The Role of Communities of Practice for Registered Nurses in Specialized Practice

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Abstract

Purpose: The purpose of this qualitative study was to explore nursing specific processes associated with communities of practice (CoPs) in specialized acute care settings with a focus on their potential role in Registered Nurse (RN) integration and professional development. The following research questions were formulated to support the achievement of this purpose: (a) What are the key features, roles, and processes of a community of practice (CoP) in specialized acute care nursing practice settings?; (b) What are the social processes that are integral to the integration of RNs into their chosen specialized acute care nursing practice settings; (c) What role, if any, do CoPs serve in the integration process of RNs into their chosen specialized acute care nursing practice settings?

Research Design: This research was conducted using a constructivist grounded theory approach.

Sample/Setting: The Canadian Nurses Association (CNA) has designated 20 areas as specialties, examples of which include Cardiovascular Nursing, Emergency Nursing, Neuroscience Nursing, Perinatal Nursing, Perioperative Nursing, and Oncology Nursing. From these 20 CNA designations, three specialized areas were chosen for this study. To safeguard the confidentiality of study participants, the units are identified only as A, B, and C. These nursing units were situated within the same urban tertiary institution in a mid-sized Western Canadian city. In total, 19 RNs employed in specialized care units participated in this research.

Methods/Procedure: The study was conducted from March 2012 through September 2013 following ethical and operational approval from all required institutions. During this 18-month period, 19 RN participants were engaged in a total of 25 interviews and several participants were invited to submit personal reflective journals, with 8 sets of journals submitted and included as part of the study data. Following transcription, the interviews as well as the journal entries were entered into the ATLAS.ti software program to aid with organization of study coding. Data

analysis was completed following the constructivist grounded theory approach of Charmaz (2006).

Findings: Key findings from this research included the identification of competence in the specialized RN role as a main concern for participants. The achievement of competence was influenced by two Basic Social Processes (BSPs) relating to the transition and integration of new RNs into their specialized environments. For each of these BSPs, there are additional phases that further define the experience. *Developing a Sense of Specialized RN Self* (transition) included the phases Finding RN Fit, Sharing Passion and Community Values, and Embracing Life-Long Learning. *Integrating into Specialized RN Practice* (integration) included the phases Learning the Ropes and Settling In. The social context for this development was a CoP in each specialized unit and the particular aspects of these nursing community groups were also uncovered during the course of this research and are detailed in the study findings.

Conclusions: These research results have highlighted the importance of delineating the fundamental differences in the processes of RN transition and integration. The findings have also provided a foundation for a newly emerging consideration of CoPs in nursing and their potential role in supporting the transition and integration of RNs. Knowing more about how CoPs function in their workplaces may allow RNs, either newly graduated or new to their specialty areas, to be more successful in their own transition and integration experiences.

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To begin I would like to acknowledge the support and wisdom of my supervisor, Dr. Linda Ferguson. Mine was a complicated journey, as perhaps many doctoral pursuits are, but Dr. Ferguson's support was a key constant in the years that resulted in this effort and I am exceedingly grateful for her guidance in seeing this to completion. My thanks also to my committee members, initially Dr. R. Thomas-MacLean, Dr. L. Racine, and Dr. J. Anonson. Following the completion of my comprehensive exams Dr. R Schwier graciously joined this committee in place of Dr. Thomas-MacLean. I have greatly appreciated the diverse expertise of my committee members and their ongoing support and guidance. Having an opportunity to work through this process with my supervisor and committee members I feel extremely proud of the final document that has been produced.

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Last, but certainly not least, I would like to thank each and every RN who participated in this research as well as the Saskatoon Health Region for supporting this study. It has been a great honour in my life to be a RN, but it is a demanding career choice. Despite the intensity of their specialized practice, the participants in this research invested a great deal of time and energy to add their voices to this exploration. Without their dedicated participation this research would not have been successful and working with these RNs has reinforced my own commitment to the profession of registered nursing.

Dedication

For the three men in my life who freely admitted me to their boys club and who colour my world with a riot of love and laughter...

~ my husband Derek who already knows everything I want to express here that there are no adequate words for and will understand when I simply say ‘because reasons’

~ and my sons Isaac and Samuel for whom this dedication is partially about ensuring that the word Batman appears in this dissertation, but more importantly allows me to tell them that they are now, and will always be, my own personal superheroes.

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Chapter One

In this chapter an overview of the author's doctoral research is provided including an introduction to the community of practice concept. The specific problem statement, purpose of the research, and the research questions are included as well as a review of the significance of the study and the assumptions pertinent to the research process. The chapter concludes with a review of the key terminology used in the research.

1.1 Study Overview

Much of the professional development of registered nurses (RNs) occurs within the specific contexts in which they practice. When that context is an acute care specialized nursing environment new nurses, especially graduate nurses, can become overwhelmed leading to feelings of inadequacy and disillusionment (Valdez, 2008). There is an established body of research on the issue of transition or culture shock for nurses integrating into acute care practice (Bowles & Candela, 2005; Chernomas, Care, McKenzie, Guse, & Currie, 2010; Duchscher, 2009; Harwood, 2011; Kramer, 1974; Rush, Adamack, Gordon, Lilly, & Janke, 2013; Valdez, 2008; Walker, Earl, Costa, & Cuddihy, 2013) including the high costs associated with nursing turnover (De Gieter, Hofmans, & Pepermans, 2011; Hayes et al., 2012; Li & Jones, 2013).

While there are established financial implications associated with nurse turnover, recent research is beginning to show that care quality and patient safety can also be affected (Li & Jones, 2013). As noted by Li and Jones (2013), Canadian nurse turnover rates of approximately 20% not only cost health-care organizations millions of dollars but there is a potential loss of productivity as well as the loss of "the intellectual capital of nurses who leave" (p. 406). The issue of RN integration and the successful development of acute care nursing practitioners, including those in demanding specialized care areas, remains an urgent concern for the nursing profession and all those it serves.

The specialized acute care communities that RNs enter can function as conduits for the sharing of tacit knowledge and the support of new members transitioning into these practice areas. The term community of practice (CoP) is often applied to such groups and they can serve as key learning and support resources for RNs. A CoP may be particularly useful for nurses engaged in areas of specialized practice where learning and care demands can be intense and potentially overwhelming. The purpose of this constructivist grounded theory study was to explore nursing specific processes associated with CoPs in specialized acute care settings with a focus on their potential role in RN integration and professional development.

For this study, specialized nursing practice was considered to be those areas where RNs are required to complete further training and possible certification beyond the generalized foci of their undergraduate education. The Canadian Nurses Association (CNA) has designated 20 such areas as specialties, examples of which include Cardiovascular Nursing, Emergency Nursing, Community Health Nursing, Neuroscience Nursing, Perinatal Nursing, Perioperative Nursing, and Oncology Nursing. From these 20 CNA specialist designations, three areas were chosen for this study. To safeguard the confidentiality of study participants the units are referred to only as A, B, and C. These nursing units were situated within the same urban tertiary institution, Royal University Hospital (RUH), located in Saskatoon, Saskatchewan, a mid-sized Western Canadian city.

The study was conducted from March 2012 through September 2013 following ethical approval from the Saskatchewan Behavioural Research Ethics Board and operational approval from the local health region. During this 18-month period, 19 RN participants were engaged in a total of 25 interviews; 12 participants were also invited to submit personal reflective journals, with 8 sets of journals submitted and included as part of the study data. Key findings from this research included the identification of competence in the specialized RN role as a main concern

for participants. The achievement of competence was influenced by two Basic Social Processes (BSPs) relating to the transition and integration of new RNs into their specialized environments. The social context for this development was a CoP in each specialized unit and the particular aspects of these nursing community groups were also uncovered during the course of this research and are detailed in the study findings.

1.2 Background: Communities of Practice (CoPs)

The CoP concept has become progressively more popular since its inception by Lave and Wenger (1991) more than 20 years ago. At the time, CoP was only one component of the authors' larger exploration of situated learning theory. With a specific focus on apprenticeship, Lave and Wenger examined learning that occurs, or is 'situated', within work practices. In conjunction with their concept of "legitimate peripheral participation" (LPP), the authors explored how individuals learn by becoming increasingly more committed and involved members of specific CoPs. LPP was a key characteristic of Lave and Wenger's (1991) early work detailing how "a person's intentions to learn are engaged and the meaning of learning is configured through the process of becoming a full participant in a sociocultural practice. This social process includes, indeed it subsumes, the learning of knowledgeable skills" (p. 29). The authors posited that through LPP, new practitioners could create relationships with existing community members and "move toward full participation in the sociocultural practices of a community" (Lave & Wenger, 1991, p. 29). CoPs were another key element in this exploration of situated learning.

Following the work of his partnership with Lave, Wenger (1998) further developed the CoP concept, alone and in other collaborations (Wenger, McDermott, & Snyder, 2002). More recently, he has defined a CoP as "groups of people who share a concern, a set of problems, or passion about a topic, and who deepen their knowledge and expertise in this area by interacting

on an ongoing basis" (Wenger et al., 2002, p. 4). As Wenger further developed the CoP concept, it began to be used and researched in a number of disciplines such as nursing (Andrew, Ferguson, & McGuinness, 2008a), education (Jawitz, 2009; Warhurst, 2008), and business (Nagy & Burch, 2009; Scarso, Bolisani, & Salvador, 2009). It has also been used to explore the delivery of health care services (Chandler & Fry, 2009; Fung-Kee-Fung et al., 2008) and the uptake of evidence based practice in health disciplines (Barwick, Peters, & Boydell, 2009; Booth, Tolson, Hotchkiss, & Schofield, 2007). As will be detailed in Chapter Two, a multi-disciplinary review of the CoP research literature in the last five years revealed a substantial increase in publications on the concept in diverse fields. Nursing is no exception to this recent CoP publication trend; however, facets of the CoP concept have been represented in nursing literature beginning with the work of Cope (2000), who examined situated learning in clinical education.

The first substantial discussion of the specific CoP concept in nursing can be credited to Andrew, Tolson, and Ferguson (2008b). In their work, *Building on Wenger: Communities of Practice in Nursing,* the authors examined the CoP concept as a means of supporting professional collaboration to enhance knowledge development and translation (Andrew et al., 2008b). "A CoP can provide a platform for collaborative workplace learning, leading to practice development and the creation, management and dissemination of new knowledge" (Andrew et al., 2008b, p. 247). The authors proposed that CoPs could be used to facilitate collaboration, and knowledge exchange, between academics and practitioners to improve working and learning environments for nurses (Andrew et al., 2008b). This team expanded upon their early proposal for CoP use, along with others based in the United Kingdom, and produced additional articles and research publications featuring the concept (Andrew & Ferguson, 2008; Andrew, Ferguson, Wilkie, Corcoran, & Simpson, 2009; Tolson, Booth, & Lowndes, 2008; Tolson, Lowndes, Booth, Schofield, & Wales, 2011). Their work continued to reflect the value of CoPs in enriching

professional practice (Tolson et al., 2011). “This is achieved through learning mediated by social interaction that is situated in the practitioners’ work context. This produces knowledge for practice and practice change, which is a blend of culture, context, and activity that is embedded in practice” (Tolson et al., 2011, p. 171). It is precisely this kind of knowledge exchange and ongoing professional development in nursing practice that is of interest in this study.

Other nursing researchers have also explored the CoP concept in their work; however of the 40 nursing CoP articles examined in the literature review for this study, only half were research articles. Those studies represented work regarding the use of CoPs in nursing education, practice, and the nursing academy. There is a large amount of exploratory, CoP program evaluation, and general conceptual discussion publications in the collected body of CoP nursing literature. This situation seems indicative of the concept’s developmental state in nursing. Although nursing is increasingly represented in an expanding body of CoP work, questions remain about the discipline specific nature and operationalization of this concept in a Canadian nursing context.

1.3 Statement of the Problem

There are unabated global concerns regarding nursing shortages and the myriad of issues associated with an inability to successfully manage predicted future scarcities (Deschamps, 2013; Gillen, 2014; McMenamin, 2014; Myer & Amendolair, 2014). There are now renewed calls in the United States to heed warning signs regarding a potential “tsunami of retirements” (McMenamin, 2014, p. 9). The CNA has also predicted that Canada could face RN shortages of up to 60,000 full-time equivalent positions by 2022 (Canadian Nurses Association, 2009). The issue of potential RN shortages seems compounded when ongoing challenges regarding successful transition and retention of RNs are considered. As has previously been noted, the concern is not simply having enough nursing graduates to fill predicted vacancies, but improving on current rates of retaining and successfully integrating these nurses into practice (Bowles &

Candela, 2005; Chernomas et al., 2010; Duchscher, 2009; Harwood, 2011; Lavoie-Tremblay et al., 2010; Rush et al., 2013; Valdez, 2008; Walker et al., 2013). The inadequate distribution of nurses is another factor that could be considered as contributing to potential shortages in rural, remote, and specialty areas. A better understanding of the processes associated with RNs arriving in, and successfully navigating, acute care practice settings may provide additional insight into managing nursing turnover challenges.

The nursing profession is a knowledge intensive, fast-paced, ever-evolving entity that demands nothing less than life-long learning from its members. Very few years in a professional nursing career are spent in a formal education setting. The majority of learning in the career of a RN is done in the very professional networks, through a variety of social interactions and collaborations increasingly featured in CoP study. A deeper understanding of the creation and sharing of tacit knowledge in the practice setting could prove most valuable in creating and maintaining enriching environments for nurses to learn and work in. An improved understanding of nursing CoPs could also provide further information on the integration of new members into a community. Lave and Wenger (1991) examined not only situated learning in workplaces, but the transition of apprentices into a CoP. Much more remains to be discovered about the professional journey of RN integration and the specific processes nurses engage in during the successful development of their needed specialized practice knowledge.

1.4 Statement of Purpose and Research Questions

The purpose of this constructivist grounded theory study was to explore nursing specific processes associated with CoPs in specialized acute care settings with a focus on their potential role in RN integration and professional development. The following research questions were formulated to support the achievement of this purpose.

1) What are the key features, roles, and processes of a CoP in specialized acute care

nursing practice settings?

2) What are the social processes that are integral to the integration of RNs into their chosen specialized acute care nursing practice settings?
3) What role, if any, do CoPs serve in the integration process of RNs into their chosen specialized acute care nursing practice settings?

It was hoped the findings from this constructivist grounded theory study would contribute to the development of a substantive CoP theory for specialized acute-care nursing practice.

1.5 Assumptions and Research Considerations

There were two primary assumptions made by the researcher in regards to this study. The first of these was that CoPs, in some form, were present in specialized acute care nursing practice settings. Wenger (1998) has asserted that "communities of practice are everywhere" (p. 6). While the researcher concurred with this basic assumption, it seemed there was much less clarity regarding the specific form and function of nursing specific CoPs.

The second assumption was an acknowledgement that CoPs are not inherently positive entities. While there is research supporting the positive influence of CoPs, it did not follow, in the opinion of the researcher, that all CoPs would function in this manner. Again, Wenger himself has noted that CoPs can potentially have a negative influence on members and organizations (Wenger et al., 2002).

Finally, with respect to nursing science, the researcher has considered the issue of the CoP concept originating from outside of the nursing discipline. McEwen and Wills (2007) have noted debate regarding the use of borrowed theory in nursing persists back to the 1960s. During this time there has been engagement from nursing scholars on both sides of the argument. There are many nursing scientists that have promoted the exclusive use of nursing theories in advancing nursing knowledge (Barrett, 2002; Cody, 2000; Fawcett, 1999; Parse, 1999); while others have

promoted the use of theory from outside nursing as a more inclusive view of nursing science and a more diverse means of advancing nursing knowledge (Carper, 1978; Giuliano, Tyer-Viola, & Lopez, 2005; Moore, 1990; Rawnsley, 2003). There was consensus, from both sides of this issue, that nursing did require a unique body of knowledge, and the role of nursing theory in providing the foundation of that unique knowledge was acknowledged (Peterson, 2009). McEwen and Wills (2007) have echoed this sentiment asserting that nursing does incorporate theories and concepts shared with other disciplines. The authors have issued a caution about the appropriate use of such concepts however, reminding researchers that "emphasis should be placed on redefining and synthesizing the concepts and theories according to a nursing perspective (Cull-Wilby & Pepin, 1987; Levine, 1995)" (McEwen & Wills, 2007, p. 42). There is further consideration of this caveat in the chapters that follow.

1.6 Rationale and Significance

The use of the CoP concept is gaining momentum both in nursing and other health science literature (Ranmuthugala et al., 2010); a trend that is perhaps supported by the previously noted declaration from Wenger (1998) that "communities of practice are everywhere" (p. 6). While this assertion could be considered to encompass nursing as well, little appears to be known about the form and functional processes associated with communities specific to the nursing discipline. This research could assist in providing an ontological and epistemological foundation for further CoP study in nursing and give voice to the nursing specific experience that is a CoP. Of what value might this CoP exploration and any resultant theory development be? It is both an ethical and regulatory requirement that RNs remain engaged in the process of learning throughout their professional careers in order to keep pace with the challenges of an ever-evolving healthcare landscape (Canadian Nurses Association, 2008; Saskatchewan Registered Nurses Association, 2007).

With this requirement for continual development well established, exploring means to better support the life-long and workplace learning critical to the professional growth of nurses is of value. There is, however, much more to understand about the specific processes of social learning and the social and professional contexts, or CoPs, in which much of this learning occurs. Examining learning in the workplace was at the heart of Lave and Wenger's initial work on situated learning and in the development of the CoP concept. Returning to the idea that a CoP can function as a hub for both acquiring and creating knowledge, further research into how this concept might influence the dissemination and uptake of new nursing knowledge could be valuable.

In a recent systematic literature review of the use of communities in practice in healthcare, Ranmuthugala et al. (2010) found there was not enough amassed data to support a systematic evaluation of the effectiveness of CoPs in healthcare organizations. "It is necessary to study CoPs in greater depth with the aim of understanding how CoPs contribute to improved performance in health care (if they do), and to identify the conditions or contexts required for CoPs to make health care more effective" (Ranmuthugala et al., 2010, p. vi). Nursing practice is a pervasive feature of any healthcare landscape, and nurses should continue to be leaders in terms of organizational change, knowledge development, and patient care and safety. Exploring the CoP concept within the nursing context with the express purpose of identifying such conditions and processes is a necessary step for strengthening nursing CoPs with the hopes of benefitting nurses, their organizations, and those in their care.

