were all seen as unifying team factors to guarantee satisfactory practice. This was not so in the MDM where the nurses viewed themselves as representative of the nursing profession.

The MDM was seen as a meeting, and not a team-building exercise. This meeting influenced the professional identity of the nurses through the need for the nurse within this meeting to advocate for the nursing profession by performing as a nurse. In the handover the nursing group was testing, and building group norms for the oncoming shift. The ways of working as a professional group were subtly reinforced in the handover. The difference being influence of the group in handover was to develop a collective self, and influence the individual nurses’ identity to the group.

The understanding, and significance of team was identified on many occasions during the interviews. Some of these concepts included the idea that there was a fluidity or flexibility within the nursing team. Another identified the metaphor of wheels on a bike with the recognition that nursing work was difficult, and there must be an ability to work as a nursing team to enable the complexities of nursing work to be achieved. In particular, the senior nurses interviewed reinforced the importance of the team, and identified with these concepts of wheels on a bike. The senior nurses actively promoted, and influenced the nurses to work as a team.
In relation to the social identities of the nursing group it is hypothesised that the ability to promote the team, work within the team, and contribute to the team is a salient characteristic in the development of nurses' professional identity.

**The Expectation of Conformity to the Handover Process**

The representation of team was demonstrated through behaviours that support conformity to the structure of the handover. The handover structure encompassed the physical environment, and social behaviours. What was of particular interest, and was contrasted in the MDM, and nursing handover was the prominence of equal participation within the MDM, and the contrasting fact the participation was limited to specific members in the handover. The undisputed hierarchical structure of the handover meant that only certain people were socially validated to participate. The majority of participants were comfortable with the way the handover runs. It was interesting that it was only the junior nurse in Unit A (who had not yet learnt to conform) who challenged some of the handover practices. This junior nurse did not demonstrate a strong affiliation with the nurses in Unit A; she questioned their expertise, and made it clear that she was not particularly happy in this unit. There was a clear lack of identity to the group, and this did not go unnoticed by the other nurses interviewed. Rather it was remarked upon by one of the senior nurses interviewed that this junior nurses was not considered by the others as a team player. This junior nurse did not conform to the usual communication hierarchy of the handover, and frequently spoke up; she was at times not acknowledged by the other members.

The importance of conforming to the handover process was reinforced by negatively viewing individuals who were not willing to conform to the process. People who do not conform will receive negative nonverbal responses during handover. Handover then was a social activity that sought to reinforce professional conformity. It is hypothesised that the handover reinforces the nurses’ salient group identity.

The salience of conformity in the handover meeting was contrasted in the MDM, where the behaviours promote individualism. Each of the participant’s voice opinions in relation to their differing roles, and this was accepted, and expected. There was not any obvious need in the MDM to conform to the hierarchical communication evident within nurse group handover. This was apparent in the MDM when health professionals can leave the meeting to answer a pager without any of the participants being concerned or troubled by this behaviour. It is hypothesised that the salient group identity conformity during the MDM is not reinforced.
The Reinforcement of Identity Salience through the Communications that occurs within the Handover

There were significant communication techniques used to strengthen the salient commitment to the nursing group during the handover activity. The use of collective language when discussing nursing, creating a notion of a homogenous group was one technique. This was reinforced by the senior members of the group. The senior nurses refer to each other as *we* or *us*, when referring to others outside the nursing group they were referred to as *them* or *they*.

The use of storytelling was another communication technique that also bound the nurses together as a homogenous group. The importance of storytelling is a well reported on strategy in nursing (Haigh & Hardy, 2011; Johnson, 2012), however, in relation to its use in handover there has been limited investigation. The use of storytelling within the activities of handover, and the MDM, particularly by the nurses, is worthy of further investigation as a salient activity to develop homogeneity within a group or group activity. Specifically the use of storytelling within the handover activity was used to normalise complexity of the nurses working environments, to engage their teams or working groups. The last hypothesis in relation to social identity salience is that the forms of communication that occur during handover advance the salient identity of the nursing group.

Ethnographic Hypotheses: Development for Social Identity Salience

Four ethnographic hypotheses relevant to the development from social identity salience emerged from the research, these are listed below.

- The development or forming of nurses’ professional identity is influenced by the development of the collective self, and nursing activities such handover reinforce the salience of the collective self.
- The salience of team contributes significantly to the professional identity of nurses.
- The salience of conformity during specific nursing activities, in this case handover, will also contribute to the individual nurses sense of professional identity.
- Specific forms of communication reinforce the salience of the nursing group. Specifically these were identified as referring to the nursing group as a collective *us*, and *we*. Also the use of storytelling within the handover activity is a unifying communication technique.

Nested Identities

The professional identities of nurses, revealed a complicated network of interconnections amid their social working groups. The most influential of these groups was undoubtedly that of the nursing group. From a SIT perspective, the nursing group studied in this research represented a
lower order nested group. The SIT concept of nested groups or nested identities relates directly to “formal social categories” often being those of workgroups (Hogg & Terry, 2001, p. 41). There are three identified dimensions to a lower order nested group: specifically these identities tend to be proximal, concrete, and exclusive. The significance of the lower nested groups through these three dimensions has a direct influence on the day to day performance of workgroups, and therefore the social identity of each individual within that group. This lower order identity is viewed as more influential on behaviours than a higher order group within the organisation, which is viewed as more abstract. The results from this research project support the findings from the social identity literature that social interactions influence professional identity in work-groups. This was obvious in the closely nested work-groups within ward/units within the hospital structure studied for this project.

What was evident from this study was the recognition that nurses in hospitals or organisational settings work primarily in teams of nurses, and their professional practice to a great extent was directed by their immediate day to day, shift-to-shift nursing team. There was interdependence within this nursing team, and it was frequently identified within the data that in order to achieve the outcome of patient management the team members needed each other.

On a shift-to-shift basis, nurses’ work intimately together in lower order nested groups, and they categorically define themselves within these workgroups. This was evident from the study when there was any threat to the homogeneity of the group, and this threat for the in group of nurses translated to a potential threat to patient safety. A clear example of this was the perceived threat of the junior nurses who had not as yet embodied the in group norms.

As a result of the salient identities, the nested nursing group was a very stable homogenous in-group. This then translates into a potential to influence the nurse in developing a professional identity that aligns closely with this in-group. These identities become formal, and this was shown when identification of team behaviours are valued, and reinforced. When nurses choose to work outside the nested identity there was a threat to the homogeneity of the in group, this was demonstrated by the quiet junior nurse, and the loud junior nurse. What was particularly evident in relation to the SIT work was that the handover activity very much promoted an exclusive, concrete, proximal nested identity amongst the participants interviewed. The nested identity of the nursing group was important in the development of the professional identity of the nurses who participated in the project.