1.7 Definition of Key Terminology

Community of Practice: "groups of people who share a concern, a set of problems, or passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis" (Wenger et al., 2002, p. 4).

Concept: "a labeled phenomenon or set of phenomena is a concept, and a concept could be operationalized further and is more amenable to be translated into a research tool" (Meleis, 2012, p. 26). Although Wenger (1998) described his CoP development as a social theory of learning, for the purposes of this research it seems more appropriate to identify the CoP phenomenon as a concept. Wenger (1998) himself stated "when I use the concept of 'community of practice'…I really use it as a point of entry into a broader conceptual framework of which it is a constitutive element" (p. 5). Although others, as featured in the literature review for this study, have characterized a CoP as a theoretical framework or theory, it is the opinion of this researcher that these classifications are not warranted.

Specialized Nursing Practice: The Canadian Nurses Association (CNA) has designated 20 specialties in which RNs can pursue further certification. The nursing areas chosen for this study are included in this list of practice areas and for the purpose of this research specialized nursing practice refers to those areas designated as such by the CNA.

Chapter Two

2.1 Literature Review

This chapter includes the results of the literature review conducted to support this doctoral research. A discussion of the literary search techniques employed to collect the data is included, followed by a review of both the qualitative and quantitative nursing CoP research as well as a synthesis of relevant findings. A brief review of the non-research nursing CoP literature is also featured prior to a presentation of the implications of the review in relation to future nursing CoP research.

2.1.1 Introduction

A considerable amount of literature has been amassed on the CoP concept since its introduction by Lave and Wenger (1991) more than two decades ago. A January 2014 search for *community of practice* and *communities of practice* in the comprehensive Web of Science database returned 1846 article entries on the topic, not limited by publication year or language. The most heavily represented disciplines comprising this body of literature, as identified by the Web of Science citation tracking tool, were education, business economics, health care sciences, psychology, and computer science. Healthcare sciences had not featured in this top five ranking list as recently as August 2013, when it was reported in sixth position with 75 categorized articles; a few months later, it appeared in third position with 252 articles. Nursing has made similar publication progress in this database, moving from sixteenth in the 2013 search with 34 CoP articles, to position eleven with 70 articles in this 2014 report. These publication rates are one indicator of the ongoing exploration and pursuit of the use of the CoP concept in healthcare science in general, and nursing specifically. Citation tracking can be a valuable tool in quickly monitoring disciplinary participation in a research topic over time. For the purposes of this research a more extensive and in-depth literature review was also conducted.

There is debate regarding the purpose and timing of a literature review for researchers engaged in grounded theory study, as was employed in this research (Charmaz, 2006; Glaser, 1978). In their seminal work on the methodology, Glaser and Strauss (1967) prescribed that a literature review only be undertaken after the data analysis was complete. This was an attempt to avoid arming researchers with preconceived notions that could potentially subvert the grounded theory process thereby devaluing the directiveness of the data. This stance however has been a point of contention for critics of grounded theory methodology (GTM) and both Strauss and Corbin (1990) and Glaser (1978) softened this position slightly in subsequent work. However, in 1992 Glaser renewed his advocacy of remaining as free from extant theory as possible.

For the purpose of this constructivist grounded theory research, the guidance of Charmaz was sought in relation to literature review. Charmaz (2006) has provided a practical view of the use of literature in GTM. Charmaz does not support the avoidance of a thorough literature review prior to conducting a grounded theory study. In fact the theorist has noted that for graduate students a thorough literature review is a commonly expected dissertation element (Charmaz, 2006). Charmaz has observed that researchers may also need to conduct literature reviews to meet grant requirements, or will have developed extensive subject knowledge as the result of years of study. The theorist has stated skillfulness in managing an extensive literature review "is to use it without letting it stifle your creativity or strangle your theory" (Charmaz, 2006, p. 166). With this direction from Charmaz in mind, an initial literature review was conducted in relation to this study with a plan to return to the literature as needed in the theoretical coding process. The primary objective in completing this literature review was to provide a context relevant for further exploration of CoPs in nursing: to achieve an understanding of how the concept has developed during the last two decades and to determine potential gaps in existing CoP research.

2.1.2 Literary Search Techniques Employed

A review was undertaken to examine CoP literature with a specific focus on nursing science. Several criteria were employed in framing the search parameters for the review as follows: a) peer reviewed article publications; b) English language; c) publication years from 1991 to present; d) community, or communities, of practice featured as the central focus of the study or publication. For the purposes of this review, in order to have an opportunity to examine the full scope of CoP writing, both research papers and other publications types were included.

The first phase of the search was conducted between September and December 2011, with ongoing search alerts established for all relevant databases to alert the researcher of further publications as the study progressed. The search alerts were useful in cueing a return to the literature as new relevant studies emerged during the course of the research study.

Beginning with the year of the origination of the concept by Lave and Wenger in 1991, the following databases were searched for all variations of CoPs: CINAHL, Web of Science (multidisciplinary content from 10, 000 journals worldwide), EMBASE, and MEDLINE. Further key words eventually included “nursing” and “nursing practice”, although in this initial comprehensive search, no disciplines were excluded. A large number of articles were retrieved utilizing these parameters.

2.1.3 Review of the Research Literature

In all, 300 articles were initially printed, categorized by discipline, and reviewed. The Web of Science citation tracking discussed previously, revealed the CoP concept had been taken up by numerous disciplines. CoP work has been heavily featured in education, from elementary (Levine, 2011; Mortier, Hunt, Leroy, Van de Putte, & Van Hove, 2010; Parker, Patton, Madden, & Sinclair, 2010) through to higher education publications (Hodge et al., 2011; Hung & Yuen, 2010; Jawitz, 2009; Schwier & Daniel, 2008) as well as in the technology and computer science

fields (Gammelgaard, 2010; Tang & Yang, 2005). In addition, emerging from a wide-range of disciplines, there is a further body of work addressing specific CoP components often highlighting how to create or sustain such groups (Lee & Valderrama, 2003; Vestal, 2006; Zboralski, 2009), as well as several conceptual critiques (Bentley, Browman, & Poole, 2010; Contu & Willmott, 2003; Fox, 2000; Roberts, 2006). Finally, there are articles, again from several disciplines, that focus on situated or social theories of learning as they pertain to the CoP concept (Handley, Sturdy, Fincham, & Clark, 2006; Reed et al., 2010; Yakhlef, 2010). For the purposes of this doctoral study, nursing-focused CoP literature and Canadian nursing research in particular was obtained and reviewed.

There were 40 nursing specific CoP articles within the initial group of 300 articles, or approximately 13% of the publications, that were examined in further depth. Of these, 20 were research articles and the remaining 20 were publications such as concept analyses, program evaluations, and other more anecdotal opinion pieces regarding the concept. This non-research literature grouping will be discussed prior to the conclusion of this review, along with the contributions of three systematic reviews on CoPs that have been completed in the last several years (Fung-Kee-Fung et al., 2009; Li et al., 2009b; Ranmuthugala et al., 2010).

The nursing specific CoP research papers that were retrieved are summarized in Table 2.1 (Appendix A), detailing the study authors, year of publication, country of origin, study purpose, sample, study design, variables or instrument use, and study findings.

2.1.3.1 Study characteristics. When Li et al. (2009b) completed their systematic review of the CoP concept in healthcare and business, they found that the majority of research being conducted was qualitative in nature. This methodological trend was confirmed in a more recent systematic review completed by Ranmuthugala et al. (2010) who focused solely on CoP use in healthcare fields. These findings are also consistent with this review of nursing specific CoP

research; of the 20 research articles, 16 studies featured qualitative methodologies (noting that a singular study is represented in three publications), while there were only three quantitative studies. There was also a single mixed methods research publication included in this grouping that incorporated both qualitative and quantitative elements. Several countries were represented in this publication grouping, with Australia and the United Kingdom the most frequent. There were only three Canadian studies.

2.1.3.2 Qualitative CoP study design and methodological congruence. While a mix of qualitative methodologies were noted in this body of research, most focused on naturalistic inquiry through the use of case study, ethnography, and phenomenology. The primary data collection method for most of these reviewed studies was semi-structured interviews. The researchers typically detailed how their data was organized into thematic groupings as well as identifying any specific supports which aided their analysis. Further discussion regarding the design, sampling, data collection, and analysis in several of these studies follows.

Sandelowksi (1993) has cautioned the demonstration of rigour in qualitative research should not include a harsh and inflexible application of positivistic ideals, but rather a comprehensive and decidedly transparent look at the research process in question so the that the trustworthiness of its outcomes is beyond question (p. 1). Authors must be clear about the methodological foundations of their work and include sufficient detail and explanation for methodological and study design choices to ultimately support the value of their findings.

In this grouping of CoP nursing research, there are three qualitative studies that do not clearly identify a methodological approach instead referring only to an analysis of experiences (Cope et al., 2000), a constructivist ontology (Grealish, Bail, & Ranse, 2010), and a workplace learning theoretical framework (Boyd & Lawley, 2009) respectively. Without a clear depiction of the methodological choices made and the resulting decisions regarding sampling and data

analysis, trustworthiness in these works could be compromised.

These same studies employed convenience sampling (Boyd & Lawley, 2009; Grealish et al., 2010) and a random sample (Cope et al., 2000) with little or no explanation of the methodological connections of each. The choice of a random sampling technique applied to a qualitative inquiry is a particularly strong example of researchers needing to further outline and support the choices they have made in study publications. Without such clarification, it appears there is lack of knowledge regarding some of the most basic premises of qualitative research. Grounded theory, for example, requires the use of theoretical sampling and there are similar methodological specificities for other qualitative methods that should be reflected in sampling discussions.

Lastly, the thematic analysis for each of these three studies was either not strongly tied to any stated methodological approach (Grealish et al., 2010) or was based on the researchers' own design (Boyd & Lawley, 2009; Cope et al., 2000). Thematic analysis is "a method for identifying, analyzing, and reporting patterns (themes) within data. It minimally organizes and describes your data set in (rich) detail" (Braun & Clarke, 2006, p. 77). While it is possible that the choice to proceed with a generalized thematic analysis was in the best interest of these studies, and the associated research aims, with no clear published accounting of why each decision was made, the work seems methodologically unfocused and the resultant findings potentially influenced by this lack of clarity.

In contrast to these works, there were two studies that demonstrated a consistent methodological application in their design and execution (Murphy & Timmins, 2009; Thrysoe, Hounsgaard, Dohn, & Wagner, 2010). Thrysoe et al. (2010) detailed the use of a "phenomenal hermeneutic interpretation methodology inspired by the philosophy of Paul Ricoeur (Ricoeur, 1976)… in order to uncover the interaction between the participants and members of the staff" (p.

362). Each research step of this report was clearly outlined and connected to the methodological choice made by these researchers. Similarly Murphy and Timmins (2009) used the work of Rolfe and applied his "understanding-action-evaluation (UAE)" (p.75) cycle to their study. "This reflexive action research process is cyclical in which the outcomes from one cycle informs and directs the next" (Murphy & Timmins, 2009, p. 75). While the research report was a clear application of this method it was noted the sample consisted of only one participant (the researcher). In addition, there was a self-declared lack of need for ethical approval and a data collection description centered on informal discussions with colleagues and nursing students which raised additional questions. Indeed there were several sampling issues that caused concern within this immediate grouping of research.

There was a great deal of diversity in sampling both in terms of size and participant selection in this collection of qualitative nursing CoP research. The majority of the study sampling was reported to be purposive or convenience in nature, with several mentions of deliberate pursuit of diversity in the sampling, be it by gender, age, or context. The sample sizes ranged from 1 to 49 (Table 2.1). The issue of the reported use of a random sample has already been detailed; however, there was a lack of detailed discussion regarding sampling choices in this entire research grouping. "In qualitative research sample selection has a profound effect on the ultimate quality of the research. Researchers have been criticized for not describing their sampling strategies in sufficient detail, which makes interpretation of findings difficult" (Coyne, 1997, p. 623). This information, especially regarding sufficiency of sample size, the achievement of saturation, if needed, or the suitability of the sample in answering the stated research aims or questions was not clearly detailed in these research reports. There was also limited, or no, discussion of how the sampling choices connected back to chosen methodologies.

The most commonly employed data collection method in this qualitative work was

participant interviews, specified as semi-structured in most cases, with one mention of ethnographic interviewing (Roberts, 2009), and several reported uses of focus groups (Booth et al., 2007; Grealish et al., 2010; Uys & Middleton, 2011). The researchers in two of the ethnographic studies employed participant observation as part of their data collection (Griffiths, 2010; Roberts, 2009) although one claimed to have done a majority of this observation while working as an RN on the ward in which the study was being conducted (Griffiths, 2010). Although this employment was a means for this researcher to observe her chosen study area and participants, it does raise questions about the ability of one to be a participant, and a participant observer, simultaneously. Despite this concern, these ethnographic researchers (Griffiths, 2010; Roberts, 2009)) were clear about how their choices to use participant observation in data collection related back to their methodological choices and overall study design. In the other studies, however, there was very limited discussion and a lack of clear connection made between methodologies and the chosen means of data collection.

A review of the qualitative analysis applied to these studies also revealed some mixing of qualitative approaches. There is a long established caution to researchers about the blending of qualitative methodologies (Baker, Wuest, & Noerager-Stern, 1992; Morse, 1991), with the accompanying warning that "credibility for existing qualitative methods will only be established if nurse researchers explicitly describe their data collection and analysis procedures" (Baker et al., 1992, p. 1359). Methodological slurring seemed to be of particular concern in the early 1990s when qualitative researchers were still working to establish the validity and worth of their methods within a still largely positivistic scientific community. The application of more than one qualitative approach may be identified by researchers as the most appropriate way to address stated research questions and aims; however the decision making processes supporting these choices should be made explicitly clear in any resultant research publications.

One of the most common applications of differing or mixed approaches applied in the data analysis of the qualitative work examined in this nursing CoP literature review was the use of frameworks in addition to stated methodological approaches. Several researchers talked about utilizing theoretical frameworks in the analysis of their data, but there was little or no discussion about whether or not these frameworks aligned with the stated methodologies of the project, or if the application of such frameworks raised any concerns regarding data forcing. The research of Garrow and Tawse (2009) is an example of this concern. They authors conducted a phenomenology study and stated their data was analyzed using a "Framework Technique" along with the application of an ethical framework (Garrow & Tawse, 2009). There was no further discussion about the fit of these frameworks with the phenomenological origins of their work. A further example is the work of Anderson (2009) who concluded her self-identified naturalistic inquiry by coding the resultant data with a schema developed by Morse and Richards (2002). While she noted that member checking and peer debriefing were done during the analysis, there was not any discussion of the philosophical underpinnings of the schema or its methodological fit with her approach.

In examining CoPs and nursing research the CoP concept seems to not only be a subject of research, but a tool for it as well. In this grouping of qualitative research there are several articles that serve as an example of this. First the actual creation of CoP as part of the stated research process is featured in two studies, one on the use of the CoP as part of an action research study in gerontology nursing, accounting for three articles in this research grouping (Booth et al., 2007; Kelly, Tolson, Schofield, & Booth, 2005; Tolson, Irene, Booth, Kelly, & James, 2006), and one with a consortium of international nurses (Uys & Middleton, 2011). There has been debate in CoP literature regarding the forced creation of CoPs and further discussion on this will be included in Chapter Five. The study with the international nursing group as well as another on

men's health (Creighton & Oliffe, 2010) identified the CoP concept as the theoretical or conceptual framework for the qualitative work.

This literature review has revealed some interchangeable use of key terms in research discourse such as theoretical and conceptual frameworks, and the word theory itself. For the sake of clarity, a review of these terms as they are understood by this researcher, is included here. As stated in Chapter One, for the purposes of this doctoral work, CoP has been defined as a concept. Wenger (1998) also identified CoP as one element of a conceptual framework supporting what he termed to be a social theory of learning. Aligning CoP with terms such as conceptual framework, theoretical framework, or theory itself seems to require further discussion at this point.

According to Meleis (2012), a theoretical framework is a how a grouping of concepts, typically addressing a particular question or set of questions, can be organized and structured. Meleis (2012) also noted an interchanging of terminology in the literature and provided direction in differentiating these terms:

> Theories are developed to answer specific questions. Frameworks and models are developed to provide direction for research projects. Models are developed to represent theories and to provide direction for research projects. Theoretical and conceptual frameworks evolve from theory, theories, or research. Theories differ from frameworks in coherence, a connection between concepts, and the nature of propositions. (p. 29)

Although she did not specifically differentiate theoretical and conceptual frameworks, in describing historical trends in applying these terms, there was information to aid in further distinguishing these. There seems to be support from the work of Meleis (2012) to apply the term conceptual framework when the "use of concepts from different theories are linked together to form a new whole" (p. 31). A theoretical framework is better applied "when concepts from one theory are given new meanings or when they are linked with another theory to form a new

structure that will be tested" (Meleis, 2012, p. 31). There appears to be some imprecise use of this terminology in the qualitative work of Uys and Middleton (2011) and Creighton and Oliffe (2010) with a misapplication of the term theoretical framework in particular.

Some serious questions and concerns remain about the work that has been done in the qualitative research available on the CoP concept in nursing. There is a great deal of diversity in the use of the concept in nursing research and based on this review, there may be some lingering questions regarding the rigour and trustworthiness of the work. Both of these points however, support the position that there is an ongoing need for CoP research in nursing.

2.1.3.3 Quantitative CoP Study Design. In comparison to the qualitative research being done in nursing on CoPs, there is very little quantitative study reported in the literature. In the 20 nursing research articles examined for this review, only three papers reported quantitative CoP findings (Giddens, Fogg, & Carlson-Sabelli, 2010; Smedley & Morey, 2010; Tolson et al., 2008). Also included in this summary are the results from the only mixed methods study discovered, a Canadian paper (Valaitis, Akhtar-Danesh, Brooks, Binks, & Semogas, 2011). There were quantitative CoP researchers who also elected to use the CoP concept as part of the research framework itself; concerns regarding this choice have previously been raised in the qualitative research discussion (Smedley & Morey, 2010). Overall, this research was split between study on nursing students (Giddens et al., 2010; Smedley & Morey, 2010) and nurses in practice (Tolson et al., 2008; Valaitis et al., 2011).

In examining the research designs presented in this grouping (Table 2.1), there appeared to be an appropriate alignment of the designs with the stated overall purpose for each research study. However, formal research questions were only stated in one of the quantitative studies (Giddens et al., 2010) while another included some general study aims (Tolson et al., 2008). This lack of specificity in stating research questions did make it difficult to evaluate the success and

relevance of the statistical analyses done in the research. In addition, there was no detailed discussion in any of the quantitative research reports regarding why the chosen methods were the best option for meeting said aims. The authors of the mixed-methods publication did include a discussion on the appropriateness of the Q-methodology approach in addressing the research population in question in their study (Valaitis et al., 2011).

There also appeared to be some sampling issues in this collective of quantitative reports. Only one paper included a discussion of power analysis in detailing sample sizes (Giddens et al., 2010). Giddens et al. (2010) determined that their sample (n=350) was adequate for a medium effect size and would be appropriate for their planned descriptive and comparative data analysis. This study was the largest sample size in this grouping with the remaining studies reporting a n=16 (Valaitis et al., 2011), n=24 (Tolson et al., 2008), and n=65 (Smedley & Morey, 2010). Tolson et al. (2008) experienced a 62% attrition rate from an initial n=34, resulting in the need to recruit additional participants. Even though 10 additional nurses were recruited, accounting for their reported n=24, for the bulk of their qualitative analysis (paired), they used a sample of only n=14 (Tolson et al., 2008). There was little further noted about the adequacy of this sample size especially in relation to the specific analysis completed, although in the discussion the attrition issue was mentioned as a weakness to the study (Tolson et al., 2008).

Smedley and Morey (2010) also seemed challenged by sample size, with an intended target of n=65, but an actual sample size of n=55 and n=38 for their two survey distributions. The researchers also had no way to identify the survey participants' responses and were not able to pair the completed surveys by participant, thereby eliminating several statistical analysis options which appeared highly relevant to the stated research aims. Lastly, the mixed-methods paper reported a relatively small sample size of n=16, although the authors stated that their chosen Q-methodology worked with smaller samples and so there was no risk of bias to the results due to

the same (Valaitis et al., 2011).

There was a better discussion of the chosen data collection instruments in these papers, with relevant reporting of validity and survey construction choices. As a whole, the descriptions of the data collection tool choices and methods were very thorough and clear. All three purely quantitative works employed pre-existing survey instruments either adapted by the researchers or used unaltered, details of which are included in Table 2.1.

Similarly to the data collection discussions, the analysis reports for all four of these studies were quite detailed and clear. SPSS was used to the support the data analysis for the quantitative reports, and a detailed PQMethod was used as part of the mixed-methods study, with the study authors referring readers to online resources to learn more about this method (Valaitis et al., 2011). As has been highlighted, there was little discussion about the analysis and its fit with the chosen methodology, but appropriate power calculations were shared for most data points, and the resulting findings discussions seemed clear and comprehensive, further details of these are included in Table 2.1.

The study by Giddens et al. (2010) demonstrated the strongest design and reporting overall. The two research questions were clearly stated and addressed student use of virtual communities. The power analysis showed a medium effect size, and a positive correlation analysis was reported between community use and perceived benefits ($r = .416$ (318), $p = .001$) "larger than Cohen's medium effect size" (Giddens et al., 2010, p. 265). The researcher's also shared results related to their second question regarding what student group found the virtual community of greater benefit. "A simple t-test comparing utility between the 2 groups revealed a greater perceived benefit among white/Asian students compared with URM students ($t = .219$, $df = 330$, $p = .03$)" (Giddens et al., 2010, p. 265).

As noted in the summaries in Table 2.1, the remaining quantitative CoP reports did not

contain this same amount of detail in reporting the structure and results of their work. Although each report claimed some successes, overall there appeared to be enough design issues to warrant caution in considering the results. However, as was noted in the review of qualitative study, there were some findings of note especially for those contemplating further CoP research.

2.1.4 Synthesized Research Findings

2.1.4.1. Qualitative. The qualitative research was divisible into four distinct areas. First, study done with nursing students examining their experiences in clinical practice (Cope et al., 2000; Grealish et al., 2010; Grealish & Ranse, 2009; Roberts, 2009; Thrysoe et al., 2010) and secondly, research on the experiences of new faculty transitioning to academic roles (Anderson, 2009; Boyd & Lawley, 2009; Garrow & Tawse, 2009; Murphy & Timmins, 2009). Third, there were two qualitative studies that examined the use of CoPs in nursing practice arenas (Burgess & Sawchenko, 2011; Griffiths, 2010). Finally there was a body of work where the CoP concept was applied as part of the research methodology itself, where communities were specifically formed for the purpose of the research, or where the researchers stated that CoP was applied as a theoretical framework (Booth et al., 2007; Creighton & Oliffe, 2010; Kelly et al., 2005; Tolson et al., 2006; Uys & Middleton, 2011).

2.1.4.1.1 CoP and professional belonging. A CoP does seem to be a potential vehicle for providing nursing students with a sense of professional belonging (Cope et al., 2000; Grealish & Ranse, 2009; Thrysoe et al., 2010). In addition, nursing research has begun to support the idea that "engagement in the practice of nursing work is the trigger for learning. Wenger (1998) identified engagement as a mode of belonging necessary to shape identity" (Grealish & Ranse, 2009, p. 86). Nursing students in a variety of clinical placements seemed to be searching for an opportunity to *fit* into the professional landscape with entry into a CoP described in terms of being a *feeling* in one study (Thrysoe et al., 2010). It may be beneficial to have a better

understanding of what specific social processes are at play in a nursing CoP that give rise to these feelings of belonging.

It is not just a professional fit that nursing students are seeking. Making social connections during clinical placement is also important (Cope et al., 2000; Thrysoe et al., 2010). Social acceptance could be granted as early as the first clinical day in some experiences and often preceded full acceptance into the professional CoP (Cope et al., 2000). Full incorporation would then require a "basic familiarity with the context of the placement, confidence in one's own capability within the context and acceptance by the professionals themselves. This latter has to be earned by working in the community and gradually building up professional trust" (Cope et al., 2000, p. 853). It appears there is a long-term investment to be made in sustaining social connectivity in nursing workplaces.

2.1.4.1.2 CoP and workplace transition. This research also highlighted the potential of a CoP to aid in the transition of novice student practitioners along the continuum to more *expert* levels of practice (Grealish et al., 2010; Roberts, 2009). This expertise was not just sought in the application of complex practice skills, but could be as simple as students in a peer community identifying the most experienced amongst them in a given clinical location and directing questions to that person to improve their individual knowledge (Roberts, 2009). The importance of allowing student peer communities to thrive in practice settings and exposing students to CoPs with a diverse mix of staff were noted as valuable discoveries (Grealish et al., 2010; Roberts, 2009). Finally, when it came to nursing students and learning in a CoP setting, the importance of engagement, imagination, and alignment was noted by one research team (Grealish & Ranse, 2009). The authors concluded their work with a call to recognize that students engaged in work and assigned relevant tasks should be able to move beyond simple skill application in practice to examining the challenges met in their placements with imagination and creativity (Grealish &

Ranse, 2009).

In further CoP research, it was discovered that new faculty members face similar transition issues (Anderson, 2009; Boyd & Lawley, 2009). This work, focused mainly on the evolution of practitioners to education and research roles and detailed the difficulties novices may have in navigating the unique challenges of the academic environment, including new role acclimation and immersion within a different organizational culture (Garrow & Tawse, 2009). A CoP was considered part of an evaluation of the kinds of supports needed to successfully sustain these new educators (Garrow & Tawse, 2009).

2.1.4.1.3 CoP and workplace innovation. Another noteworthy area is the ability of an academic CoP to foster an environment of innovation, especially in teaching (Garrow & Tawse, 2009; Murphy & Timmins, 2009). It has been suggested that a CoP could support more rapid innovation in teaching methods by facilitating the meaningful sharing of teaching practice developments resulting in an expansion of classroom confidence, especially for novice faculty (Murphy & Timmins, 2009). It should be noted however, that an established CoP may also influence the novice teacher is another way: "New academics… appear to be able to differentiate fairly rapidly between systems of assessment that have a tendency to encourage conformity for both markers and learners and systems of assessment that enable more creative and critical possibilities" (Garrow & Tawse, 2009, p. 584). There may be other institutional influences at play that would induce new faculty to choose one teaching approach over another. Boyd and Lawley (2009) echoed this caution and noted that not considering the influence of context and tensions present in an academic workplace could hamper new academics in forming a clear personal view of themselves in their new role, thereby hindering successful transition. These points support further consideration of the potential negative effects of any CoP and these concerns are further addressed in a review of CoP critique in Chapter Five.

In this review, a positive CoP outlook was the result of research efforts situated in nursing practice setting. Burgess and Sawchenko (2011) studied Nurse Practitioners (NP) in British Columbia and highlighted the establishment of a vibrant CoP as one of the key factors in the successful placement and retention of NP staff. The researchers reported the NP CoP supported positive connections for the NPs in the areas of education, practice, research, and leadership and was a collaborative effort between health region administrations and the nurses themselves (Burgess & Sawchenko, 2011). This cooperative approach, giving full support and funding to the CoP project, was identified as key to the initiation and sustainability of this professional community. Griffiths (2010) had similar findings in her CoP work, which defined the nursing role on a medical assessment unit (MAU). Griffiths identified groups of nurses at work on the MAU as a CoP and the learning and interaction that occurred in this group "lead to a new identity as a MAU nurse: A construction gained by experiencing and engaging in what was meaningful to the community of practice" (Griffiths, 2010, p. 253). These positive findings are supportive of further nursing research related to CoP in the practice arena.

Finally, as has been previously noted, there is a body of research literature developing where the CoP concept is not necessarily the object of investigation, but a part of the research approach itself. Often paired with an action research methodology these studies include the creation of a CoP for the purpose of the research, although typically without accompanying definition or verification that such a group has actually resulted (Booth et al., 2007; Tolson et al., 2006). Upon initial examination, this approach is concerning. There are no details in these research reports regarding additional theoretical development or further CoP concept analysis work as recommended by Meleis (2007) or Fawcett (2005). This work may have been done and not reported; however the whole issue of the creation of a CoP for research purposes and the application of the concept as a complete theoretical framework for nursing research, with no

evidence of further development, may be contributing to the conceptual confusion some critics have noted is of issue for CoP.

Many of the qualitative research publications featured in this literature review recommended additional CoP research be done (Anderson, 2009; Roberts, 2009; Tolson et al., 2006), or for the CoP concept to be further developed as theoretical framework (Creighton & Oliffe, 2010), although questions remain about the feasibility of this pursuit. Recalling the work and definitions of Meleis (2012) shared previously, it is worth asserting again that the interchangeable use of terms such as concept and theoretical framework is problematic in efforts to achieve further CoP conceptual clarity. It is not useful to advance the CoP concept to the level of a theory or framework without completing the developmental work required. It remains the opinion of this researcher that concept is the most appropriate term to apply to CoP.

With regards to research on the transition of new nurses and nursing students, the critical importance of strong relationships with existing nursing staff was noted (Cope et al., 2000; Grealish & Ranse, 2009) as well as the amount of overall member participation in the studied communities during the transition period (Grealish et al., 2010; Thrysoe et al., 2010). The role of a community in supporting new nursing academics was also highlighted (Anderson, 2009; Boyd & Lawley, 2009; Garrow & Tawse, 2009). In one practice setting a specific nursing role was defined based on what resonated with the community of practice observed (Griffiths, 2010). Finally, in some instances, successful creation of a nursing CoP was among the stated research outcomes (Burgess & Sawchenko, 2011; Uys & Middleton, 2011). Despite these reportedly successful CoP creations, the researcher believes judicious use of the attempted creation of any CoP remains warranted.

Although concerns remain regarding methodological consistency, there has been a diverse range of qualitative exploration done on CoP in nursing. The results of these studies provide a

disciplinary context for future research as well as serving as a reminder about the necessity of rigorous future research design. With so few CoP studies completed, due in part to the diverse application of the concept in nursing, more questions remain about CoPs in nursing.

2.1.4.2 Quantitative. Quantitative research findings further supported CoPs as a way to facilitate creative problem solving of practice issues and the identification and application of evidence-based practice guidelines (Valaitis et al., 2011). The efficiency of using virtual CoPs for students or practitioners and uniting practitioners across geographical distances in a single virtual CoP was also highlighted (Andrew et al., 2008b; Giddens et al., 2010; Tolson et al., 2008; Valaitis et al., 2011). Smedley and Morey (2010) reported the importance of connection and relationships in a CoP, as had been noted in some of the qualitative studies.

Similar to the qualitative body of work, these quantitative studies also recommended further exploration and clarification or replication of findings. In Australia, a large mixed-methods evaluation of CoPs in healthcare is underway (Ranmuthugala et al., 2011a). The project is expected to take several years to complete and identified goals include isolating key factors in a CoP and examining the "multi-component nature and the influence of context in determining impact. The systematic approach proposed will help identify key mechanisms that operate within particular contexts which in turn help optimize the establishment and effectiveness of CoPs" (Ranmuthugala et al., 2011a, Discussion, para. 6). Specific evaluative tools for exploring the influence of CoPs that may result from this work have yet to be detailed by the study authors. However, developing a deeper understanding of the inherent social processes at work in a CoP is a relevant endeavour for nursing researchers, especially in the Canadian context. Further study may begin to answer some of the questions that remain about the value of CoPs for the nursing discipline.

In summary, although the body of quantitative nursing CoP research is quite sparse, some

of the previously noted outcomes do lend support to calls for further research. The positive use of a virtual CoP in undergraduate nursing education (Giddens et al., 2010) and a nursing CoP as a forum for developing evidenced based practice (Tolson et al., 2008) are both promising findings. Further support for the importance of relationships between staff, faculty, and students in the clinical environment is a notable finding from this CoP research (Smedley & Morey, 2010), in addition to the reported success of online CoPs to "support tacit knowledge development and sharing" (Valaitis et al., 2011, p. 1282). This collective of nursing research CoP literature is a key component of the overall historical development of this concept.

2.1.5 Historical Development of the CoP Concept in Nursing and Beyond

A historical evaluation of the development of the CoP concept both within nursing and in other disciplines is useful to further an understanding of how the concept has evolved. The inclusion of expository nursing CoP literature within this examination is appropriate as these discussion papers and evaluation of CoP projects add a relevant, albeit anecdotal, context. The CoP concept has a more than 20 year history in the literature since its introduction by Lave and Wenger (1991) but could still be considered conceptually young in certain contexts. The uptake and application of the idea has resulted in a diverse and, some might suggest, diffuse collection of literature that has increased exponentially during the past two decades. While there was an early adoption of CoP work in the business literature, the authors of one systematic review on its use in health care and business noted uptake in the healthcare field was not as quick to develop (Li et al., 2009b). In the last ten years there has been a notable increase in the number of CoP publications in the health literature, as evidenced in part by the recovery of three health-focused systematic reviews (Fung-Kee-Fung et al., 2009; Li et al., 2009b; Ranmuthugala et al., 2010). The nursing CoP research literature also supports this trend. Of the 20 studies reviewed there was one published in 2000, and one each year from 2005 to 2008, with an increase to seven

publications in 2009, five in 2010, and three in 2011.

The systematic reviews of the CoP literature in healthcare, published within the last five years, are barometers regarding the historical progress of the CoP concept and are worth further consideration. There were two reviews completed in 2009 including the aforementioned study that examined the CoP concept in both health and business literature (Li et al., 2009b) and another that incorporated CoPs into a larger examination of regional collaborations amongst surgeons (Fung-Kee-Fung et al., 2009). The most recent review encapsulated the work of these previous publications and provided a comprehensive review of the CoP literature in the health sector up to, and including, September 2009 (Ranmuthugala et al., 2010). Published by an Australian health research group, this review has been identified as part of a lengthy, multi-phased, realist exploration to provide a "rigorous [CoP] evaluation methodology and deliver supporting tools for the benefit of researchers, policymakers, practitioners and consumers within the health system and other sectors" (Braithwaite et al., 2009, Background, para. 1). The research team has defined realist evaluation as "a theory-driven approach to understanding what it is about a program that achieves a particular outcome in one setting and a different outcome in another" (Ranmuthugala et al., 2011a, Background, para. 2).

This most recent systematic review, like the others before it, includes the conclusion that further research on CoPs in the health sector is needed (Ranmuthugala et al., 2010). "Overall, there is not sufficient information in the peer-reviewed literature to determine the role of CoPs in improving organisational value and capability beyond immediate members of the CoP" (Ranmuthugala et al., 2010, p. 28). The Australian team is using this review as a foundation to pursue the construction of a formal method that will allow for more systematic evaluations of CoPs.

When Li et al. (2009b) examined CoPs in the business and health sectors, they also

concluded that further research was needed to be able to operationalize the concept. The authors specifically noted needs related to the development of "indicators for identifying CoP groups and for describing the stages of existing and emergent CoPs" (Li et al., 2009b, Discussion, para. 7). Having this kind of concrete CoP knowledge could support the process of transitioning loosely associated groups, to a more complex CoP state (Li et al., 2009b).

2.1.5.1 Review of the conceptual CoP nursing literature. There were 40 nursing specific articles in the group of 300 CoP articles. The 20 research papers have been categorized and reviewed. It may be of interest to also examine this grouping as a whole for a complete contextual consideration of the nursing areas in which the CoP concept has been applied. Of the 40 nursing articles available for examination, six such distinct areas emerged.