**Ethnographic Hypothesis Development for Nested Identities**

The clinical nursing unit is a well-defined nested identity, each shift represents a subset of this nested group, and homogeneity is of paramount importance to this group. The nested identity of
the nursing had a significant influence on the development, and reinforcement of nurses’ professional identity.

**Cross Cutting Identities**

Cross cutting identities is the last concept identified in the SIT literature as part of social identities (Hogg & Terry, 2001, p. 41). These can be either formal or informal usually they are seen as cliques or friendship groups (Hogg & Terry, 2001, p. 41). Cross-cutting identities tend to work face to face on cooperative tasks, differentiated by specific social categories (Goar, 2007). Similar to nested identities, these groups tend to be proximal. It is also common to continue to identify with other salient social groups whilst undertaking activities within the cross-cutting identity. Deschamps and Doise (1978) identified that cross-cutting identities encourages multiple categories, which may be the same or similar to the salient in-group. This may decrease the salience of the original categorisation. From this project, the MDM would fit the criteria of a cross-cutting group. The nurse’s participation in these meetings was viewed by each of the nurses as significant. However, their participation was always as a nurse, and they saw themselves as representing, and performing the nurse’s perspective. This differs from Deschamps and Doise (1978) findings, as the nurses did not identify with multiple categories during the MDM instead performed, and represented the nursing group throughout their involvement with these meetings.

**Ethnographic Hypothesis Development for Cross-cutting Identities**

It would be hypothesised that the MDM represents a cross-cutting identity that reinforced the salience of the nurses to the nursing group.

**Conclusion to Social Identities**

It was evident from the research that the social identities of nurses was developed, and reinforced within the professional activity of the nursing group handover. The commitment to the salient identity was enacted during the MDM.

The development of the collective self was a complicated process, and the nursing group handover was an important professional activity where the professional identity of nurses was sculptured. The evidence suggests that the handover activity contributes to the development of a much formed nested identity amongst the nursing group, one that was then enacted when the nurse moves into other cross cutting identities such as the MDM.

Elements that shape performance will be discussed under the heading of Self categorisation, with particular emphasis on the in-group influences.
**Self-categorisation**

The findings about construction of professional identity in relation to group performance, and social identity have been discussed in the previous section of this Chapter. The third, and final elements of these findings of self-categorisation are now discussed.

Self-categorisation recognises the cognitive processes that enable salient in-group membership of an individual. “Categorisation is helpful because it allows people to respond rapidly to stimuli, without evaluating them exhaustively... social as well as non-social stimuli can be categorised, and the categorisation of social stimuli involves the self as well as others” (Hogg & Abrams, 2001, p. 95). Communication is important in the self-categorisation of individuals by playing a significant role in "social influence, and consensual grounding of norms" (Hogg & Reid, 2006).

An important consideration of self-categorisation is the recognition that there needs to be a stimulus in order for self-categorisation to occur. Stimuli here relates to people, and interactions that create opportunities for the cognitive process of self-categorisation (Haslam, 2004, p. 31). The development of the prototype was broadly investigated in this project; relevance of the structural context as well as the social context was evidenced as significant. There were three key insights of self-categorisation from this research study. These insights are presented below, and then discussed.

- Group activity occurs because of social identity, and this is a cognitive process.
- The self-system of the categorisation process is context sensitive, people either see themselves as "sharing category membership with others or not" (Haslam, et al., 2012, p. 206).
- Mutual social influence is based on shared social identity.

**Group Activity as a Cognitive Process**

The importance of self-categorisation to this discussion is in its recognition that group membership is psychological, and not formal. Group membership is based on cognitive salience, abstract social categories, internalised to become aspects of their self-concept (Turner, 2010). This was demonstrated in this project through the acknowledgment by the nurses interviewed of the importance experience was afforded by the nursing group. These experienced nurses were considered significant members of the in-group due to their shared characteristics, and not their personal idiosyncrasies. The notion of experience within the results of this project was a complicated cognitive attribute. The recognition that experience was a valued in-group attribute was a cognitive development, which then contributes to the social identities within the activities of the handover, and the MDM. In the handover, the desire to conform to this activity
was influenced the experienced nurse who leads it. This was a direct result of the cognitive self-categorisation of the senior nurses to their commitment to the nursing in-group. The other nurses then choose to either align themselves or not with the attributes of the senior nurses, they make a cognitive decision as to whether they want to be part of the in-group.

The cognitive processes that subject personal characteristics to self-categorisation can be explained through the concept of prototypes. Prototypes are “fuzzy sets, not checklists, of attributes (e.g., attitudes, and behaviours)” (Hogg & Reid, 2006). The prototype was demonstrated, and enacted throughout the data, but very specific behavioural attributes were identified by the nurses themselves. These included a positive attitude regardless of the work complexity, and the notion of being able to work together. The senior nurses have specific attributes that have been developed, and were enacted intuitively. The senior nurses themselves identified some of these during the interviews, and they included such things as having knowledge, and experience of, and in nursing; being approachable, able to make the difficult decisions, and prioritise care to advantage the patients, and the nursing team.

The need for positive self-esteem has implications for in-group members, and can result in members differentiating themselves from fellow members to ensure they are closer to the normative ideal (Turner, 2010). This was evidenced in the interview data when the junior nurse was seen to not have the attributes that were considered part of the nursing prototype. For the junior nurse, she chooses not to align herself with the in-group; instead she feels the differences align her with a specific group of other nurses, those that were university trained as opposed to hospital trained. She was putting the experienced nurses into a group who were trained through the hospital system, and not through the university, and this was her reasoning for not being able to embody their prototype.

The obvious use of us and them in describing the members of the MDM was another demonstration of cognitive development of self-categorisation, reinforcing the notion of the salience of the nursing group who were defined as us. They define themselves positively and differently to the multidisciplinary team members. This defining of differences is a characteristic considered significant for the cognitive development of self-categorisation (J. Turner, 2010). The cognitive development of self-categories is a form of stereotyping leading to homogenisation, and depersonalisation of the out-group, this was evidenced in this research project.

**Context Sensitive: Sharing Category Membership**

Self-categories are not fixed or absolute, and are always context dependent (Postmes & Branscombe, 2010, p. 290). Metacontrast assists in defining categories. The notion of self-
categorisation is selected by the individual on the basis of meaningful relations between the self, and others, this is not fixed, and self-categorisation is selective depending on an individual’s context at any given time (Turner, et al., 1994, p. 457). This notion of metacontrast relates to the allocation of oneself to a particular self-category when the differences with the in-group are perceived to be less than others within a given context. This metacontrast was demonstrated by the way the nurses absolutely identify with the nursing group when compared with the multidisciplinary group (Postmes & Branscombe, 2010, pp. 348-349). The comparative fit from the data, supports that nurses within their work contexts, define themselves primarily as nurses. As a result, the identities of the nursing in-group were a validation of self-categorisation as a nurse. This validation is context specific to the nested group of the clinical unit. This resulted in a specific normative fit for each of the clinical units when undertaking the activities of the MDM, and the group handover. The ability to play out the salience to the nursing group within these two activities was supported by the physical environment. The rooms were considered as nursing spaces within the clinical unit, and the evidence supports that this influenced the types of interactions that occurred. This resulted in a dominance of the nursing group, and the need for the MDM members to obtain permission before entering the space. The informality of the room set up, and the privacy of the space enabled the promotion of collegial citizenship behaviours. The privacy of the space allowed autonomy to use communication techniques that the nursing in-group valued. The enaction of the espoused nursing prototype was unchallenged in this space during the nursing group handover. There were no threats in this space to the cohesion of the nursing identity.

The internalisation of the norm of team, and was demonstrated in the pride the nursing group had with being part of the clinical team, the nurses overall categorised themselves positively as a big team, as being there for each other. This reaffirmed the self-categorisation to the nursing team. They identify togetherness in their daily work, and a commitment to the members of their nursing team. What was evident from the data was that the physical environment played a role in the self-categorisation of the nurses to the nursing group.

**Mutual Social Influence**

Mutual social influence is more likely to occur when members expect to agree, and is again more likely if they are perceived to be of the same category (Hogg & Abrams, 2001, pp. 280-281). The nursing groups promoted this mutual social influence as demonstrated in the significance they place on their nursing group. The findings reveal that frequently the nursing group emphasised mutual esteem, they often evaluated themselves, and others in terms of their common category membership (Postmes & Branscombe, 2010, p. 219; Turner, et al., 1994).
Ethnographic Hypotheses Development for Self-categorisation

Four ethnographic hypotheses were developed from the findings, and discussion on self-categorisation.

- It is hypothesised that the self-categorisation of nurses to their nursing group influences their behaviours to conform to professional group activities during their working shift.
- The sharing of stories, and working within the complexity of the nursing environments, further strengthens the self-categorisation of nurses to the nursing group.
- It is hypothesised that the groups of nurses studied had a similar prototype, and this may well be because there is a shared professional prototype similar to all nursing groups. This prototype is demonstrated through in the attributes of those who were considered the experienced nurses.
- It is hypothesised that the prototype only remained salient whilst the nursing group is within their working environment, and during their shift. This working environment includes the whole of the hospital environment, and is not confined to the physical space of the clinical ward unit.

Conclusions to Self-categorisation

Self-categorisation is complicated, and comprehensive, and its evolution is systematic. The self-categorisation findings are new as there have not been previous investigations into this theory related specifically to nurses' professional identity. In consideration of the self-categorisation of the nurses within this project, the data demonstrates that the prototype reinforces the importance of good team dynamics, and the significance of experience. The expectation of individual nurses, to be recognised as part of the in-group of the nested identity of the clinical team, has shed new light on the attributes that contribute to the prototype of the professional nurse. Social identity becomes more salient in intergroup contexts, and personal identity becomes more salient in intragroup (or in group) contexts (Postmes & Branscombe, 2010, p. 291). Level, kind, content, and internal structure differs between self-categories. Self-categories are context dependent social definitions of self therefore they vary, dependent on the social reality. This was demonstrated in the study by the ways in which the salient identity of nursing was reinforced by the activities occurring within the social, and physical context.

Finally, the prototypes for the clinical units were similar, and this common prototype was cognitively salient, and reinforced by all the nurses interviewed, but particularly by the nurses who were considered experienced. The more experienced nurses had well established professional identities, which reflected the prototype. The hypotheses presented have particular
significance to nurses, and the understandings of professional identity. Further tested of the ethnographic hypothesis is needed.

**Limitations**

This research was limited by the assumptions of ethnography, and by the use of a single case context. But within this, the research has successfully achieved ethnographic understandings, and insights into the professional identity of nurses from a SIT perspective. The data was limited to the particular time, and space generated by the context, and the participants. However, in ethnographic terms saturation was sufficiently achieved to enable the use of SIT produce significant new findings in relation to the social processes involved in constructing nurses professional identity in the work place.

The acute healthcare context within which this research was undertaken was recognised as only one specific work environment where professional nursing practice was undertaken. Professional nursing practice is undertaken in many varied work contexts. Some of these diverse work environments include acute healthcare contexts, community contexts, aged care contexts, metropolitan, rural, mental health contexts to name a few. Therefore, the rich insights from this project drawn from the specificity of the context of this research need testing in these other work contexts.

The activities of handover, and the MDM were only two professional activities that nurses undertake within their social work environments. The findings from the study of these activities were rich, and useful to understanding the constructions of nurses’ identity to the workplace. Other nursing activities need to be studied using SIT, and the same or similar ethnographic processes. This will assist understanding about whether the findings were limited to these nursing activities as studied or more generalisable to nursing work in general.

**Developing a Theoretical Framework**

In keeping with the tenets of ethnography the findings from the study has led to a series of ethnographic hypotheses, and sufficient information about the construction of nurses’ professional identity in the workplace. This has enabled the postulation of an ethnographic theoretical framework. The framework will require further testing, and validation by studying nurses professional identity using SIT, and ethnographic processes in relation to other nursing activities, and other case contexts. What is presented in this final section of the Chapter is the emergent theoretical framework from this study.
In this study the interactions of nurses with nurses in two professional activities have been extensively investigated in one case context. Through the application of ethnography in conjunction with SIT the elements of group performance, social identity, and self-categorisation have enabled identification of the constitution, and the performance of professional identity. Consideration, and insights into internal influences, and external factors that determine the development of the nursing group have enable construction of the emergent theoretical framework (Tables 12, and 13).