A large portion of the CoP publication (15 articles) involved nursing practice settings (Becker, 2007; Benton & Mitchell, 2004; Booth et al., 2007; Burgess & Sawchenko, 2011; Cassidy, 2011; Creighton & Oliffe, 2010; Drummond et al., 2010; Griffiths, 2010; Kelly et al., 2005; Lori, Land, & Mamede, 2007; Ousey & Gallagher, 2010; Rashleigh, Cordon, & Wong, 2011; Tolson et al., 2008; Tolson et al., 2006; Tolson et al., 2011; Valaitis et al., 2011). There were five articles related to nursing education (Barton, 2005; Hovancsek et al., 2009; Murphy & Timmins, 2009; Uys & Middleton, 2011; Windle, Laverty, Herman, Hallawell, & Wharrad, 2010) and three articles that focused on virtual CoPs in nursing education (Giddens & Walsh, 2010; Giddens et al., 2010; MacPhee, Suryaprakash, & Jackson, 2009). Another seven articles highlighted the use of CoPs in clinical nursing education (Cope et al., 2000; Grealish et al., 2010; Grealish & Ranse, 2009; Roberts, 2009; Smedley & Morey, 2010; Thrysoe et al., 2010; White, 2010). There were nine publications focused on the development or evolution of nursing academia (Anderson, 2009; Andrew & Ferguson, 2008; Andrew et al., 2009; Berry, 2011; Boyd & Lawley, 2009; Garrow & Tawse, 2009; Gieselman, Stark, & Farruggia, 2000; Short, Jackson,

& Nugus, 2010; Thompson, Galbraith, & Pedro, 2010) and finally one article addressed the use of the CoP concept for nursing in general (Andrew et al., 2008b). This work by Andrew, Tolson and Ferguson (2008b), based in the UK, is one of several articles that members of this group have published in one of the most comprehensive CoP examinations in nursing that has been done to date.

In addition to the findings from the nursing research literature, several themes emerged from the non-research collective. When Lave and Wenger (1991) introduced the CoP concept, it was viewed as a marked departure from the cognitive or internalized learning approach (Contu & Willmott, 2003; Handley et al., 2006). The concept called into question "the pedagogic assumption that classroom-based 'learning' (as a discrete and decontextualized activity) is as effective as learning with the communities in which what is 'practiced' is learnt [*sic*] and vice versa" (Handley et al., 2006, p. 641). It is this approach to understanding and improving professional learning that seems to hold appeal for the application of the CoP concept in nursing. The possibility that such an approach may in fact enhance learning has been noted in reference to nursing students in many non-research papers (Berry, 2011; Windle et al., 2010), as well as in those addressing the professional development of nursing academics (Andrew & Ferguson, 2008; Andrew et al., 2009; Barton, 2005; Berry, 2011; Short et al., 2010), and practitioners alike (Benton & Mitchell, 2004; Berry, 2011; Drummond et al., 2010).

A CoP approach may be a potential vehicle to promote the creation or adoption of innovative practice approaches (Barton, 2005; Hovancsek et al., 2009) or to strengthen and even hasten, the adoption of best, or evidence-based, practice guidelines (Drummond et al., 2010; Lori et al., 2007; Tolson et al., 2011). Membership in a CoP is viewed as means to "build capacity and capabilities together by using the collective knowledge and resources of the entire group…CoPs can facilitate team work, enhance member awareness of global issues, provide for the horizontal

exchange of information and bridge gaps in information exchange" (Lori et al., 2007, p. 347).

The CoP concept has also been highlighted as a means to improve connection, such as for practitioners working in rural areas (Cassidy, 2011) or those collaborating in international or national groups (Drummond et al., 2010; Giddens & Walsh, 2010; Hovancsek et al., 2009; Lori et al., 2007). The ability of a CoP to improve communication in general terms has also been stressed from the perspective of several authors in a variety of nursing practice areas (Becker, 2007; Berry, 2011; MacPhee et al., 2009). The CoP concept has also been offered as a possible remedy for addressing potential disconnect between the nursing academy and professional practice (Andrew & Ferguson, 2008; Andrew et al., 2008b; Berry, 2011; Short et al., 2010). "A CoP recognizes the symbiotic relationship of theory and practice" (Andrew et al., 2008b, p. 251) and provides an opportunity for practitioners to see research integrated into their everyday practice (Andrew et al., 2008b). A CoP situated within a practice context providing an opportunity for collaboration between the nursing academy, practitioners, and patients could prove to be a valuable tool in advancing research application related to professional practice issues.

A CoP could also positively support the development of professional identity (Andrew & Ferguson, 2008; Andrew et al., 2009; Andrew et al., 2008b): "Individuals are primarily motivated to join a CoP to develop a sense of professional identity and belonging…The community acts as a vehicle for collaboration, allowing members to enter dynamic and engaged relationships with colleagues and others" (Andrew et al., 2009, p. 609). This principle may be beneficial to nurses entering any new professional situation, including brand new nurses in their first roles, nurses transitioning to different roles in practice, or those moving from practice to the academy. In the academic arena specifically, it has been noted that a CoP can "support transference by promoting collaboration and peer support allowing new academics to work through the issues and

challenges of developing an identity in education; contributing to an expansion of innovation and excellence in teaching and learning" (Andrew et al., 2009, p. 610). A positive outcome of this kind in the academic nursing community could potentially be achieved in other nursing domains. This raises questions about what kind of specific CoP processes may facilitate the positive transition of members and the creation and application of professional innovations. These are questions that can be addressed in future CoP nursing research.

2.1.6 Implications for Further CoP Nursing Research

The CoP concept has been widely applied across a number of diverse disciplines and along a continuum of complexity. At one end of this continuum the concept has been used as an undefined or convenient group label with no further CoP discussion, and at the other end the concept has been presented as a theoretical framework. Recent systematic reviews on CoPs have confirmed that this conceptual confusion is still very much an issue. For example, Li et al. (2009b) noted that "perhaps one of the reasons that the CoP has not inspired much evaluative research is that it is actually not a theory of social learning; rather it is a broad conceptualization of how learning occurs in the social environment" (Li et al., 2009b). This concept is still in need of further conceptual clarity.

2.1.7 Conclusion

This literature review and analysis demonstrated a lack of substantial CoP nursing research, especially that situated within the practice setting and from a Canadian perspective. The researcher could not locate any other purely grounded theory examinations of the concept within the nursing practice setting. This kind of research could provide further detail regarding the core processes at work in the CoP phenomenon, especially as it may be used nursing practice. As such, this review supported the researcher's intended methodological approach for further exploration of this concept that could aid in addressing this identified gap. While this literature

review supported the researcher's supposition that further exploration of the CoP concept in nursing was needed, an ongoing reflexive approach was employed during the course of the resultant research to avoid potential bias related to the knowledge gained in the review.

The lack of substantial valid and applicable CoP findings indicates a need for further theoretical exploration and construction. Murillo (2011) conveyed just such a sentiment when he noted that in the business sector, the CoP concept is facing "a midlife crisis in the form of mounting conceptual critiques and a recent downturn in hitherto robust publication trends" (Introduction, para. 1). It is probable that the CoP concept could face a similar crisis in the health sector if more in-depth and rigorous study is not pursued. The purpose of this constructivist grounded theory study was to explore nursing specific processes associated with CoPs in specialized acute care settings with a focus on their potential role in RN integration and professional development. This research was an opportunity to establish a more robust theoretical presence for CoPs within a nursing context and a necessary step towards developing a substantive CoP theory for the discipline.

Chapter Three

3.1 Methodology

This chapter includes a detailed overview of the chosen methodology for this doctoral research. To begin a brief historical review of qualitative inquiry and the grounded theory method is presented, followed by a more in-depth examination of the constructivist grounded theory approach chosen for use in this study. Specific details regarding the setting and participant sampling for this research are also reviewed preceding an overview of the data collection and analysis processes employed. Reflections on study rigour, researcher as instrument, ethical considerations, and study limitations are included prior to the conclusion of this chapter.

3.1.1 Qualitative Inquiry

Qualitative research in nursing does not have a lengthy history when considering the context of scientific inquiry as a whole. Morse (1991) has identified the 1980s as the time when interest and pursuit of qualitative inquiry, in nursing and other disciplines, greatly increased. This was a time of methodological struggle according to Denzin and Lincoln (2011), when the "very existence of qualitative research was at issue" (p. 1). From a philosophical perspective, qualitative inquiry can claim its foundations as far back as the work of Kant, who examined the importance of perception, including the notion that what could simply be observed was conceivably not the only reality (Streubert-Speziale & Rinaldi-Carpenter, 2007).

With the caveat that any definition of qualitative research must be considered within the context of its complex history and development, Denzin and Lincoln (2011) have defined qualitative research as "a situated activity that locates the observer in the world. Qualitative research consists of a set of interpretive, material practices that make the world visible" (p. 1), a pursuit often achieved through the means of naturalistic inquiry (Patton, 2002). In stark contrast to positivistic controlled experimental designs, naturalistic inquiry "minimizes investigator

manipulation of the study setting and places no prior constraints on what the outcomes of the research will be" (Patton, 2002, p. 39). This means of discovery is included as one of six characteristics attributed to the work of qualitative researchers by Streubert-Speziale and Rinaldi-Carpenter (2007):

> (1) a belief in multiple realities; (2) a commitment to identifying an approach to understanding that supports the phenomenon studied; (3); a commitment to the participant's viewpoint; (4) the conduct of inquiry in a way that limits the disruption of the natural context of the phenomena of interest; (5) acknowledged participation of the researcher in the research process; and (6) the reporting of the data in a literary style rich with participant commentaries. (p. 21)

From these common ontological and epistemological characteristics, qualitative researchers can elect to work further with a number of different methodological approaches.

The selection of a qualitative method of inquiry is strongly directed by the research question or aims that are to be answered or achieved. Simply put, and in contrast to quantitative scientific method, "the discovery leads the choice of method rather than the method leading the discovery" (Streubert-Speziale & Rinaldi-Carpenter, 2007, p. 21). There are a multitude of method choices within the qualitative realm; ethnography, phenomenology, grounded theory, and action research methods, just to name a few. Within these methodology families, further development and diversification typically means additional choices for the researcher, and a need for explicit methodological clarity well beyond a statement that one is engaged in ethnography, for example. Qualitative researchers need to clearly outline the details of their chosen ontological and methodological approaches. As Denzin and Lincoln (2011) have stated, there is no one methodological practice superior to another in qualitative research; it is an complex set of practices requiring application by skillful researchers.

Perhaps it is this complexity that has contributed to the challenges present in some qualitative research and resultant publication. For a considerable portion of the historical evolution of qualitative research, there have been concerns about the misuse and misapplication of various methodologies. Foremost among these is the issue of research design featuring the use of multiple qualitative methodologies, potentially creating risk for methodological slurring. Morse (1991) has long questioned the effectiveness of mixing qualitative methods, pointing to inherent conflicts between data collection techniques and analysis, for example, and suggesting that especially in the hands of neophyte researchers, the final products of these amalgamations are typically not strong science. This sentiment was echoed by Baker et al. (1992) in response to what the authors felt were two of the most misused and misinterpreted methods, grounded theory and phenomenology. In a further call for researchers to be explicitly clear in their methodological choices including study execution details, the authors stated without such detail in publication, the credibility of qualitative research could suffer (Baker et al., 1992).

It seems that there are some biases that still persist within the scientific community regarding qualitative research. Fortunately, the pursuit of qualitative research continues unabated providing opportunities, as noted by Morse (1991), for the sharing of rich descriptions of phenomenon such as illness, motherhood, grief, or nursing life, just to name a very few. Qualitative inquiry can also be an effective vehicle to challenge the status quo, open new avenues of exploration, and provide conceptual clarification, frameworks, or theories that can be tested with further research as needed (Morse, 1991). Denzin and Lincoln (2011) have highlighted ongoing challenges from the evidenced-based research movement as another potential threat to the perceived view of qualitative work.

The research questions for this study, focused on key features, roles, and processes of a CoP in specialized acute care practice settings directed the researcher towards a grounded theory

methodology deemed most appropriate for exploring community social processes. From within this methodological choice a further decision to use the constructivist grounded theory approach of Charmaz was made.

3.1.2 Grounded Theory

3.1.2.1 History and development of grounded theory. It has been more than 40 years since Glaser and Strauss (1967) introduced a new methodology to the research world with their seminal work, *The Discovery of Grounded Theory.* In this time, grounded theory methodology (GTM) has undergone an extensive evolution and diversification. In the past four decades, the method has become "the most widely used and popular qualitative research method across a wide range of disciplines and subject areas" (Bryant & Charmaz, 2007, p. 1), including nursing.

For grounded theory, the beginning was during what Denzin and Lincoln (2000) referred to as the modernist phase or *second moment*. This phase was identified as the time period from the end of World War II through to the 1970s in the author's presented history of qualitative research (Denzin & Lincoln, 2000). The modernist phase was shaped by the increasing influence of the postpositivist paradigm, as well as the use of interpretive paradigms or approaches such as hermeneutics, critical theory, and feminism. It was what Denzin and Lincoln called "the golden age of rigorous qualitative analysis" (2000, p. 14). The work of the modernist period was infused by the "language and rhetoric of positivist and postpositivist discourse" (Denzin & Lincoln, 2000, p. 14).

Essentially, the 1960s partnership of Glaser and Strauss united a researcher with positivistic sensibilities and knowledge of quantitative methodology (Glaser), and a qualitative, pragmatic, symbolic interactionist (Strauss); with each partner "acting as a lens that refracted diverse and profound traditions (both theoretical and methodological) towards the focal point of GTM" (Bryant & Charmaz, 2007, p. 5). Immersed in an academic world where positivism was still a

dominating paradigm, Glaser and Strauss wanted to demonstrate the explanatory power of qualitative studies with the creation of their classical grounded theory (Birks, Chapman, & Francis, 2006; Thomas & James, 2006). Armed with the knowledge that any qualitative methodology they created would have to withstand positivistic scrutiny related to rigour, Glaser and Strauss infused positivist and postpositivist principles into their new approach (Birks et al., 2006; Seldén, 2005; Walker & Myrick, 2006). With some insight into the contextual environment that supported the development of grounded theory, it is not surprising to discover the methodology is considered by some to be both positivistic and postpositivistic in nature (Mills, Chapman, Bonner, & Francis, 2007).

Although often identified as solely postpositivistic (McCann & Clark, 2003; Reed & Runquist, 2007), there is a strong positivist stance to classic GTM. Bryant and Charmaz (2007) have noted the constant references and focus on *the data* to be one of the key positivistic features of this form of grounded theory. Annells (1996) highlighted the objectivist view of the relationship between researcher and participant as another, with the former recommended to remain separate from the later thereby maintaining a formal objective observer status. This stance was not shared by Charmaz (2006) who championed the co-construction of data through a relationship between researcher and participant in her grounded theory approach. Although Glaser's positivistic influence can be seen in the structure and process of GTM, Birks et al. (2006) have argued that the views of Strauss had the most influence on the overall philosophical direction of GTM. Eventually however, the theory duo parted ways, each taking GTM with them while returning to their ontological and epistemological origins. Glaser pursued objectivist GTM from positivist stance and Strauss, in a new partnership with Corbin, continued development of a postpositivist version of the methodology (Charmaz, 2011). Charmaz (2006), a student of Glaser and Strauss, is now largely credited with a third variation of GTM, a constructivist adaptation.

GTM is rooted in symbolic interactionism (SI) (Annells, 1996; Cutcliffe, 2000; Streubert-Speziale & Rinaldi-Carpenter, 2007). Attributed to Mead (1964) and Blumer (1969), SI serves both as a human behaviour theory and an approach to examine human and group behaviour (Annells, 1996). Seeking to "determine what symbolic meanings, artifacts, clothing, gestures and words have for groups of people as they interact with one another. Symbolic interactionists stress that people construct their realities from the symbols around them through interaction" (Cutcliffe, 2000, p. 1477). In a similar fashion, GTM is employed to produce explanatory theory related to common patterns in our social lives (Annells, 1996). Perhaps it is easiest to view the relationship between SI and GTM as a theory/methods package (Bryant & Charmaz, 2007). "Both the theoretical perspective and the method assume an agentic actor, the significance of studying processes, the emphasis on building useful theory from empirical observations, and the development of conditional theories that address specific realities" (Bryant & Charmaz, 2007, p. 21). This focus on processes is an elemental component of both SI and GTM and highlights the pragmatist underpinnings of each (Bryant & Charmaz, 2007).

Charmaz (2011) has said that constructivist grounded theory in particular acknowledges influences of positivism and pragmatism, seeking to develop further emphasis on the later. "Constructivist grounded theory acknowledges multiple perspectives and multiple forms of knowledge" (Charmaz, 2011, p. 374). Grounded theory purports a practical usefulness that also supports its alignment with pragmatism (Lomborg & Kirkevold, 2003).

The popularity of GTM has led to gross misapplication of the method at worst, or at best, application with no consideration of the pressing ontological and epistemological issues that have been reviewed here. Bryant and Charmaz (2007) have repeatedly called for the continued evolution of GTM. "We must distinguish what is key to the method, and what needs to be discarded or reformulated if the method is to shake off its reputation for being positivist,

philosophically naïve, and refuge for the methodologically indecisive" (Bryant & Charmaz, 2007, p. 49). Charmaz has been engaged in the work of such methodological reformulation since see began publishing on grounded theory in the early 1990s.

3.1.2.1 Constructivist grounded theory. The methodology that has been selected to complete this study is grounded theory, specifically the constructivist grounded theory method as outlined by Charmaz (2006). This approach is founded on a "relativist epistemology, sees knowledge as socially produced, acknowledges multiple standpoints of both the research participants and the grounded theorist, and takes a reflexive stance toward our actions, situations, and participants in the research setting – and our analytic constructions of them" (Charmaz, 2009, p. 129). From a social constructivist perspective, Charmaz began a journey that would ultimately result in her publishing her own grounded theory text, *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis* in 2006.

Charmaz felt her constructivist approach could assuage a great deal of the criticism that had been directed at grounded theory. "Ontologically relativist and epistemologically subjectivist, constructivist grounded theory reshapes the interaction between researcher and participants in the research process and in doing so brings to the fore the notion of the researcher as author" (Mills, Bonner, & Francis, 2006a, p. 6; Mills, Bonner, & Francis, 2006b). In essence, there is a merging of ontology and epistemology as "the knower is inseparable from whatever can be known within the overall construction of a particular reality" (Norton, 1999, p. 34). This reflexive version of the methodology requires researchers to remove themselves as distant experts and engage with participants as co-constructors of meaning and data (Mills et al., 2007). Hall and Callery (2001) found the contention by Charmaz and others regarding the movement of grounded theory towards a more reflexive and constructivist stance incongruent with the GTM authored by Strauss and Corbin. The authors did however support means of addressing the social construction of

knowledge in the processes under examination and recommended "combining theoretical sensitivity with reflexivity and relationality…[to create] a more rigorous form of grounded theory" (Hall & Callery, 2001, p. 270). In her later work, Charmaz (2011) also noted the critical importance of integrating reflexivity and consideration of "researchers' and participants' relative positions and standpoints" (p. 360) in the grounded theory process.

Rejecting the pure notion of objectivity, this proposed relationship between researcher and participant also requires the researcher to be cognizant of potential power imbalances and to have plans in place to equalize the relationship as much as possible (Mills, Bonner, & Francis, 2006b). In acknowledging this interaction that would influence both data collection and analysis Charmaz (2000) felt she was stepping away from the originating positivistic nature of the method. By acknowledging an interaction in both data collection and analysis, Charmaz felt those who had objected to the positivistic nature of the methodology previously would be appeased. Moreover, Charmaz (2000) stated her constructivist grounded theory provided qualitative researchers with a methodology that would better allow them to examine experiences from the view of those living them. Essentially Charmaz (2011) stated the approach "loosens grounded theory from its positivist, objectivist roots and brings the researcher's roles and actions into view…Constructivist grounded theory views knowledge as located in time, space, and situation and takes into account the researcher's construction of emergent concepts" (p. 365).

Given this acknowledgement of multiple perspectives and sources of knowledge, it is not surprising to discover that Charmaz (2006) also subscribed to the originating pragmatist underpinnings of grounded theory. In fact, she went so far as to call upon scholars to "journey back to the pragmatist heritage of grounded theory and to build on these antecedents while invoking twenty-first century constructivist sensibilities. A constructivist grounded theory retains the fluidity and open-ended character of pragmatism as evidenced in Strauss's works" (Charmaz,

2006, p. 184). Charmaz (2006) added, a pragmatic foundation would aid researchers in maintaining a focus on language, meaning, and action as they used GTM. Finally Charmaz highlighted four pragmatic advantages that could be of use to researchers adopting the traditions of the Chicago school: "an openness to the world…an empathetic understanding of research participants' meanings…[taking] temporality into account…[and a] focus on meaning and process at the subjective and social levels" (2006, p. 184). Aligning constructivist grounded theory with this pragmatic tradition, championed by Strauss, was the means by which Charmaz (2011) felt she could shift the ontological and epistemological foundations of the methodology from its objectivist, positivistic beginnings.

3.1.2.3 Reflection on methodological fit with research aims. This methodology, the philosophical foundations on which it was instituted, and the constructivist approach developed by Charmaz, resonated with my sensibilities as a researcher. All versions of GTM are inductive, demand a rigorous adherence to the constant comparative relationship between data collection and analysis, and value the construction of practical theoretical analyses that may be of use in informing policy and practice (Charmaz, 2009). The acknowledgement of the significance of reflexivity and relativity in the constructivist methodology was essential to me as a researcher. The positivist undertones of Glaser's objectivist GTM did not align with my planned research approach, nor did the rigid data analysis structures in the version of Strauss and Corbin (1998).

Even though each version of grounded theory shares key processes, it is the epistemological allegiances and methodological strategies, as Charmaz (2009) has termed them, that have ultimately informed my methodological decisions. Charmaz (2011) stated that with Glaser's classical GTM, the researcher stands outside of the phenomenon, as opposed to entering and attempting to see it from the inside, as the constructivist approach supports. The idea of entering into the research perfectly summed the kind of researcher I was hoping to be and the

kind of research I wanted to conduct. I was confident that constructivist GTM would support my efforts to answer my research questions.

The CoP concept is laden with reference to the social processes and group influences on both learning and the construction of knowledge or innovations. As has been detailed, Charmaz has founded her methodology on elements of social constructivism providing what seems to be an excellent fit for the proposed research. She has further stated that constructivist grounded theory can provide qualitative researchers with a methodology to better allow the examination of social processes incorporating the views of those engaged in them.

3.1.3 Setting: Research Context

This research was situated within three acute care nursing units in an urban hospital in Saskatchewan, Canada. Royal University Hospital (RUH) is located in the city of Saskatoon, an urban center with a population of more than 225,000 residents. RUH is a tertiary teaching hospital located on the grounds of the University of Saskatchewan. It has approximately 300 beds and is the trauma and pediatric centre for the city of Saskatoon and the surrounding area including northern areas of the province of Saskatchewan.

All three of the specialized units featured in this research typically have high patient census counts and participants in the study consistently reported their work environments as busy with demanding patient assignments. Saskatoon has two additional hospitals that could have served as settings in addition to RUH. The use of one institution as a study setting for the research was deliberately done to minimize the influence of potentially differing organizational contexts.

3.1.4 Sampling Study Participants

The sample for this study was comprised of RNs employed in three specialized areas of acute care nursing practice; referred to as units A, B, and C. Wenger (1998) has declared that "communities of practice are everywhere" (p. 6). However, the exact form or function of such

communities within nursing practice, and these particular research settings in particular, was not known. It was not the intent of the researcher to attempt a forced creation of a formal CoP as part of this research. Whatever existing nursing community processes were present were of interest.

With these considerations in mind, the following inclusion criteria were identified for the initial round of purposeful sampling: 1) practicing RNs; 2) employed at RUH in either units A, B, or C (no specific length of employment was required); 3) of any age, gender, or ethnicity; 4) of any educational background (BSN or diploma prepared); 5) English speaking, and; 6) freely willing to participate in the study. Charmaz (2006) has noted "initial sampling in grounded theory is where you start whereas theoretical sampling directs you where to go" (p. 100). These inclusion criteria were crafted to support an exploration of purposeful initial sampling that then gave way to theoretical sampling as the study progressed. As recommended by Charmaz (2006), this sampling transition was driven by data analysis, the creation of conceptual categories, and theoretical questioning and development.

The recruitment of participants for this study commenced following ethical approval by the University of Saskatchewan (granted in February 2012 see Appendix B) and operational approval from the Saskatoon Health Region (granted in February 2012 see Appendix C). Initial meetings were arranged with the three nurse managers of the aforementioned units (February and March 2012). A request was made to each to allow a brief presentation about the research project and recruitment process at any upcoming staff meetings. There were either no meetings planned in the near future for these units, or the nurse managers felt the meeting time was already filled. Instead, the nurse mangers initially approved the use of pamphlets (Appendix D) promoting the study to be left in relevant staff locations in each department and to be placed in mailboxes of all RN staff. The first study participant was recruited from unit A in March 2012.

When initial recruitment efforts produced fewer participants than hoped, the researcher

initiated an amendment to the initial ethics application. In April 2012 approval was granted from the University of Saskatchewan Behavioural Research Ethics Board for the use of a study recruitment poster (Appendix E) as well as the use of further recruiting approaches. In addition to the open recruitment already in place, snowballing technique between participants was requested and subsequently used to support further recruitment. This same approach was also used to aid in theoretical sampling. In this case, participants were asked to pass along the study information to other registered nursing staff in their units. Any interested parties were instructed to contact the researcher to participate in the study on a strictly volunteer basis. Posters were also placed in all three nursing units.

A further use of third party recruitment was also requested and received ethical approval in the April 2012 amendment. This technique allowed the researcher to provide information about the study to known nursing colleagues who did not meet the study inclusion criteria, but who could potentially have connections within the target units. This networked approach to sampling provided more successful. Ultimately, repeated contact with the nurse managers was required to seek permission to speak briefly with registered nursing staff. Although the researcher left several posters, messages, and pamphlets in all three units several times over the course of a year, it was speaking directly to RNs that proved the most useful for participant recruitment. In all, 19 participants were recruited to participate in this research. The sample included practicing RNs from each of the three units as well as one RN from each unit who was an experienced member of the community with responsibility for some aspect of oversight in the setting. These later nurses were not working in the provision of direct patient care. The recruitment of these additional experienced participants was a direct result of theoretical direction that arose during data analysis.

As was previously noted, the initial participant for the study was recruited from unit A in

March 2012. In all, six participants were recruited from this area. Participant recruitment concluded on this unit in July 2013. The first participant from unit B was recruited in May 2012. There were seven participants from this unit. Recruitment on this unit concluded in June 2013. The first participant from unit C was recruited in June 2012, there were six participants in total from this area and recruitment concluded here in September 2013. The last participant from unit C was the final participant recruited for the study as a whole. The multiple data points provided by these 19 participants allowed the researcher to achieve theoretical saturation of the key conceptual categories developed during the constant comparative analysis process and the study was closed for data collection and any further participant recruitment in January 2014.

Although participant recruitment for the study took considerably longer than anticipated, the RNs involved in the research provided rich and detailed descriptions of their experiences. The use of theoretical sampling aided the researcher in successfully concluding the data analysis. Memo writing was a valuable tool in directing the theoretical sampling in this study. Charmaz (2006) has stated that memo writing can be used to flag categories requiring more data and potential gaps in the developing theory, and thus serve as cues for theoretical sampling needed to saturate categories. In this research, theoretical sampling was used to facilitate the development of the needed sample to support a thorough exploration of community social processes. The aforementioned snowballing technique was used with participants when other key community members were identified during data collection and analysis. Increasingly focused "theoretical sampling ensures that you construct full and robust categories and leads you to clarify the relationships between categories (Charmaz, 2006, p. 103).

Theoretical sampling imposes no limits on the size of the sample; rather the researcher continues with data collection until theoretical saturation is reached and no new codes emerge in the simultaneous data analysis (Cutcliffe, 2000; Streubert-Speziale & Rinaldi-Carpenter, 2007).

Sandelowski (1995) has noted however, that "a common misconception about sampling in qualitative research is that numbers are unimportant in ensuring the adequacy of a sampling strategy" (p. 179). Qualitative samples which are not a sufficient size may impede a researcher's ability to claim theoretical saturation (Sandelowski, 1995). Sandelowski (1995) goes on to recommend, with a consideration of work published the previous year by Morse, that for GTM approximately 30-50 interviews and/or other observations or data points be sought.

With these recommendations in mind, a recruitment target of 15 to 20 RNs had been set for this study to facilitate a sample resulting in upwards of 40 interviews and/or other data points. The resultant recruitment of 19 participants successfully met this target. Charmaz (2006) has also cautioned against small sample sizes for researchers who wish to move beyond modest claims and simple projects, especially when the nature of human interaction is under consideration (p. 114). An initial interview (averaging approximately 60 minutes each) was conducted with each of the 19 participants, with several second interviews held for a final study total of 25 interviews. All interviews were recorded and transcribed to ensure the researcher had a comprehensive data set. In addition to the interviews, eight participants provided journal entries for the study (four from unit A, three from unit B and one from unit C) for a combined total of 34 entries. These reflective journal entries in combination with the participant interviews provided 59 data points for the study creating a substantial and rich data set for the researcher to work with.

During the combined data collection and analysis process, additional interviews and participants were sought until theoretical saturation could be achieved. Evidence of saturation was noted after the sixteenth interview and was then further advanced by the coding of participant journal entries. The completion of the first round of interviews and the second interviews with six participants allowed the researcher an opportunity to confirm information and facilitate the saturation of specific categories. In her article on the importance of reflexivity and

relationality in grounded theory, Hall reflected on a recent GTM she had conducted and noted her use of second meetings with participants as a way to facilitate the sharing of diagrams or other work from her ongoing analysis (Hall & Callery, 2001). A similar process was used in this study in the pursuit of a more equal relational power with participants.

3.1.5 Data Collection

In contrast to Glaser's (2002) "all is data" assumptions, Charmaz (2006) has noted that although everything a researcher encounters may indeed serve as data, there is likely to be a great deal of variety in the quality and relevance of this information. The nature of all data as constructed, be it interviews, texts, or government documents, is also a central point in this iteration of the methodology (Charmaz, 2006). Charmaz agreed with Glaser that the nature of the research should direct the data collection process. She further noted that certain research problems lend themselves to certain data collection methods, and issued a reminder to researchers that with GTM, the need for a different method could arise from the data at any point. Charmaz cautioned, as Glaser had before her, that grounded theorists "do not force preconceived ideas and theories directly upon our data. Rather we follow leads that we define in the data, or design another way of collecting data to pursue our initial interests" (Charmaz, 2006, p. 17). These were key considerations in the planning and implementation of the data collection for this study.

In the pursuit of rich data, Charmaz (2006) has highlighted several approaches that could be utilized, including those used in this research: intensive interviewing and textual analysis. Intensive interviewing is an interpretive inquiry method which allows for a topic or experience to be explored in-depth (Charmaz, 2006). Charmaz (2006) has differentiated the intensive interview from informational interviewing, stating that the former "permits an in-depth exploration of a particular topic with a person who has the relevant experience" (p. 25). In these types of interviews, it is the participants who should do most of the talking (Charmaz, 2006). This type of

interviewing takes practice to execute well. During this study the researcher made a focused effort to improve her interview technique, reviewing early interview recordings carefully to note where improvements could be made. Research notes made following interview appointments also helped to further refine the interviewing skill of the researcher. Charmaz has stated the use of intensive interviews is well suited to grounded theory methods. Both "grounded theory methods and intensive interviewing are open-ended yet directed, shaped yet emergent, and paced yet unrestricted" (p. 28). The researcher found this interviewing technique produced data well suited to grounded theory analysis.

Where Glaser (1992; 1978) favoured less structure in terms of gathering data in an interview format, Charmaz (2006) had no objection to utilizing an open-ended interview guide. She noted that the debate over what was a valid data collection strategy in grounded theory and what constituted forcing was not resolved (Charmaz, 2006). Charmaz felt that the use of a few predetermined, broad, opened-ended questions could assist a researcher to avoid blurting out a question that could inadvertently result in data forcing. The researcher was cognizant of her novice status and the use of an interview guide was deemed a prudent support for this study. Charmaz has noted that while intensive interviewing is often used alone, in grounded theory it can be paired with additional data collection methods. In the case of this study participant journals served as an additional means of data collection and proved a rich source of reflection.

Charmaz (2006) has stressed the usefulness of textual analysis for the grounded theory researcher. Having noted that all qualitative research makes use of analyzing texts, Charmaz differentiated between elicited and extant texts. The former are those constructed by research participants at the request of the researcher, and the latter documents are those which the researcher has had no influence over the production of (Charmaz, 2006). Although Charmaz specified that these texts could be used as primary or supplementary data sources, she also

stressed that texts are not considered objective facts. “People construct texts for specific purposes and they do so within social, economic, historical, cultural and situational contexts” (Charmaz, 2006, p. 35). Due to this construction, Charmaz emphasized the importance of studying and situating texts in their contexts. These guidelines were applied to the use of the participant reflective journal entries collected in this study.

The quality and credibility of any study begins with the data (Charmaz, 2006). As previously noted, Charmaz (2006) has cautioned researchers against small studies and the production of thin data and recommended the pursuit of rich and substantial data through the use of appropriate numbers and sources. In keeping with this directive, several data collection tools were used for this study beginning with a demographic data collection form and the use of digitally recorded, semi-structured, participant interviews. The interview data also included observations made by the researcher regarding non-verbal cues and other relevant contextual elements. There were several electronic or hand-written reflective journals entries completed by the participants as well as research notes and analytical memos written by the researcher to complete the data set.

As was noted, Charmaz (2006) is a strong proponent of situating data within context. The use of a demographic form is one way to begin to frame the context of the communities under study, by providing detailing about the members that comprise them. Found in Appendix F, the demographic form provided information about age, gender, ethnicity, location and length of practice, and level of education for each participant. Further contextual detail, including historical, social, economic, and cultural components came from the participants through their interviews and reflective journal entries.

The initial interviews were planned to take approximately 60 minutes each. This was the average length of these first discussions with some having a slightly shorter run-time and some

longer. Each interview was scheduled at a location most convenient and comfortable for the participant. Several interviews were conducted in participants' homes, some in the researcher's office which was in a building attached to the hospital, and several were conducted in coffee shops. The later location was eventually ruled out as an option by the researcher owing to difficulties with background noise and concern regarding the confidentiality of the participants; the use of this location was only initially pursued at the request of a few participants.

As recommended by Charmaz (2006), a very broad and open-ended interview guide was used in all initial interviews (Appendix G). The interview guide began to be modified after the first three study interviews were completed. Additional questions and modifications were made to the guide from this point right up until the final interview was conducted. In addition to the interview guide, the evolving theoretical model was also shared with participants during second interviews. The evolution of the interview guide and the model were driven by ongoing data analysis, the resultant creation of conceptual categories, and emerging theoretical development. All of the interview recordings were transcribed and entered as data into the Atlas.ti software for coding and analysis.

In the pursuit of rich data and to allow participants to more deeply reflect on their experiences, short journal entries were encouraged between the first and second interviews. As noted, eight participants elected to complete these reflective journals. Participants were offered the option of completing their entries on their personal computers and saving them to a provided memory key or to record them in a provided paper journal. This data collection tool allowed participants to relay daily events closer to the moments of occurrence and to reflect further on the processes inherent in their professional communities. The exercise of reflexivity on the part of the participants also seemed to inspire new information to be shared in second interviews and enriched the overall quality of the data as a whole. As additional interview questions were added

during the theoretical progression of the study, so did further discussion with the study participants about what they might choose to reflect on in their journals. Ultimately the participants were supported to journal on whatever seemed most relevant to them. The initial introduction to the task of reflective journaling is in Appendix H. The reflective journal entries were also transcribed and entered as data into the Atlas.ti software for further coding and analysis.

Finally, the researcher engaged in an ongoing personal reflexive process through the use of research notes and memos as recommended by Charmaz (2006). Research notes were taken after each interview, either written in a research notebook or recorded typically in transit from the participant interview while impressions on the experience were fresh in the researcher's mind. These notes included information regarding the perceived mood of the session, any non-verbal communication signals, the feelings of the researcher during and upon conclusion of the interview, and any other notations of relevance. These notes were transcribed to become part of the data set. The use of memo writing to direct theoretical sampling has previously been noted and the influence of these memos in this study will be explored further in the data analysis discussion.

According to Charmaz (2006) memos are a central component in the constant comparative analysis process (pp. 80-85). Notations on the developing theory, the feelings of the researcher, possible gaps, and ways and data sources that could be utilized to fill those categories can all be included in these researcher reflections. Robust use of memo writing was incorporated into the data collection process of this study. All relevant research notes and memos were transcribed and entered as data into the Atlas.ti software for further coding and analysis.