**Table 12: Social Identity Framework for Nurses’ Professional Identity**

<table>
<thead>
<tr>
<th>SIT Constructs</th>
<th>Intent</th>
</tr>
</thead>
</table>
| **Group Performance** | • Many professional activities in nursing are aimed at developing the collective behaviours  
| Motivation         | • These activities are frequently led by senior nurses;  
|                    | • Motivations are often focused on conformity of participants through communication strategies of which storytelling is specifically significant  |
| Goals              | • Reinforce the ability of the professional nurse to manage complex work situations  
|                    | • Promote a philosophy of patient centeredness or the centrality of the patient to all activities of the nurse, including the valued notion of patient advocacy  |
| Norms              | • To enact, and promote the nursing prototype which includes:  
|                    | • The acceptance of complexity, and uncertainty of nurses’ work.  
|                    | • The valuing of the senior or experienced nurse as the aspired prototype.  
|                    | • The importance of the nurse collective through the salience of the concept of the nursing team  
|                    | • The significance of the team to ensure support for each other.  
|                    | • Normalisation of work complexity often through storytelling, and humour.  |
| Group efficacy     | • In the threat to volitional control, nurses’ will seek to maintain their group efficacy, and not always follow the organisational directive  
|                    | • Nurses’ commitment is first to the nursing group  |
| Social Identities  | • The salience of team is significant to the development of professional identity  
| Identity Salience  | • Much of the development of nurses’ professional identity can be attributed to salient communications specifically storytelling  
|                    | • Conformity to specific professional activities contribute positively to the development of professional identity  |
| Nested Identities  | The clinical unit where a nurse works is a nested identity  
|                    | These nested groups significantly impact on the development of a nurse's professional identity  |
| Cross cutting Identities | The less formal groups that nurses come in contact with within their work contexts serve to reinforce their salient commitment to the nursing group  |
| Self-categorisation | • The development of nurses' professional identity is a cognitive process that is influenced by the working context of an individual nurse. Specifically the clinical nursing unit, and |
the nurses within that group.

- The prototype within nursing is possibly represented through the nurse who is considered by other nurses as experienced.
- When an individual nurse does not conform to the attributes that are considered the normative fit then self-categorisation with the salient nursing group is faulty.
- Self-categorisation is the result of the cognitive choices in relation to the stimuli received by each nurse within the context of their work specifically their clinical unit.

Table 13: Nursing Group Handover, and its Influence on Professional Identity

<table>
<thead>
<tr>
<th>SIT Constructs</th>
<th>Intent</th>
<th>Demonstrated Behaviours</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group Performance:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Motivation</td>
<td>Unification of the nurses who were rostered for the oncoming shift</td>
<td>Development of a group think</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use of humour</td>
</tr>
<tr>
<td>Goals</td>
<td>organise the oncoming shift, and unify the group</td>
<td>Allocation of patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Offering of strategies for expected complex situations during the shift</td>
</tr>
<tr>
<td>Norms</td>
<td>Reinforce the need of team conformity in order to carry out the nursing practice requirements during the shift</td>
<td>Dissemination of non-clinical patient information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reinforcement of the valued prototype</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reinforcement of patient advocacy</td>
</tr>
<tr>
<td>Group-efficacy</td>
<td>Volitional control of nurses work is reinforced during the handover</td>
<td>The continuation of the meeting regardless of organisational directives</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The privacy of the environment of the handover space</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The acceptance of interruptions</td>
</tr>
<tr>
<td><strong>Social Identities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identity Salience</td>
<td>Reinforce the salience of the collective self</td>
<td>Identification with the collective self through communication strategies i.e. storytelling</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The emphasis on team</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The expectation of conformity to the handover process</td>
</tr>
<tr>
<td>Nested Identities</td>
<td>Develop a specific nested identity of the nurses rostered to the specific shift</td>
<td>Conformity to the hierarchical structure of the handover process</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Respect for the nurse considered experienced (usually those in charge of the shift)</td>
</tr>
<tr>
<td>Cross cutting Identities</td>
<td>Involvement in activities with groups that are less salient than that demonstrated in the handover group</td>
<td>Commitment to the nurse collective of the specific clinical nursing unit</td>
</tr>
<tr>
<td><strong>Self-categorisation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>An important opportunity for stimuli, that then creates opportunities for self-categorisation within the nursing group</td>
<td>Behaviours that represent mutual performance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reinforcement of attributes of the aspired prototype</td>
</tr>
</tbody>
</table>
In Table 12 the Social Identity Framework for Nurses’ professional identity is postulated. In Table 13 Nursing Group Handover, and its influence on Professional Identity is postulated. These frameworks are summarised below, and they will provide a new beginning point for further research. The information presented in Table 12 provides a new framework that acknowledges the significance social identity attributes to the construction of professional identity within nursing.

The information presented in Table 13 reveals the robustness of the social processes, and interactions embedded in the group handover processes which construct, and sustain nurses professional identity. This finding generated an alternative view to what clinical handover is traditionally considered to be about. The presiding question that arises from this handover framework is, has the true meaning of handover ever really been understood? This activity is significant in its effect on professional identity.

The findings of this study have been discussed in this chapter. The contribution of the research to new knowledge on Nurses’ professional identity is concluded in the next chapter.
Chapter 7: Conclusion

In the nursing tradition, professional identity is intrinsically linked to the in-group dynamic. At the outset of this research, the undertaking was to contribute to the existing body of knowledge on nurses’ professional identity, this purpose has been achieved. The particular significance of this research lies in the application of a theoretical perspective SIT, which has not previously been used within the nursing context. Use of this perspective has uncovered some new, and important findings.

The overall aim of this project was to investigate elements that constitute the performance of nurses’ professional identity within a specific work environment. This has produced new insights, and ethnographic hypotheses, and new theoretical frameworks which can now further drive research policy education, and practice.

Major findings of the research include the following points.

- SIT provides an effective analytical framework for the examination of the development, and performance of the professional identity of nurse.
- The *group dynamic* has a significant influence, and connection with the development, and affirmation of the professional identity of nurses.
- Professional activities such as the group clinical handover provide the sites for the ongoing social construction of nurse professional identity.
- Professional activities such as the multidisciplinary activity provide sites for the performance of nursing professional identity.

This chapter is organised in relation to three key components these are conclusion in relation to nurses’ professional identity generally, conclusions on nurses professional identity specifically related to nursing group handover, and general implications arising from the research study.

**Nurses Professional Identity- Generally**

As noted throughout the thesis, the concept of social identities helps us to see nurses’ professional identity as socially-mediated performances in particular professional contexts. SIT allows us to describe the many, and varied contexts in which professional nurses undertake their work, and give voice to the diversity of nursing identities within context.
The influence, and connection of social identity to professional identity was clearly evident in the research findings. These findings are summarised under the headings of group performance, social identities, and self-categorisation.

**Group Performance**

In this context, a group performance is a professional activity undertaken by a group of co-workers in a particular setting for a specific shared purpose. In the context of nurses functioning in a hospital ward, the shared purpose is patient care. These group performances can be discussed using the categories of group motivation, group goals, group norms, and group efficacy. The findings from this study demonstrate the importance of these group performances in the formation of professional identity.