3.1.6 Data Analysis

As has been established, the use of constant comparative analysis is a central tenet in

grounded theory methodology (Boychuck-Duchscher & Morgan, 2004). "This technique of contrasting data, first against itself, then against evolving original data, and finally against extant theoretical and conceptual claims, facilitates the emergence of knowledge" (Boychuck-Duchscher & Morgan, 2004, p. 607). This methodological directive requires grounded theory researchers to consider data analysis and data collection processes simultaneously. As the researcher was solely in charge of data collection and analysis, this aided this process during this project. As participant interviews, reflective journals, research notes, and memos were collected for this study they were transcribed verbatim either by the researcher, or a chosen reputable transcription service, and entered into the Atlas.ti qualitative data analysis suite. Each transcription was carefully reviewed for accuracy prior to being added to the data set.

As the first data points were accumulated, data analysis began. Despite some of the philosophical and epistemological differences in the GTM approaches that have been previously highlighted, researchers using both objectivist and constructivist grounded theory employ relatively the same coding procedures. There are some differences in nomenclature between Glaser and Charmaz in describing the coding process, but the procedures themselves are comparable. Glaser (1978) first described the three coding phases as substantive, further divided into open and selective coding, followed by theoretical coding. Charmaz (2006) defined the same process as initial, focused, and theoretical coding (p. 46). To begin, open or initial coding consists of examining the data, frequently line by line, and coding with words that reflect action or events (Boychuck-Duchscher & Morgan, 2004; Charmaz, 2006). Glaser referred to this phase as "coding the data in everyway possible" or "running the data open" (p. 56). Asking questions about what is happening in the data, what problem(s) the participant is facing, what process may be at issue, and what the consequences of the process may be, assist in the formation of core categories (Charmaz, 2006; Glaser, 1978). An illustration of the coding process applied by the researcher

can be found in Table 3.1 (Appendix I). Memo writing was used in this phase of coding to track conceptual and theoretical ideas that were emerging (Walker & Myrick, 2006). Examples of the researcher's memo writing are included in Appendix J.

It is crucial during this time that researchers, especially novices, guard against data forcing, the application of preconceived ideas or knowledge, to the data and emerging concepts. For this study, the researcher used memo-writing and ongoing consultation with her doctoral supervisor during early coding to guard against data forcing. The use of gerunds (verb form ending in –ing), as recommended by both Glaser and Charmaz (2006), was extremely helpful to the researcher in early coding, allowing the focus to remain on actions and processes as opposed to people or things (p. 49). Exploring data in a grounded theory study should be an exciting and surprising enterprise. With no fixed destination the data, the words of the participants directed the journey. It was very useful for the researcher to be aware of developing and employing a theoretically sensitive approach during this time (Charmaz, 2006). Charmaz (2006) has noted that "to gain theoretical sensitivity, we look at studied life from multiple vantage points, make comparisons, follow leads, and build on ideas" (p. 135). There is a great sense of discovery in this process when researchers approach theorizing as an opportunity for "seeing possibilities, establishing connections, and asking questions" (Charmaz, 2006, p. 135).

Once a picture begins to emerge with categories that encompass the data, open coding gives way to focused or selective coding and the establishment of a core variable (Walker & Myrick, 2006). Charmaz (2006) has defined focused coding as a means to process large amounts of data by utilizing the frequent and noteworthy codes identified in initial coding. "Focused coding requires decisions about which initial codes make the most analytic sense to categorize your data incisively and completely" (Charmaz, 2006, p. 57). Memoing and the use of extensive diagramming were vital in helping the researcher identify the focused codes in this study. The

visual representation of the data proved key in moving the process on to the final coding phase.

For both Glaser (1978) and Charmaz (2006), theoretical coding was viewed as an opportunity to make connections between previously established codes and categories. The process can be summed this way: "theoretical codes conceptualize how the substantive codes may relate to each other as hypotheses to be integrated into a theory. They, like substantive codes, are emergent; they weave the fractured story back together again" (Glaser, 1978, p. 72). For Charmaz, this process takes the analysis that has been developed and moves it towards theory. Once theoretical coding is concluded, researchers should move on to further theoretical memoing as the next step in the grounded theory derivation process (Charmaz, 2006; Glaser, 1978).

Although all memo writing is, in essence, a reflexive act, Charmaz (2006) has advocated the presence of the participant's natural voice in constructivist grounded theory memoing (p.84). This supports the ongoing co-construction of data and its analysis. In this process, "the theoretical world that we attempt to reconstruct is being constantly rewritten in our memos to reflect both participants' stories and our own making of meaning" (Mills et al., 2006b, p. 11). In this research project, this point in the data analysis process was also an opportunity to engage participants in second interviews and reflect on the resonance of the developing concepts with them. As a novice, the researcher wanted to remain vigilant against any risk of data forcing in this crucial analytic stage. As Charmaz (2006) has stated, as grounded theorists, "we do not force preconceived ideas and theories directly upon our data. Rather, we follow leads that we define in the data" (p. 17). Again, the support of the doctoral supervisor for this project was essential in this stage. Diagrams were reviewed, and coding decisions reported and discussed. These conversations along with extensive memoing and further discussion with study participants aided the researcher in concluding this phase of analysis.

The final consideration in the data analysis process for this study was to reflect upon how to manage the ongoing use of existent literature. As was noted in Chapter Two, in contrast to Glaser, Charmaz (2006) has provided a very practical view of the use of literature in GTM. Noting the realities of students engaged in graduate work, grant requirements, and simply the results of years of study, Charmaz does not promote the avoidance of a thorough literature review prior to conducting a grounded theory study. The theorist has stated skillfulness in managing an extensive literature review "is to use it without letting it stifle your creativity or strangle your theory" (Charmaz, 2006, p. 166). The researcher had amassed a substantial body of CoP literature to serve as a data source, as appropriate, in the theory derivation process. The key element in determining the appropriateness was the use of literature to support emerging conceptual or theoretical work as opposed to forcing the same. The existing CoP literature, especially within nursing, served as a key data source during theoretical analysis and in providing further relevant contextual details for reporting final results and future directions related to the newly developed theory. The use of existing literature was carefully managed throughout the data analysis process and during the authoring of the study results.

3.1.7 Rigour

Charmaz (2006) has highlighted four distinct criteria that can be applied to the evaluation of grounded theory studies: credibility, originality, resonance, and usefulness. Credibility can be achieved by demonstrating research that has discernibly reached an intimate familiarity with the subject and includes conclusions that are sufficiently supported by rich data from a sufficient number of sources (Charmaz, 2006). Details provided in Chapter Four will further illustrate how the researcher strove to achieve credibility. This study included sufficient data collection methods and an accompanying data analysis process to support credible final results. As a novice, the researcher also relied on the mentorship and guidance of her doctoral supervisor and committee

to further support the credibility of study process and conclusions.

According to Charmaz (2006), evidence of originality are results that can serve as a challenge to, or evolution of, current ideas or analysis, and that provides "a new conceptual rendering of the data" (p. 182). This research was undertaken with the use of grounded theory methodology to specifically expand current knowledge regarding CoPs in nursing in the hopes of moving towards a new conceptual rendering of CoPs specifically within a nursing context. The researcher feels the result of this work is an original theoretical presentation of CoPs in specialized acute care nursing.

To achieve resonance, Charmaz has suggested that study results must have meaning to the participants that shaped them, and ideally offer deeper insight into their social structures. Categories should "portray the fullness of the studied experience" (Charmaz, 2006, p. 182). The researcher used second interview opportunities to seek confirmation from participants regarding the resonance of this work. In the opinion of the researcher, the categories detailed in Chapter Four are a comprehensive portrait of the CoP experience in the specialized nursing units that served as the context for this research. The researcher has a knowledge translation plan to further share the study results with both the study participants and other practicing nurses. Knowledge translation has been defined by "The Canadian Institutes of Health Research…as the exchange, synthesis and ethically sound application of knowledge within a complex system of interactions among researchers and users" (Estabrooks, Thompson, Lovely, & Hofmeyer, 2006, p. 28). These planned knowledge translation activities will be an opportunity to further gauge the resonance of this research as well as providing additional direction for future research in this area.

Usefulness speaks to the easy and real-world application potential of the study results, and to how well the work encourages further substantive research (Charmaz, 2006). This study was planned as an initial step in a full program of research related to CoPs in nursing. As has been

noted, specific knowledge translation plans have been made regarding the results of this research. This plan includes sharing the results with practitioners on the three nursing units that participated in the study as well as with nursing administrators in the health region, as deemed appropriate.

Finally, as a further guide to rigour in grounded theory study, researchers can employ methods highlighted by Chiovitti and Piran (2003). While acknowledging the variety of GTM in use, the authors noted that despite the specific GTM approach chosen by a researcher, "the question of rigour remains" (Chiovitti & Piran, 2003, p. 428). Chiovitti and Piran (2003) expanded on broader rigour concepts such as credibility, auditability, and fittingness in GTM, which seem to complement those recommended by Charmaz previously:

> (1) let participants guide the inquiry process, (2) check the theoretical construction generated against participant' meanings of the phenomenon, (3) use participants' actual words in the theory, (4) articulate the researchers' personal views and insights about the phenomenon explored, (5) specify criteria built into the researcher's thinking, (6) specify how and why participants were selected, (7) delineate the scope of the research, and (8) describe how the literature relates to each category that emerged in the theory. (p. 427)

These practical guidelines combined with the rigour recommendations of Charmaz were extremely valuable in supporting the work of a novice GTM researcher during this process. As part of the consideration and application of these guidelines, for example, an explicit audit trail of decisions made during the data collection and analysis process of this study was kept to support transparency in pursuit of rigorously sound results. The researcher was cautious not to override the voice of the participants and to check back regarding the developing theory. For example, the model being constructed as a visual representation of the work was shared with several participants as it was being developed. The sharing of the model was especially helpful in

allowing participants to see the theory as a whole in this visual presentation and elicited excellent feedback regarding the development of this crucial theoretical piece. The researcher used personal reflexivity during the study process as well as employing the guidelines noted here to produce robust and rigorous results.

3.1.8 Researcher as Instrument

With many qualitative research methodologies, it is valuable to consider the role of the *researcher as instrument* within the context of the study. Often the consideration of researcher as instrument is raised in conjunction with the use of certain data collection methods such as semi-structured interviews. I argue however, that there are many choices made in the conceptualization and completion of a qualitative study where this concept may apply especially for novice researchers, and that considering the researcher as instrument for the entirety of a project supports ongoing reflexivity and disclosure. In her article on quality and trustworthiness in qualitative research, Morrow (2005) discussed the importance of including a researcher as instrument statement in research writings. It was recommended the statement include a discussion of reflexivity, the researcher's experience with the population of interest, pre-existing biases or other assumptions or expectations, and a thorough accounting of how such issues would be managed during the research process (Morrow, 2005).

I took the concept of this type of statement and combined it with recommendations on reflexivity and relationality for grounded theory study from Hall and Callery (2001) to ensure a strong foundation for self-reflection and disclosure during this research. "Reflexivity, which addresses the influence of investigator-participant interactions on the research process, and relationality, which addresses power and trust relationships between participants and researchers, have the potential to increase the validity of the findings in grounded theory studies" (Hall & Callery, 2001, p. 258). A novice researcher should invest time in understanding the depth of the

concept of reflexivity. It is more than simply engaging in periodic self-reflection during the research process. As this study progressed, I came to realize that there needs to be enough depth to self-questioning to result in a deeper understanding, not just of self, but of the influence of self in the resultant work. The act of reflexivity "reminds the qualitative inquirer to be attentive to and conscious of the cultural, political, social, linguistic, and ideological origins of one's own perspective and voice as well as the perspective and voices of those one interviews" (Patton, 2002, p. 65). Patton (2002) has provided researchers with some direction in how to be reflexive in research including using an active rather than a passive voice, including "I" statements, especially in describing analysis decisions; providing rich description and detail in research writing; ensuring contextual clarity; and giving readers a clear view of the researcher's own voice and perspective. I found these concrete recommendations extremely helpful during my research. By incorporating these suggestions into my memoing writing as well as the study results, it aided me in maintaining a focus on the importance of reflexivity in the process.

Relationality is something that can be reflected on within the reflexive process, but it should also be a way of being with participants during data collection encounters. Relationality should work to maximize participant voice as was previously highlighted in a discussion of work by Hall who suggested emerging diagrams arising from analysis be shared with participants for their feedback and direction (Hall & Callery, 2001). The researcher also noted the importance of recognizing when biases might need to be disclosed during an interview and the importance of reflection on what might be directing conversation within these moments (Hall & Callery, 2001). I employed both of these approaches, the sharing of emerging diagrams from my data analysis with participants for feedback, and the appropriate use of disclosure in interviews during this research. I also used personal audio-recorded research notes immediately following interviews both as a tool for reflexivity and more specifically as a means for maximizing relationality as my

study progressed.

I needed to acknowledge my personal context as part of the larger sphere of my doctoral research. I am a female, with liberal political views, and several years of pediatric registered nursing experience in the same facility utilized as a research setting. I deliberately did not pursue the use of my own nursing unit as a study setting, but did have to acknowledge my existing relationship and any accompanying biases with this hospital context in general. I had no strong negative feelings about this setting entering into my doctoral research. I have had both good and bad nursing experiences during my own career in the institution and anticipated I would recognize any potentially influencing biases related to my status with this setting, were they to arise. After concluding my data collection, I again reflected on any personal issues I may have had with the study setting, and I noted none.

I think that my relationship with reflexivity in my doctoral work was a factor even in my choice of methodology. When questioned about why I chose one variation of grounded theory methodology over another, I realized that it had little to do with the specific details regarding how to proceed with each method and much more to do with the philosophical and epistemological differences of each. This realization allowed me to acknowledge that I did not share the positivist views associated with objectivist grounded theory, nor could I fully embrace the concept that any qualitative research effort could be wholly objective. Charmaz's idea of social constructivism deeply resonated with me as a researcher.

This research was an opportunity for me to acknowledge a bias towards a process of co-construction and collaboration in the research process. Although I personally had limited training in grounded theory research I did have a depth of experience, both with this methodology, and with qualitative research in general, within my doctoral committee to draw upon. This was an invaluable resource during my research process. As a methodical and organized person, I also

had a deep commitment to the details and steps that should be attended to in the pursuit of a quality research product.

Finally, I had to reflect on what I felt was the strongest bias I was bringing into this research. As I have noted previously, Wenger (1998) has stated that CoPs are everywhere. I agreed with this view, and felt strongly about the community of practice concept and its role in learning. I worked to acknowledge, with support from my doctoral committee, that Wenger's assertion did not guarantee the existence of CoPs in specialized nursing practice, especially exactly as he had defined them. Moreover, with a commitment to a GTM in place, it would be a violation of the essence of this method to enter into the research process with a predetermined view of what would be found. A fundamental component of GTM, regardless of the specific approach applied, is to allow the inductive process of conceptual or theoretical outcomes to arise from the data. With a personal in-depth understanding of the key elements of CoP groupings as outlined by Wenger, I knew I needed to be vigilant not to steer discovery towards my existing understanding of CoPs and instead be open to what would come from the data. This realization allowed me to more openly explore the relationships and community structures present for nurses in specialized practice.

In summary, my personal tools for ongoing reflexivity during my research process included: ongoing discussion with my doctoral supervisor and committee members regarding the research processes and potential influence of personal biases; written or recorded research notes completed immediately following interview sessions; and the inclusion of reflexivity while memoing during the process of my constant comparative analysis. Memoing has an influential role in the grounded theory process and it was beneficial for me to include my reflexive writings in these same documents. These memos then served as cues to my position at any given point in the data collection and analysis and allowed me to keep reflexivity close to the analysis process.

These comprehensive memos then served as an additional way to guard against data forcing in my analytic work.

3.2 Ethical Considerations

This research was subject to ethical approval by the University of Saskatchewan Behavioural Research Ethics Board (initially granted in February 2012 see Appendix B) and additional agreement from the Saskatoon Health Region (operational approval granted in February 2012 see Appendix C). The ethics approval was amended once to support further methods of participant recruitment and renewed twice to ensure coverage for the entirety of the study. Ethics was closed for this research in August 2014. The rights of the study participants were safeguarded in accordance with all standards set forth by both agencies.

The demands of qualitative research must be accompanied not just by informed consent, but also with a deeper application of the concept, process informed consent. This refers to the need for the researcher to confirm participants' consent at varying points during the study (Streubert-Speziale & Rinaldi-Carpenter, 2007). It is the ever-changing nature of the grounded theory research process, and its unknown direction, that requires investigators to be vigilant in discussing consent as well as providing regular reminders that informants are free to discontinue their participation in a project at any time.

Potential risks for participants in this study included emotional reactions or feelings of fatigue that could present during interviews. Information regarding the employee family assistance plan for hospital employees was available for participants in the event that unexpected emotions or stress resulted from participating in the interview process. Participants also had the right to refuse to answer any questions, stop the interview, or remove themselves from the study altogether at any time, as was noted at the beginning of each interview. No participants during the course of the study felt the need to make any of these requests.

The data collected from this study was managed and secured to ensure the confidentiality of the participants. Demographic information and any identifying materials have been stored separately from interview transcriptions, reflective journals, and research notes. A coding system was put in place and data was reported as a collective with codenames used for any direct quotations to further safeguard the identity of the participants. Collected data, analysis files, and other documentation have been secured in the office of the researcher and will be kept there in a locked filing cabinet for a period of five years after the end date of the study, in accordance with University policy

3.2.1 Consent Processes

The Canadian *Tri-Council Policy Statement: Ethical Research Involving Humans* has detailed explicit procedures regarding participant consent in research projects. First and foremost, that participants must engage in research voluntarily with a full understanding of the project and any potential risks or benefits. For this research, in adherence with these guidelines, I used informed consent as well as ongoing or process consent. Participants were provided with a comprehensive overview of the purpose of the study and the risks, although these were noted to be minimal. Through process consent, participants were reminded at each interview that they were free to refuse to answer any question and could request the recording device be turned off at any time. They were free to leave at any time and could also request that their data not be used for the study. None of the participants refused any questions during the interviews nor did any request the process be stopped at any time. There were no requests to withdraw from the study. The researcher made it part of her regular practice to frequently check with participants regarding any questions or concerns and all 19 contributed fully with no stated concerns. Finally, participants were made aware during the initial consent process that once data had been integrated into the ongoing analysis it would likely be impossible to remove its effect on the

theory development or subsequent theoretical sampling.