Professional activities within nursing practice are often motivated by the need to develop collective behaviours, led usually by those considered senior. Conformity of nurses to the norms of practice of the in-group is reinforced by using motivational techniques through communication strategies, commonly storytelling is significant here.

A key goal of group performance is the normalisation of practice in order to develop nurses’ ability to manage the complexities of their work. This is done by promoting a philosophy of patient centeredness allowing the often unconventional behaviours of patients to be accepted. These normalised practices can be very different from the social practices that would be employed by the same nurses outside the hospital context.

The research findings demonstrated that there is a development of behaviours that are considered normal or normative by the group which are then endorsed amongst the in-group of the nursing clinical unit. One of the key findings is the demonstration of acceptance by nurses of the complexity of their work, and the associated professional valuing by the group of the senior or experienced nurse is most noticeably observable. Identification of the individual nurse with the nursing team is central to all aspects of working within a clinical shift. This is a theme that runs through all aspects of nurses’ professional identity, and although already well acknowledged in the research literature, cannot be overstated in relation to professional identity. The use of storytelling as a group communication strategy along with humour are emphasised as particularly important behaviours for nurses to enact to reinforce the nurse collective. Both humour, and storytelling are well researched within the nursing literature, and their significance to nursing practice is well documented. What this project presents, building upon the existing body of knowledge, is that these two skills are well engrained in the essence of nurses’ professional identity. Group efficacy has also been shown to be of importance to professional identity. In this context, group efficacy refers to the group’s capacity to usefully
plan, and implement patient care. What this research demonstrates is that if there is a threat to the volitional control of nursing practice within the clinical unit, then the nurses belonging to that unit will ensure group efficacy is maintained. This may mean that if requested to follow an organisational directive that is deemed by the relevant group of nurses to threaten group efficacy, then the nurses will find alternative ways to maintain volitional control by modifying organisational directives.

**Social Identities**

The salience of the nursing identity presides over all other identities whilst the nurse is working as a nurse within their work context, and if that nurse espouses the prototype. This is evident in the commitment of individual nurses to their clinical unit or nursing team. Conformity within specific professional activities contributes positively to the development of a professional identity. This then results in a strong nested group that relates closely with the identity of nursing, and specifically nursing as undertaken within the given clinical unit. When the nurse comes in contact with more cross-cutting multidisciplinary groups, the nurse who has a strong commitment to her professional identity maintains an overriding commitment to the nursing group.

**Self-categorisation**

The cognitive development of the professional identity of a nurse has been shown in this research to be predominantly influenced by the clinical nursing unit where the nurse works. The nurse who is identified as experienced or senior whether or not this is a formal position is considered to embody the prototype of a professional nurse specific to the units researched, and the other nurses within the group either support or distance themselves from this prototype. The homogeneity of the nursing group is easily threatened when individual nurses do not wish to embody the prototype.

**Nurses Professional Identity- Nursing Group Handover**

It is significant to say that this research indicates that the loss of group handover would compromise the forming of nurse professional identity, and the significance of further investigation into this, and other such professional nursing activities, and the relatedness to professional identity must be notably emphasised.

The findings in this project have demonstrated that group clinical handover is a significant professional activity that is something other than the simple dissemination of clinical communication. This activity for the group of nurses studied was an important daily process,
whereby the constructs of social identity are played out. This is not to say, that this activity would hold the same value for all working contexts. However, what is interesting from the findings of this project is that significance of the group processes of handover appears to have been paid little attention in previous research. The current move to disband group handover in light of these research findings has potential to compromise the forming of nurse professional identity. This therefore gives weight to the importance of further investigation into group handover, and other such professional nursing activities, and their relatedness to professional identity.

**Group Performance**

What this research shows is that for the nurses investigated, the motivations for handover revolved around a unification processes that prepared the nurses who were to work together during the oncoming shift. The goals focus specifically on organising this unification into workable strategies. The norms reinforce the team conformity, and this is done through disseminating patient-related information that includes non-clinical information. The norms also promote a valued prototype, which is role-modelled by those considered as experienced nurses. Part of this prototype enactment *calls* the group together around the notion of patient advocacy. The threat to group efficacy is clearly demonstrated when the activity of clinical handover is threatened to be disbanded, and the covert way the nurses modify, but continue the clinical handover. This activity is considered particularly important in endorsing group efficacy.

**Social Identities**

During the handover, the nurses display commitment to nursing. The handover is a closed activity that is very structured, and the participants are only nurses. It is nurses’ business. During this activity, the nurses demonstrate a very hierarchical and conformist process. During this process, there is continual emphasis on the team, and the need for the team to manage the complexities of the work on the shift to come. The salient identity of nursing is often reinforced through the specific strategies of storytelling, and the use of humour. This is done to normalise what may become difficult or challenging during the coming shift. The undertaking of the handover also strengthens the already formal nested identities amongst the nurses of the clinical units. The handover further aligns the nurses of the particular oncoming shift to become an even more nested group for the following eight hours. The interactions of nurses with other health professionals during their working environments reinforce their salient identity to nursing, whilst still being able to demonstrate appropriate organisational citizenship behaviours.
Self-categorisation

It is significant that handover provides a particular forum to stimulate the development of self-categorisation of each individual as a nurse. Handover offers the experienced or senior nurse a forum to almost solely demonstrate or role model the espoused prototype.

What had not been anticipated at the outset of this project were these distinctive findings on handover. The identification of this professional activity as something more than the delivery of clinical communication is possibly intrinsically accepted amongst nurses but not commonly identified in research. This project has quite explicitly outlined this. This phenomenon invites further analysis.

Reflections on the Methodology

The choice of organisational ethnography as the overarching methodology for the study was rewarded by the quality, and originality of the findings. The use of SIT as a theoretical framework for the inquiry gave focus to the design, and outcomes of the study. The case context of acute care was appropriate to the inquiry, and enabled the ethnographic methods to be applied to two core nursing activities; nursing group handover, and the MDM. The findings are limited to the assumptions, and contexts of the research design, yet they are clear, and powerful enough to have implications for further research, practice, policy, and education.

Based on the experience of using this research design I would recommend that other studies be constructed in the same way. I have been struck by the powerful data that emerged from the use of SIT in conjunction with ethnographic methods; the detailed cultural assessment of the construction of nursing identity within the nursing activities would not have been achieved without this combination. The ethnographic framing around two activities highlights the need for similar research to be undertaken with other nursing activities; similarly different case contexts of nursing practice should be studied.

The use of the video-recording as a method was useful to ensure I did not interrupt the activity. It also provided an opportunity to observe the activities repeatedly, and gave rise to the unusual opportunity of the participants themselves participating in participant observations.

Implications

The overall implications of this research is to generate further knowledge, and that there are many questions still to be answered around professional identity, and nursing. It has been demonstrated in this project that SIT was a useful theory to study professional identity within
the case environment of the nursing activities that were studied. The findings of this research project have significant implications for future policy development, education, research, and practice for nursing.

The significance of nursing to our healthcare environments cannot be underestimated, and therefore clarity of who we are, and what we do must be understood firstly by nurses themselves. Nurses, and midwives make up 63% of all health care professionals (AIHW, 2012, p. 501). We are the largest, and most diverse of all healthcare professionals in our practices, and contexts. Yet there is limited research into how the professional identity of nurses is developed, and sustained in the working context. This research has sought to contribute to the body of knowledge on nurses’ professional identity, and the ethnographic hypotheses presented as conclusions in the previous chapter are needed to prompt further debate action, and investigation.

Social interaction is fundamentally important for the construction of professional identity.

The expression of nurse identity is played out in activities where there are interactions with other health professions; this has implications for interprofessional practice. There needs to be opportunities for nurses to present their professional identity. The role of citizenship behaviours in the interactions with other members of the healthcare team has been understudied. This research reveals important social processes that the nurses’ offer to the interprofessional team, policy makers need to promote, and encourage the investigation, and development of these processes. Policy makers need to be conscious citizenship behaviours nurses contribute to the interprofessional team. Policy makers then need to ensure these are sustained, and maintained through enabling systems of work. Undergraduate, and postgraduate education strategies need to include the training, and analysis of the nurses’ work in interprofessional groups, particularly the social processes that express professional identity, and goals, and behaviours that sustain good citizenship. Nurses in practice need to be aware of their contribution to citizenship behaviours, and the recognition of the role they, and their physical spaces play in the social functioning of the group. There is limited nursing research into citizenship behaviours, and their relationship to the expression of professional identity.

In order for professional identity to be constructed, and advanced by members of the profession there needs to be opportunities for nurse to nurse communication, connection, and social expression of their central work foci. There are strong findings about the construction of professional identity from study of the nurse group handovers as revealed in the results chapter (Chapter 5), and discussed (Chapter 6). There were numerous features in nurses to nurse interaction that evidentially sustained, and advanced the construction of nurses’ professional
identity. There was paucity of research that investigated nurse-nurse interactions in relation to nursing acts, and professional identity. The richness of the data, and findings gained from this study create an imperative for investment into researching this domain. Implications for policy arise from the aspects associated with group performance, social identities, and self-categorisation. Policy makers need to be cognisant of the importance of group motivation, group goals, group norms, and group efficacy on group performance. In addition they need to understand the importance of nested, and cross cutting identities, and identity salience to the construction of nurses professional identities. Policy needs to support nurses’ cognitive processes of self-categorisation. Education, and developers of nursing curricular need similar understanding of these constructs, and how they manifest in the context of nursing practice. Nursing educationalists need to find mechanisms to teach, and coach to strengthen the attainment of professional identity.

The investigation of nursing handover as an example of a nursing group activity in relation to SIT revealed a series of intents, and demonstrated behaviour which are important, and central to the construction of nurses’ professional identities. The findings generated new knowledge about nursing practices for their group intent. The handover specifically revealed intent related to social unification, organisation of normative behaviours, reinforcement of team conformity, the volitional control of nursing work. In addition there were intents around reinforcing the salience of collective identity to the nursing group, and achieving a functional nested identity for the oncoming shift. The combination of the social, and physical context provided the stimuli that supported, and sustained professional self-categorisation. In practice the nurses’ demonstrated behaviours such as use of humour, development of group think, storytelling, discursive emphases on the development of we, and team processes that created expectations of social conformity, and practical respect for the experienced members of the team. Research studies into each of the aspects of professional identity need to be undertaken. Policy, and educationalists both need to use the understandings about these social practises to inform policy development, and educational strategy.

For example educationalists would not teach group handover as a forum primarily for clinical communication if they understood the powerful social processes of professional identity construction, and maintenance of this activity. Nor would policy makers consider bed side handover as an appropriate alternative to replace private nurse-nurse group professional interactions for the construction, and expression of nursing in practice.

The results from this study indirectly suggest that the construction, and performance of nursing identity in the workplace occurs after initial academic, and professional preparation. Further
research into this is needed. Research needs to be done into the construction of professional identity within the social setting of the work space. This study has identified the significance SIT can have in revealing identification significant elements that impact on the construction of nurses’ professional identity. Rituals in ethnography are considered important arenas for investigation. Many of the rituals embedded in nursing activity have not been investigated nor are they understood in relation to how they construct, and maintain nurses’ professional identity. Without such investigation the termination of activities that are considered rituals may have long standing negative repercussions on the profession.

The interesting finding from the application of SIT that the structure of communication in nursing handover was strongly hierarchically, and socially organised, while in the MDM the same nurses would flatten the model of professional communication to deliberately share, and create voice for the other professionals. Nursing educationalists should take note of these skills, and social processes, and they need to be taught as a communication technique for nursing intragroup, and also interprofessional activities. Policy makers, and nurses in practice need to notice these social processes more formally, and make them explicit. Further research into other nursing activities in relation to how communication is enacted as an expression of professional identity is needed. It may be that other important models of communication have not yet been uncovered.

As stated previously the goal of normalising the complexities of practice to manage the work is an important social process that happens in nurse-nurse private spaces. The finding that this normalisation process also attunes the skill of patient advocacy to ensure patient centeredness is a significant way of holding the focus of the work while encountering it in the context of the shift. This has implications for policy, practice, and education. The literature is devoid of commentary in relation to the interplay of normalising complexities to manage work, and the socially unreal aspects of patient care. Research is needed into these aspects of professional identity, and professional work.

This project opens up future opportunities to employ SIT in the study of different nursing groups. The scope of this research does not, however, need to be limited to nurses. With the current changes in healthcare environments, and the continuing development of new ways of working within healthcare, understandings in the social dynamic within context of professional nursing groups is possibly particularly contemporary. The focus on interprofessional practice, and the need for health workers to work in teams opens up future possibilities for the findings of this project to be extended.
References


LeCompte, M. D., & Schensul, J. J. (1999a). Analyzing and interpreting ethnographic data. Walnut Creek, Calif.: AltaMira Press.

LeCompte, M. D., & Schensul, J. J. (1999b). The ethnographer's toolkit. Walnut Creek, Calif.: AltaMira Press.


Muehlbauer, P. M. (2012). How can we improve the way the media portrays the nursing profession? *ONS Connect, 27*(12), 21.