Although this did not occur during data collection for this study, should participants have become distressed at any point information regarding personal support through the workplace employee and family assistance plan was available. Written informed consent was obtained from each participant in accordance with Tri-Council and University of Saskatchewan policy with the use of a participant consent form (Appendix K). A summary of the research findings will be made available to those participants who requested it.

3.3 Study Limitations

This study was limited by the context in which it was carried out, an urban Saskatchewan, acute-care hospital setting, further delineated to three specific specialized nursing care areas. The voluntary recruitment of participants may have resulted in a skewed view or conceptual rendering as only certain member personality types may have elected to participate. Given that the exact form and function of any existing CoPs was not known, there was no way for the researcher to determine whether or not participants were part of existing CoPs prior to the beginning of data collection and analysis. Potential bias, or a skewed representation of certain types of the community members who did self-select to participate may also be a limitation to this research. Given that the researcher has been a nursing educator within this same region for many years it is possible that a social desirability bias may have also influenced study participants in some way. When working with those few participants that had previously been taught by the researcher the use of relationality and reflexivity was vigorously pursued in order to minimize the risk for this potential bias.

The planned study sampling criteria did not guarantee a diverse representation of the population would be obtained, and although the study demographics seemed to align with the professional culture in these settings, it is possible the view of the participants represents a

perspective of nursing that is also skewed in some way. The resultant theory may only resonate with the practitioners involved in this study and may not be applicable or transferable to other nursing practice contexts.

There are situations that arise in research studies where the choice of methodology can emerge as a potential limitation. When working with GTM, for example, limitation arises if theoretical saturation cannot be obtained. In this case however, the methodology choice did facilitate achievement of the research objectives and as such, the methodological choice is not considered a limitation.

3.4 Conclusion

The methodology chosen for this doctoral study has been outlined in this chapter, along with specific details regarding the sampling, data collection, and analysis utilized. Considerations pertaining to methodological consistency and rigour have also been reviewed. The use of reflexivity and relationality to further strengthen the rigour of the work and maximize participant voice were noted to be of great benefit, especially for a novice researcher. The researcher has included an overview of existing personal biases as well as how the use of an ongoing reflexive approach aided in minimizing risks for issues such as data forcing. The researcher has concluded that the chosen methodology and the tools for its rigorous application provided a sound foundation for this doctoral research.

Chapter Four

4.1 Findings

This chapter includes the findings from this doctoral research. The purpose of this constructivist grounded theory study was to explore nursing specific processes associated with CoPs in specialized acute care settings with a focus on their potential role in RN integration and professional development. In pursuit of this purpose, it was hoped further insight into the social processes that are fundamental to the integration of nurses into their chosen specialized acute care settings, and the role of CoPs in this journey, would be discovered. This chapter begins with an overview of the participant demographics and the introduction of the Findings Component Model. The research context is outlined through the words of the participants and the remainder of the relevant data findings proceed from this point. One main concern and two basic social processes are identified as key elements in the findings for RNs in specialized acute care practice. Themes of transition and integration emerge through the data and the role of CoPs as the social context for these processes is detailed. Finally, a theoretical model is presented prior to the conclusion of the chapter.

4.1.1 Sample Demographics

There were 19 RN participants involved in this study. A full summary of participant characteristics can be found in Table 4.1 (Appendix L). The participants were divided among three acute care specialized nursing units in a Western Canadian urban hospital: Unit A (6), Unit B (7), and Unit C (6). The mean age of the RN participants was 34 years with an age range of 23-53 years. There were 15 female and 4 male participants. In terms of nursing education, the majority of the participants indicated a Bachelors Degree in Nursing or BSN as their highest attained educational level (17). One participant reported a Diploma in Nursing and one had completed a Masters in Nursing.

There was variation in the length of time the participants had been licensed to practice as RNs, with a corresponding level of experience in their specialized units. The mean time as a licensed RN for the participant group was 8.4 years, with a range of 7 months to 31 years. The reported time employed on their specialized units ranged from 2.5 months to 27 years, with a mean time employed of 7.3 years. The majority of participants worked on their units in a full-time capacity (13).

4.1.2 An Overview of the Findings Component Model

Once the data analysis was complete, the Main Concern that emerged for the specialized RN participants in this study was *Competently Fulfilling the Specialized RN Role.* Outcomes related to the achievement of competence were centered on providing safe, quality care for patients. Being able to provide consistent competent care was key to successfully managing a sense of duty. In addition to the Main Concern, two basic social processes (BSPs) were identified, *Developing a Sense of Specialized RN Self* and *Integrating into Specialized RN Practice*. These processes are distinct and yet exert influence on one another. The first BSP depicts what is essentially an internalized experience unique to each RN, while the second represents the more externalized process of RNs entering and integrating into their chosen specialized area. For each of these BSPs, there are additional phases that further define the experience. *Developing a Sense of Specialized RN Self* includes the phases *Finding RN Fit*, *Sharing Passion and Community Values*, and *Embracing Life-Long Learning*. *Integrating into Specialized RN Practice* includes the phases *Learning the Ropes* and *Settling In*. An overview of the key findings is presented on the following page in the findings component model, Figure 1. Further details regarding this model will be included as the presentation of the research findings progresses in this chapter.

Figure 1. Findings Component Model

In detailing these BSPs, the distinctive features and parameters of the nursing CoPs present in these specialized care areas were revealed, thereby meeting a key research aim. A CoP emerged as the social context for the integration of new RN members, and by exploring and delineating the BSPs present in this journey of transition and integration, the key elements of a CoP in specialized acute care nursing practice became evident. Chapter Five contains a further exploration of these nursing CoP features, including a comparison of these research findings with key originating CoP characteristics as outlined in the seminal work of Wenger (1998). The identified Main Concern and the BSPs revealed in this research are the focus of this chapter.

4.1.3 Context

Charmaz (2006) has stressed the importance of context in grounded theory research. Within the constructivist view, both data and analysis are seen as socially constructed findings and thereby "contextually situated in time, place, culture, and situation" (Charmaz, 2006, p. 131). There are two facets to consider regarding the social context of this research. First is a consideration of the specialized nursing practice areas in which the research was conducted, including the unique organizational cultural influence of these areas. The second is the existing communities of RNs practicing within each area.

4.1.3.1 Specialized nursing practice. Situating these research findings should include consideration of some of the parameters and demands inherent in any specialized practice setting. Regardless of the specific unit, participants in the study consistently identified several key features that defined their workplace context.

The Canadian Nurses Association (CNA) offers RNs practicing in Canada the opportunity to complete a certification exam in 20 specialty areas (CNA, n.d.). These areas include the three nursing units featured in this research. In order to qualify for the certification examination, RNs must have completed a substantial number of hours in their specialty area (CNA, n.d.). This

national certification program is an established parameter for determining what nursing areas are actually considered specialized practice for RNs in Canada. The time requirements before an RN can pursue certification are an indicator of the additional demands of these areas and the knowledge that must be amassed in each area, prior to seeking out and being successful in obtaining designation for that specialty. These are details that were echoed by the participants in this research.

Participants defined specialized practice environments in their own words during the interview sessions for this research. The participants portrayed an image of stimulating, yet demanding environments that often challenged them in their practice. *"It's enjoyable and it's exciting, we're a very energetic unit, fast paced. The workload can go from kind of mild to heavy in no time at all and so just to be able to adjust to that and adapt"* (RN-C). While acknowledging the stresses inherent to nursing in these fast-paced specialized environments, several participants also noted they had sought out these areas with deliberate consideration of this intensity. *"It's a nice challenging place to work and to get to learn a whole bunch. I like the fast pace and the adrenalin and stuff like that"* (RN-Q). Several other participants also identified the pace of practice in their specialized units as more demanding than previous general ward experiences as RNs or students.

In addition to the pace of work in these specialized environments, participants identified notable differences in patient acuity.

> *It's very acute. My first week there, there were emergency bells pulled all the time. I remember just having the 'deer in the headlights' look through most of it. At that point I hadn't been trained in the unit on resuscitation either and so I felt like I couldn't really help out. But going through that shock, you know it's good because then you realize what you are getting into early on and if you can hack it*. (RN-B)

Lastly, participants referenced the variety of patients and nursing care situations they faced in specialized environments. "*You never know what's coming through the door"* (RN-I). Again, although there were challenges identified to practicing in such varied and demanding environments, participants noted the variety in their practice areas as a positive, especially in terms of their professional development as RNs.

A rapid pace, high patient acuity levels, and variety in care situations were the three features that participants most consistently identified as key elements of their specialized work environment, regardless of the specialty. The experience of specialized nursing was perhaps best summed by one participant who stated, *"you know, some people really like the ward nursing where, you know, it's the same thing every day kind of thing, within reason. And you have routine and things like that. Some people thrive on that. That's not us"* (RN-H). There is something further to be taken from the statement, '*that's not us'*. This was another common theme to emerge from the participant data, an identifier of a collective 'us'. This reference was typically made in identifying the community of RNs engaged in practice within the specialized unit. Although occasionally the *us* was noted to also include other health care practitioners or unit staff, the specialized practice area seemed to promote a strong sense of togetherness or community. The researcher felt this should be explored as the second facet of the social context for this research.

4.1.3.2 CoPs in specialized nursing. During grounded theory analysis, often during theoretical sampling, questions can arise that may direct the researcher to extant texts such as literature (Birks & Mills, 2011). Charmaz (2006) has noted that such texts can be used as primary or supplementary data sources. In the case of the ongoing development of the contextual details in this research, key extant literature was used in just such a supplementary manner. The use of the literature in a constant comparative analysis process can assist in clarifying or situating

themes emerging from interview data (Birks & Mills, 2011). Although not used extensively, there are select instances in the following reported findings related to the research context, as well as the Main Concern and primary BSPs, for which extant literature is featured as a supplementary data source.

Working from the definition previously identified in this research, a CoP is typically considered to be a "group of people who share a concern, a set of problems, or passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis" (Wenger et al., 2002, p. 4). Incorporating the elements just reviewed in delineating a specialized practice area, it seemed plausible that the social context for this research was the CoP present in each of these specialized units. There are two points to consider prior to progressing with this contextual determination. The first is determining the difference between a community and a CoP, and the second is to review the role of sensitizing concepts, such as CoP, in constructivist grounded theory research.

In psychology, some researchers have defined community as a concept that demarcates a psychological *sense* of community. McMillan and Chavis (1986) produced what is considered to be a seminal work on sense of community and identified four elements for this concept in their research: 1) membership, providing emotional safety and a sense of belonging; 2) influence, which is bidirectional, meaning members can influence the group and the group the members; 3) integration and fulfillment of needs, members of a group perceive some reward related to their membership; and finally, 4) shared emotional connection, which McMillan and Chavis noted as "the definitive element for true community" (p. 14). There are a multitude of other definitions of community from such diverse fields as biology to business, and the researcher reviewed many of these the course of this study. While working to differentiate a community and a CoP, it quickly became evident that there is likely no single, all-encompassing definition of community. The

term is used for many diverse groups and contextual circumstances in slightly different ways as applicable to the disciplinary approach of each application. The researcher did come to believe that community is the broadest definition of a collective, or a social configuration as Wenger might say. The term community is broad in scope perhaps because of the extremely large and diverse groups or social structures to which it is applied and the view of community from McMillan and Chavis provides a comprehensive foundation for the discussion here. A CoP however, is much more specific.

Wenger (1998) identified three essential elements that are present within a community of practice, "a community of mutual engagement, a negotiated enterprise, and a repertoire of negotiable resources accumulated over time" (p. 126). He further went on to describe several indicators that may be present in a formed community of practice, some of which are:

> sustained mutual relationships – harmonious or conflictual…rapid flow of information and propagation of innovation; absence of introductory preambles…knowing what others know, what they can do and how they can contribute to an enterprise; specific tools representations, and other artifacts; local lore, shared stories, inside jokes, knowing laughter; jargon and shortcuts to communication…a shared discourse reflecting a certain perspective on the world. (p. 125)

There are some similarities between this consideration of the parameters of a CoP and the definition of community outlined by McMillan and Chavis; however, there are some distinct differences as well. A thorough discussion of the elements of a CoP as outlined by Wenger in comparison with the findings of this research is featured in Chapter 5. At this juncture it is relevant to note that in examining community and CoPs, the researcher came to the conclusion that while a CoP is always a community, a community may not be a CoP. Further, even though the participants in this study did not specifically identify any of their practice communities as a

CoP, their rich descriptions of these more closely align with Wenger's (1998) CoP descriptors, as opposed to the more general community indicators as outlined by McMillan and Chavis (1986).

It is not surprising that the study participants did not use the term CoP to describe their specialized practice environments and professional groupings. Although an increasingly common term in many academic fields, it appeared that the CoP concept was not familiar to many of the research participants. The researcher therefore identified this concept to be a sensitizing concept in the ongoing research process. Charmaz (2006) has noted, "grounded theorists use sensitizing concepts as tentative tools for developing their ideas about the processes that they define in their data" (p. 17). Having stressed that these concepts provide a place to start as opposed to end, Charmaz (2006) continued to caution against the risk of data forcing, and the misapplication of preconceived ideas or theories to the data. The theorist went so far as to recommend that should a sensitizing concept be deemed irrelevant or inapplicable in regard to emerging data, that it then be discarded all together (Charmaz, 2006).

As several interviews in this study progressed to include discussion of community at the participants' direction, the question of CoPs was introduced when deemed appropriate. There were no specifics provided by the researcher regarding the concept; rather it was an opportunity for participants to reflect upon what CoP might mean to them within their own professional context. The words of the participants illustrating their views of community, or in some cases CoP, are forthcoming prior to the conclusion of this discussion of research context.

A key research question in this study was to determine the key features, roles, and processes of a CoP in specialized acute care nursing practice settings. It was in explicating the two basic social processes that emerged from the research context, that the parameters and details of the specialized acute nursing CoP arose. This discovery aided the researcher in addressing the research questions regarding the social processes integral to the integration of RNs into their

chosen specialized acute care nursing practice settings and the role of CoPs in the integration process of RNs into their chosen specialized acute care nursing practice settings. Some of the key features of these work environments, as detailed by the study participants, included extensive learning and social networks. These appeared to be critical features of both the context, and as was revealed the research itself, helping the researcher to support the assertion of these communities as CoPs.

4.1.3.3 Participant views of community. It is advantageous to consider some of the views of the participants in regards to their communities within the discussion of context. It became evident early on in this research process that simply being engaged in a specialized practice setting provided a sense of this belonging. "*I think that even just even being on my unit I felt like that's a community to itself because it is specialized, and that was something I really wanted to be a part of"* (RN-L). Just as there are many academic definitions and connections to the word community, so it seems that individuals have their own unique perspectives and reactions to this term. The recruitment of one participant, in fact, appeared to be due to the discussion of community in the study promotional material.

> *I think one of the things that got to me to come was the word 'community' because I am from a small community versus living in Saskatoon is very big for me and in a community you do know everybody whether you want to or not that's how a community is. It's a group sharing, you know, some space, sharing knowledge, sharing the same goals, sharing because of similar times in their life you know and so the word community is kind of special to me.* (RN-C)

Although this was a very personal reflection on the word community, it was telling for the researcher to have the participant also include knowledge and goal sharing, features that are inherent in a CoP. It was discussions like this that supported the decision to retain CoPs as a

sensitizing concept in the research process.

Having reviewed the demands that accompany nursing practice in a specialized setting, it is not surprising to discover that participants relied on their work communities for support, and as a means of sustained engagement.

> *I think it is the best thing in the world when you can have community at work because it makes you love your job that much more and makes you want to go to your job and probably prevents a lot of burnout too because you have all of that support that you need.* (RN-B)

Of course participants also had insight into the challenges their communities encountered.

> *I mean, there's healthy communities and there's unhealthy communities…It's just basically how well we function together and I personally think that we have made huge steps to have a good community within our ward. But like every community, you're still going to have your problems. You're still going to have your little quirks that go off, but I mean, it's just trying to fix them*. (RN-J)

This resolve was a key feature of many of the community discussions that participants engaged in during this process.

Although there were realistic views of both the positive and potential negative aspects of their work communities, participants were clear about the personal value of community in their workplaces. They did not want to be involved in a workplace without community, nor did they want to become ostracized from the existing community structure. There was also a general sense of the need for everyone to contribute to keep the group functioning, as well as the value of each member.

> *Everybody has just different things to bring to the team and it could be from the most experienced person to the least experienced person still bringing something that's*

wonderful and you throw it all together and it just makes a difference. (RN-C)

While the RNs were often focused on their own disciplinary communities, there was also discussion about the importance of the interprofessional groups in which they practiced. *"We just don't function without each other and that's the big thing. I try to instill that in the care aides and in the pharmacists and tell them we can't do our jobs without you guys here"* (RN-J).

Specialized practice settings can promote community connections, be they within a single profession or between members of several groups that are engaged in the achievement of common goals, in this case often related to patient care. From the review of this data, the researcher also noted that an interesting challenge persists regarding the nomenclature of these groups. Academia, in nursing and beyond, has had its own disputes in terms of clearly differentiating teams, groups, and communities. When Wenger (1998) added the CoP concept to this already complex debate, it did not simplify matters. Rather, it added yet another potential distinction that could be applied to groupings.

4.1.4 Main Concern: Competently Fulfilling the Specialized RN Role

The RN participants involved in this research shared vivid memories of their first days in their specialized practice units. Recalling that the range of time the participant group reported being employed in these settings ranged from less than 6 months to 30 years, it would be reasonable to assume that the newer employees would have had the strongest recollection of these early experiences. Yet this was not the case. Every participant could clearly outline several aspects of their beginnings in specialized practice. The clarity with which they recalled these moments allowed the researcher insight into the significance of these experiences. The intensity of these memories was a key to identifying the Main Concern of this participant group, which was *Competently Fulfilling the Specialized RN Role.* The Main Concern is noted at the base of the Findings Component Model in Figure 1 (page 72). The two BSPs proceed from the impetus

of the Main Concern, the RN's Sense of Duty, which encapsulates the desire of RNs to be able to provide safe and quality patient care. While sense of duty is a likely constant for all RNs, these participants seemed to reflect a heightened awareness of this in their specialized areas, perhaps due to the patient acuity and complexity of care in their practice.