Appendices
Appendix A: Demographic Information

Please fill out the questions

Unit/ Ward, and campus where you are currently working:______________________________________________

Age:___________________ Gender:________________________________

1. Please list your initial nursing qualification:_________________________________________

2. Where did you complete your initial nursing registration?
   If Australia, which State:____________________________________________
   If overseas, which Country:____________________________________________

3. What nursing qualifications do you hold, and from which institution? List
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

4. How long have you been nursing? Years _________________________________________

5. What is your current nursing position?___________________________________________

6. List the tasks that you perform within your current nursing role.
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

7. How long have you been in your current nursing position? years/months
8. Which of the following nursing positions exist within your ward/unit:

Please tick
- Graduate Nurses
- Division 2 Nurses
- Clinical Nurse Specialists
- Associate unit Managers
- Clinical Resource Nurses
- Clinical Support Nurses
- Designated Nurse Educator
- Nurse Unit Manager

Other:______________________________________________________________________________

9. Which of the following is used in your ward/unit to organise patient care:

Please tick
- Patient allocation
- Team allocation
- Patient acuity
- Primary nursing

Other:______________________________________________________________________________

10. In one sentence describe:

   a. Nursing

   __________________________________________________________
   __________________________________________________________

   b. Your reasons for becoming a nurse

   __________________________________________________________
   __________________________________________________________

   c. The community perceptions of the nursing profession

   __________________________________________________________
   __________________________________________________________
Appendix B: Focus Groups

Focus Group Questions in relation to Shift Handover

Section 1

5-10 minutes

I will be showing you the video of the handover I recorded. Will be talking about what you see in the video.

Introductory remarks to establish procedure regarding: who speaks, and for how long? Under what circumstances can the speaker be interrupted?

Any ground rules around questioning

Prompt One: What do you think shift handovers are about?

Does the handover have any structure, are their sections to the handover?

Prompt Two: Let’s look at the video of your group handover together. I really want to know which parts of the handover were important or interesting to you. When I fast forward the tape, feel free to call out ‘stop, please’ whenever you find anything you would like to share with your group, and me.

[If no parts of the handover are identified, choose episodes of disagreement, uncertainty, opinion or negotiation. Then say, “There are some spots I need you to help me understand.”]

Show video (30 minutes)

With reference to each episode of the handover selected by the nurses:

1. Why do you think this was important or interesting?
2. What were you doing here?
   - Why did you do that?
   - Why those comments or interactions?
   - Have you used them before?
   - Did anyone say anything that was particularly helpful?

After the video (20 minutes)

Prompt Three: Were there any parts of this shift handover that you think were unnecessary or unhelpful for you? If so, what were they?

Prompt Four: Why (were these parts of the shift handover unhelpful)? What would have made the shift handover better for you?

Prompt Five: What are the things you would do differently?

Prompt Six: Do you remember if there were any parts of this handover that had an effect on your actions during the shift?
Prompt Seven: Considering the shift handover as a whole – is the shift handover something that is important to you or not? Can you tell me a little more about that?

Section 2

Focus Group Questions in relation to organisation of work - Professional community

2 Participants Separately (20-30 minutes)

This section will start with individuals, and a card session. All the names of the ward nursing staff will be presented on cards, and the participant will be asked to sort the cards into groups. (researcher will photograph these cards). The researcher will then ask the individual to explain the different groups, and the individuals within the groups. This will be done with a number of the focus group participants. Some of the key concepts from this will be:

How is your daily work organised within the nursing team?

1. What are the groups that you form to make sure patient care is safe, and timely
2. Who are the nurses that you would go to or go to you?
3. Who comes to you for what advice?
4. Who do you go to for advice?
5. If a patient declines who do you go to for assistance?
6. Are there people you are comfortable working with? Can you explain why?
7. Are there people you are uncomfortable working with? Can you explain why?
8. What are the responsibilities of each member of the team on any particular shift?
9. Do they take those responsibilities or does someone else often take this responsibility?
Appendix C: Individual Nurse Interview: After Handover

Section 1, Introduction – Thank you for agreeing to talk to me about the shift handover. The questions I’m going to ask you are to help me to understand the handover from your perspective.

Prompt One: What do you think the handover was about?
What can you tell me about the interactions of each member in the handover?

Prompt Two: Now, let’s look at the video of the handover together. I would like you to tell me what are the things that were interesting or important to you. You can use these buttons to pause, and fast forward the video. Do you understand how to do it? You can fast forward the video, stop at any points you would like to share with me, and play them at normal speed. OK?

Section 2, Stimulated Recall Questions

1. Why do you think this was important or interesting?
2. What were you doing here? OR/ Could you describe what's happening in this scene or segment?
3. Follow up the nurse's response as appropriate by probing further on the following:
   - Why did you/they do that?
   - Why those things?
   - Have you or your group interacted like this before?
   - Tell me more about that.
4. Did anyone say anything that was particularly helpful to you?
5. What were you thinking at this point?
6. What do you hope to achieve from what you were doing here?
7. What was your contribution to the group handover at this point?
8. How did you find participating in shift handovers?

Section 3, Stimulated Recall Questions about episodes chosen by the researcher

Prompt Three: After they've had a go, if time permits (particularly if the nurse did not choose much to comment upon): There are some spots that I need you to help me understand. Fast forward to these segments, and ask questions 1-8 above as appropriate.
With reference to each episode of the handover selected by the nurse:

Section 4, Debrief-type Questions

**Prompt Four:** What did you understand after this shift handover that you did not understand before the shift handover?

**Prompt Five:** Were there any parts of the handover that you think were unnecessary or unhelpful to you? If so, what were they? Why (did you find these parts of the handover unnecessary or unhelpful)? What would have made the handover better for you?

**Prompt Six:** Is there anything that you found difficult for you to understand? If so, what is it? What will you do to resolve this difficulty? Is there anything that affects how you understand the talk that goes on during the shift handover?

**Prompt Seven:** Considering the shift handover as a whole, was it about something that was important to you or not?
Appendix D: Individual Nurse Interview: After MDM

Section 1, Introduction – Thank you for agreeing to talk to me about the multidisciplinary team meeting. The questions I’m going to ask you are to help me to understand the team meeting from your perspective.

Prompt One: What do you think the multidisciplinary team meeting was about? What can you tell me about the interactions of each member in the multidisciplinary team meeting?

Section 2, Stimulated Recall Questions about episodes chosen by the nurse

With reference to each episode of the multidisciplinary team meeting selected by the nurse:

Prompt Two: Now, let’s look at the video of the multidisciplinary team meeting together. I would like you to tell me what are the things that were interesting or important to you. You can use these buttons to pause, and fast forward the video. Do you understand how to do it? You can fast forward the video, stop at any points you would like to share with me, and play them at normal speed. OK?

1. Why do you think this was important or interesting?
2. What were you doing here? OR/ Could you describe what’s happening in this scene or segment?
3. Follow up the nurse’s response as appropriate by probing further on the following:
4. Why did you/they do that?
5. Why those things?
6. Have you or your group interacted like this before?
7. Tell me more about that.
8. Did anyone say anything that was particularly helpful to you?
9. What were you thinking at this point?
10. What do you hope to achieve from what you were doing here?
11. What was your contribution to the multidisciplinary team meeting at this point?
12. How did you find participating in multidisciplinary team meeting?
Section 3, Stimulated Recall Questions about episodes chosen by the researcher

**Prompt Three:** After they’ve had a go, if time permits (particularly if the nurse did not choose much to comment upon): There are some spots that I need you to help me understand. Fast forward to these segments, and ask questions 1-8 above as appropriate

Section 4, Debrief-type Questions

**Prompt Four:** What did you understand after this multidisciplinary team meeting that you did not understand before the multidisciplinary team meeting?

**Prompt Five:** Were there any parts of the multidisciplinary team meeting that you think were unnecessary or unhelpful to you? If so, what were they? Why (did you find these parts of the multidisciplinary team meeting unnecessary or unhelpful)? What would have made the handover better for you?

**Prompt Six:** Is there anything that you found difficult for you to understand? If so, what is it? What will you do to resolve this difficulty?

Is there anything that affects how you understand the talk that goes on during the multidisciplinary team meeting?

**Prompt Seven:** Considering the multidisciplinary team meeting as a whole, was it about something that was important to you or not?
Appendix E: Plain Language Statement

Professor David Clarke (supervisor)
Education Faculty Melbourne University

Ms Georgina Willetts (Doctoral student)
ph. 98953415

Project: “How do nurses through their social interactions with their peers (other nurses) illustrate, and shape (perform) their professional identity?”

Introduction

Your name, and contact details has been given to me by your line manager as an appropriate participant for the above research project. I would therefore like to invite you to participate in this research project. The aim of the study is to identify, and understand the social identity of the professional nurse as it is constructed by nurses within a specific context/environment. This project has been approved by the Human Research Ethics Committee.

What will I be asked to do?

Should you agree to participate, data will be collected through:

- An initial questionnaire
- Observation, and Video recording of your handover activities, and involvement in multidisciplinary meetings
- Interviews. With your permission, the interview would be tape-recorded so that I can ensure that I make an accurate record of what you say. When the tape has been transcribed, you will be provided with a copy of the transcript, so that you can verify that the information is correct, and/or request deletions

There are a number of nurses being invited to participate in this study taking place across two sites within Eastern Health. As a participant you may be asked to participate in any one or a combination of the above activities. It is anticipated that the time commitment of any one participant will not exceed in total 4 hours over the entire research period.

How will my confidentiality be protected?

It is intended that your anonymity, and the confidentiality of your responses will be protected to the fullest possible extent, within the limits of the law. Your name, and contact details will be kept in a separate, password-protected computer file from any data that you supply. This will only be able to be linked to your responses by the researcher, for example, in order to know where I should send your interview transcript for checking. In the final report, you will be referred to by a pseudonym. I will remove any references to personal information that might allow someone to guess your identity; however, you should note that as the number of people I seek to interview is very small, it is possible that someone may still be able to identify you. The data will be kept securely for five years from the date of publication, before being destroyed.

How will I receive feedback?
Once the thesis arising from this research has been completed, a brief summary of the findings will be available to you on application at the Faculty of Education Melbourne University. It is also possible that the results will be presented at academic conferences.

**Will participation prejudice me in any way?**

Please be advised that your participation in this study is completely voluntary. Should you wish to withdraw at any stage, or to withdraw any unprocessed data you have supplied, you are free to do so without prejudice. Your decision to participate or not, or to withdraw, will be completely independent of your work within Eastern Health, and I would like to assure you that it will have no effect on your role as a nurse.

**Where can I get further information?**

Should you require any further information, or have any concerns, please do not hesitate to contact the researcher on the number given above. Should you have any concerns about the conduct of the project, you are welcome to contact the Executive Officer, Human Research Ethics, The University of Melbourne, on ph: 8344 2073, or fax: 9347 6739. Or you may receive further information from the Eastern Health ethics committee chairperson.

**How do I agree to participate?**

If you would like to participate, please indicate that you have read, and understood this information by signing the accompanying consent form, and returning it in the envelope provided. The researchers will then contact you to arrange a mutually convenient time for you to complete the questionnaire, and interview.
Appendix F: Consent Form

Faculty of Education

Consent form for persons participating in the research project 0830276.1

How do nurses through their social interactions with their peers (other nurses) illustrate, and shape (perform) their professional identity?

Name of participant:

Name of investigator(s): Georgina Willetts (Researcher); Professor David Clarke (supervisor)

1. I consent to participate in this project, the details of which have been explained to me, and I have been provided with a written plain language statement to keep.

2. I understand that this research project is being conducted by Georgina Willetts Manager of the Practice Development Unit Box Hill Hospital.

3. I understand that my participation will involve video recording, observation, and interview, and I agree that the researcher may use the results as described in the plain language statement.

4. I acknowledge that:
   (a) the possible effects of participating in the video recording, observation, and interview have been explained to my satisfaction;
   (b) I have been informed that I am free to withdraw from the project at any time without explanation or prejudice, and to withdraw any unprocessed data I have provided;
   (c) the project is for the purpose of research;
   (d) I have been informed that the confidentiality of the information I provide will be safeguarded subject to any legal requirements;
   (e) I have been informed that with my consent the interview will be audio-taped, and I understand that audio-tapes will be stored at University of Melbourne, and will be destroyed after five years;
   (f) I have been informed that with my consent the handover will be video-taped, and I understand that audio-tapes will be stored at University of Melbourne, and will be destroyed after five years;
   (g) my name will be referred to by a pseudonym in any publications arising from the research;
   (h) I have been informed that a copy of the research findings will be forwarded to me, should I agree to this.

   I consent to this interview being audio-taped □ yes □ no □ n/a

   (please tick)

   I consent to this handover being video-taped □ yes □ no □ n/a

   (please tick)

   I wish to receive a copy of the summary project report on research findings □ yes □ no

   (please tick)

Participant signature: ________________________________ Date: ________________________________

HREC: 0830276.1
Created on 4/17/2009
consentform from Melb Uni.doc