Sense of Duty is placed at the top of the model illustrating its role as a stimulus in the achievement of the Main Concern. The duty to patients is a weight upon each nurse from the first moment they step onto the floor of their specialized practice unit. There is a great sense of this burden; of protecting life and providing care within an environment they are not yet familiar with, and yet must function within safely. Achievement of the Main Concern included such outcomes as being able to provide consistently safe and high quality patient care. This often included having the time and capacity to support meaningful connections with patients.

The weight of the responsibility of specialized practice is not to be underestimated. It is the realization that the achievement of competence in the specialized role is a lengthy and complicated pursuit and yet, from that first day of independent practice, patients are assigned and awaiting care. In the words of the participants, this makes for some scary beginnings, sometimes even before the first day has even actually arrived.

> *I think I was expecting to be sent right into the trauma areas too and all that crazy stuff and then when you actually get there you realize that there's different CTAS* [Canadian Triage and Acuity Scale] *and stuff I didn't even know about* [unit] *before I went there…so it wasn't as bad as I thought it was going to be*. (RN-I)

However, even when the imaginings of how it might be did not turn out to be a bad as feared, there was no shortage of difficult first days. "*When I did my first alone shift oh my goodness, I was so scared"* (RN-G). There was a sense of fear and apprehension, but also of pressure to be able to perform.

When I first started it was very intimidating…it was just kind of like get report and go, right. So not only do I not know where anything is or what's going on, I have to listen to all this report and decide okay who's the sickest, who am I supposed to see, right. (RN-I)

There was also a stark realization of the considerable learning demands in this new specialized environment. *"It was definitely scary and overwhelming, because it's…there's wasn't a lot I could do because it was so specialized, so I can't do chemo, I can't do transplant"* (RN-J).

Learning emerged as a pervasive aspect of this research, and it therefore featured as a critical component of the context in which the BSPs evolve, as seen in Figure 1. The placement of learning as a contextual element emphasizes its importance in the processes at work in specialized nursing practice. Indeed, it is a critical feature of the Main Concern, *Competently Fulfilling the Specialized RN Role*, an importance not lost on the study participants. "*I felt like I knew nothing…because there is so much to learn and there's so much to know"* (RN-A). New and experienced RN participants alike felt the burden of the unknown upon arriving in their new specialized areas.

Even though I've had all those years of experience it was a huge learning curve for me. There was a lot that I've dealt with before but there was so much that I haven't. The complexity of the patients that we have here is quite a bit more, but in different ways. (RN-H)

It was learning, including many items of specific specialized knowledge relevant to their new environments, that the participants saw as a means to help them achieve competence. In doing so they sought to be able to provide safe and quality care for the patients they felt a duty to serve at an expected level.

Patient safety has long been a critical component of nursing education and practice and is also an outcome of the Main Concern of seeking competence. The CNA *Code of Ethics for*

Registered Nurses published last in 2008, highlights this commitment in Part One of the Nursing Values and Ethical Responsibilities. Each RN practicing in Canada is held to this code of conduct and so each is responsible to uphold the primary values contained within. The provision of safe, compassionate, competent and ethical care includes the following directive: "nurses question and intervene to address unsafe, non-compassionate, unethical or incompetent practice or conditions that interfere with their ability to provide safe, compassionate, competent and ethical care to those to whom they are providing care" (Canadian Nurses Association, 2008, p. 9). What appears to happen in the case of the specialized practice areas featured in this research is that RNs question themselves and their own abilities to work safely. As participants spoke about the fear and overwhelming nature of their new work environments it often seemed to be connected to the identification of themselves as potential safety risks.

Each of the units utilized in this research has several staged levels of RN practice requiring additional training and certification and as such, it can take months, or years, to be competent in all areas. However, caring for even the least acute patients on these units is still specialty practice. It is the responsibility of RNs to ensure that the care they are providing is safe, even if they have to admit their uncertainty and in doing so, seek support and assistance from others.

> *You have to ask questions if you don't know. I think that's huge. You need to ask questions and you need to be honest about what you know and what you don't know, especially on our ward. Because people that kind of pretend maybe that they know cause they don't want to look stupid and whatever it's going to backfire and it could be a really dangerous situation.* (RN-H)

Safety is a marker for competence, a signal to the group that the RN is going to be able to function as a contributing member of their community. Many participants talked about the critical importance of RNs being completely honest about their level of safe practice and never

exceeding that threshold. The problem for nurses attempting to integrate into these specialized areas is that the pace of care and the demands to perform quickly do not leave much room for missteps, or opportunities to admit uncertainty about skill levels and competence. For this reason, the ability to demonstrate competency and the provision of safe care seemed to be a turning point in specialized practice for these research participants.

While consistent, safe care appeared to be an absolute minimum requirement for RNs to self-identify as competent, there was also a focus on the quality of care that was being provided. There was a general acknowledgement among the research participants of the heightened needs of their specialized patients. Participants were also quick to highlight the intensive situations their patients endured. Combining a desire for quality and time to care appropriately in these intensive situations with the acuity level of these patients had participants speaking about the demands of nursing in specialized work.

> *We always worry about kind of being able to provide the care that we should be providing and hoping when it gets really, really crazy and we're not doing our one to one care like we should be, we worry about things going wrong, you know. It usually doesn't but what if it does, you know. And it's not a place where you can just pull nurses in from wherever. You need to know what you're doing.* (RN-H)

This quote demonstrates the connectedness of the outcomes that contribute to the Main Concern of specialized RN competence. There has to be a foundational amount of knowledge to be safe, and safe practice to support quality care delivery. When participants reported a perceived inadequacy in meeting these goals, there appeared to be a very real sense that they had let their patients down.

The RN's sense of duty is a distinct driver identified in relation to the Main Concern. This sense of duty, is reinforced, according to several study participants, by strong patient

connections. "*You get to know your patients really well and I don't know if that drives you more that you want to do what's best for them too, I think*" (RN-D). Participants noted that nursing in their specialized areas was more than just a job, and that an attitude of *simply showing up for the paycheque* was not acceptable.

There were reports of deeper patient connections on the one specialized unit that typically featured longer patient stays, however the commitment to *being there* for patients was equalized across all three specialized practice areas. "*The one commonality I think for us is the fact that we want to help people. In the* [unit]*, I find it is more wanting to help people, whereas up on the ward it was wanting to care for people"* (RN-Q). The recognition of the potential vulnerability of their patient populations and the obligation to serve patients' needs, combined with the extensive knowledge and skill levels required to safely deliver quality care to these patient groups underscores the complexity of the Main Concern of achieving competence in the specialized RN role. A further examination of the two BSPs featured in this research will elucidate how RNs in these areas worked to achieve this goal. Prior to beginning that discussion it may also be relevant to introduce the participant view of how long it might take to achieve this competent state.

There was some diversity in participant reports of how long it takes to achieve competence in a specialized role. However, a strong majority did note a minimum of several months was necessary to even begin to feel competent after entering an area of specialization. *"It was really intense and very overwhelming and it took probably a good six months to really feel like I somewhat knew what I was doing"* (RN-B). The term of six months was a commonly identified starting point for feelings of competence by study participants. They also acknowledged however, that with so many advanced nursing practice skills and demands in their areas, years were actually needed to be competent in all aspects of the specialized care offered.

4.1.5 Basic Social Processes

The identification of basic social processes (BSPs) is a key feature of GTM. Typically two types of BSPs are considered, a basic social psychological process or BSPP and a basic social structural process or BSSP (Morse, 2001). "A BSPP focuses on the individual, social psychological processes related to the phenomenon. A BSSP focuses on the broader structural processes inherent among groups, institutions, organizations, or governments" (Reed & Runquist, 2007). In this research two key BSPs were identified, both addressing processes of a more social psychological nature as opposed to structural. Each of these processes, *Developing a Sense of Specialized RN Self* and *Integrating into Specialized RN Practice* will be further examined.

4.1.5.1 Developing a sense of specialized RN self. This BSP illustrates the personal transition experienced by RNs as they internalize and adjust to their specialized RN status, while evaluating the fit of this status and their chosen specialized area. There are three conceptual categories encompassed within this BSP; *Finding RN Fit, Sharing Passions and Community Values,* and *Embracing Life-Long Learning.* Registered nursing is a complex and diverse profession with additional practice opportunities consistently evolving. As was noted previously, the three areas chosen for this research are only a small representation of the 20 specialties identified by the CNA. In addition, there are numerous care settings as well as community, educational, and administrative opportunities all available to RNs. Given the multitude of choices RNs can make in advancing their careers, finding a good professional fit is key. The RN participants in this study had chosen to enter into particular specialized practice areas. Each also had a unique perspective on the personal fit of this choice as well as perceived opportunities for continuing professional development. Professional fit was a key component in this research in supporting the transition of RNs into specialized practice.

Before exploring this BSP further a brief discussion on the inherent differences in the terms

transition and integration is relevant. A distinction can be made between the processes of transition and integration. This fact was central to the findings of this study and necessitated the explication of two distinct BSPs, as opposed to a single process encompassing both elements. Recent nursing literature also supports the distinction of these terms. In their article *Graduate nurses' transition and integration into the workplace: A qualitative comparison of graduate nurses' and nurse unit managers' perspectives*, authors Walker, Earl, Costa and Cuddihy (2013) address both transition theory and potential integration supports and barriers for new graduates.

Throughout the course of this study, the researcher has come to view transition as a process more focused on passage and transformation, and integration more about arrival and unification. The words of one study participant serve as a poignant reminder of the forces that often drive these transformation evolutions.

> *When you meet these people, the patients and relatives, there's something in their story that kind of, you know, tugs your heart and you're going to be changed. You're going to be a changed person, I think. That's what I saw with people here…you see the transition you know, they might be here for employment the first time, but then they work with these people and all of a sudden the concern that you develop, working with these people, it's just amazing* (RN-N).

The progression of transition also seems to ease some of the emotional strain experienced in those early days in the new practice environment.

> *I was reflecting on it the other day because I was like man, this seems easier. I was working and I was like I don't seem nearly as stressed out or it's not nearly as chaotic. And I think it's just because I'm just getting used to it. At first I thought what's with this department, why is it so different, why is it so slow or whatever—it's never slow. But I think it's just because I'm starting to find my place in* [unit]. (RN-I)

The researcher would argue that developing a sense of specialized RN self is key to personal and professional fulfillment in these demanding practice areas.

4.1.5.1.1 Finding RN Fit. While this feature is especially prominent during the early days of transition, it also remained a key component of the retention of the RN in the specialized practice setting for the duration of their employment. With so many employment options, there is a great deal of competition in recruiting and retaining RNs in a variety of specialty areas. Common past practice for many specialty areas was to hire RNs who had several years of experience in general practice. Recently however, RN shortage issues have meant that new graduates have often been able to enter the workforce directly into specialized care settings. These new graduates have had to be prepared for the additional burdens that accompany direct entry into these demanding areas.

> *Because I was a new nurse coming out, it felt like school didn't end. I just -- there was so, so, so much to learn and because I've been moved through quickly, it feels like my brain just needs a break because I feel like there's just a lot...It's a huge amount of hours that we need to spend on our own reading and doing tests for our unit. It's crazy the amount of extra work it takes to work in a specialized area.* (RN-L)

For many of the participants in this study, experienced or newly graduated, arrival in specialized care created a considerable amount of stress as well as demands for additional learning. Several participants, from all three settings, referenced the extra personal time they invested upon beginning specialized practice reading and researching conditions common in their area. It seemed as though even before they could take the time to reflect upon whether or not this particular area was a potential RN fit for them, they had to figure out how to manage the immediate day-to-day demands. This was summed well by the participant who in reflecting on early days noted, *"You just try and stay above water I guess"* (RN-O). There were other

participants, however, who reported a very early sense of fit.

> *I started on* [unit] *and I loved the idea of it. I wasn't really exposed to that area when I was in school and I just thought, 'Well let's give it a try and see where it leads'. I loved it from the get go; however it was really intense and very overwhelming.* (RN-B)

A sense of welcome from the existing RN group was an key element as well. "*I felt comfortable right away because, like I said, it helps if the staff are accommodating. That really helps"* (RN-N).

For others, a sense of RN fit began to be realized by comparing this new practice area to a previous environment.

> *I complained a lot when I was on* [another unit]*, I was just like, I just hated it. I don't know, I loved the people I worked with and my patients were great. It's just the setting wasn't for me. And it was actually a couple of months ago* [my partner] *said you don't complain anymore about work. And I don't, I don't feel like I'm complaining about it.* (RN-I)

Other experienced participants reported noting to newcomers, whom they felt were complaining about the pace of work, administrative supports, or learning demands, that there were less desirable employment locations.

The combination of personal reflection and professional peer interactions within the practice community is what seems to facilitate the determination of RN fit. The often strained view from the earliest days in the practice setting improves over time, a notable factor in this change being those events occurring within the BSP of *Integrating into Specialized RN Practice.* As has been noted, the interaction between the two main BSPs is a critical factor in the progression of each. Specifically in relation to RN fit, every shift affords additional experience and opportunity to also progress in the integration process. The resultant improved sense of comfort and support is needed for a nurse new to the area to engage in an informed reflection

about RN fit.

> *I ended up slowly finding my place and my piece of the puzzle fitting and then I started seeing others enjoy having me co-working with them and enjoy what I had to bring you know whether it was knowledge or some humour or some leadership or you know but you could feel the enjoyment was now reciprocal, it wasn't just one way.* (RN-C)

The interaction between more senior staff and new arrivals seems to alter during this transition period, and it is a moment newcomers seem keenly aware of.

> *It's funny because when I first started I didn't feel like I had much support but where I am now I feel like I have tons of support or at least more than I did when I first started out...I think it is being more comfortable with the people and the people being more comfortable with you. Also you get to know the senior staff more.* (RN-B)

Nurses who had reported moments of tears in the early days now shared in moments of camaraderie and the personal satisfaction of enhanced competence.

The sense of pride and accomplishment seems to afford the space to evaluate the specialized setting and for nurses to reflect on their personal fit with the environment. Even for those who identified an immediate affinity or love for the area, there was a level of comfort needed, it seemed, to be able to assess fit. As previously noted, several participants felt the six-month mark was the point at which a shift occurred in terms of comfort and confidence. Several participants also noted that they felt they would have to work in a specialized area for at least one year in order to be able to evaluate whether or not it was a fit for them. This seemed particularly necessary in complex care environments where additional certification and nursing knowledge were required to move into more advanced patient care areas. Additionally some nurses noted that being trained for charge nurse duties was another turning point where they evaluated their personal fit and also felt a personal sense of transition. The sense of security in *Finding RN Fit*

supported a broadening of the professional perspective to allow further development of a true passion for the chosen area and a deepening sense of personal connection to shared community values.

4.1.5.1.2 Sharing passion and community values. Without exception, participants in this study spoke of their patient populations or the type of the care they typically provided with enthusiasm, and several went further and expressed a true passion for the same. Participants highlighted the importance of RNs in specialized practice settings being able to share this kind of connection for the particular specialized work of the unit and spoke warmly of their personal passion for their chosen areas. "*I really like it, I love the patients, I love the acuity, I love the problem solving"* (RN-M). Although some participants did note that the 'love' took some time to develop.

> *It took a little while before I was really comfortable in going to work and wanting to go to work. Like I love going to work to meet new patients and see what's going on with them. I love seeing new things every day and things that you wouldn't see on a ward. It's great that way.* (RN-G)

Participants, even those from different areas, used surprisingly similar descriptors in outlining their passion for their work environments. Less surprising was the realization of the necessity for this passion in keeping RNs engaged in highly demanding care environments.

> *I love the job. I think that is what keeps me in. I love the patients that we deal with. I love what we do and I love a lot of the people on there. It's a love that had to grow and they always say, give yourself a year in a work place and see what happens. I would advocate for that absolutely.* (RN-B)

Understandably maintaining engagement in a specialized area can be challenging, especially when there is considerable potential for loss or traumatic patient outcomes. The passion for the

work seems to be a deeply sustaining personal force for many of the study participants. *"I think it's the hope that you know we can one day make a difference"* (RN-J). Often participants noted other personal connections influencing the passion for the chosen area. "*The ones* [RNs] *we have they, most of them have a common interest in this, you know they've had cancer, they have a mom with cancer, something has happened that has drawn them to this area"* (RN-J).

For some, the passion they have for their chosen specialized area appeared to serve as a strong retention influence.

> *It's a great place to work. I wouldn't want to work any other place. The difference, not just the excitement of the kind of adrenaline rush that you get from the area, but also the relationships that you develop with the patients. It's just like the perfect combination for me.* (RN-L)

This participant noted a combined passion for the specialized area and type of care with the ongoing opportunity for patient connection. Patient connections were consistently identified as powerful motivating forces for RNs seeking to achieve the identified Main Concern in this research.

A shared passion for the work of the specialized area emerged as one component of *Developing a Sense of Specialized RN Self*. It did not seem to be enough to have a personal passion for the area; it was necessary to be able to embrace and internalize, in some way, the key values of the community in the unit. Again, although the chosen areas for this study varied greatly in type of patient care, the core community values identified by participants across the units were remarkably similar. Highlighting the importance of the Main Concern, participants in the communities spoke of placing high value on competence, influenced by knowledge and practical skill, work ethic, commitment to the patient population. *"It seems like knowledge is huge, I guess yeah, for respect and competency, yeah. Yeah, for sure"* (RN-O). With competency

as a crucial shared value, a violation of such appears particularly troublesome for RNs. *"I mean if there are competency issues, people will cover because they care about the patients, but they deeply resent that"* (RN-M). The value placed on competence appeared to be so pervasive in these specialized practice areas that its importance was apparent even to newcomers, beyond simply demonstrating technically skilled proficiency in providing patients with safe care.

> *You just try to be a team player and even if you don't know anything—my thing was just my patients are going to be alive and they're going to be well cared for and I'm just going to work my ass off. And I think if I don't know something at least people can say well she really doesn't know what she's doing but she works hard, right.* (RN-I)

This was not the only participant to acknowledge the value of hard work as a substitute for a still-developing competent skill set.

Registered nursing is a demanding profession that has always required a dedication to assisting patients, often at some of the most difficult moments of their lives, with both physically and emotionally demanding care. Increasingly complex patient acuities and care environments, technological advances, and shifting budgetary supports have not decreased the workload of RNs. Not surprisingly, work ethic emerged in discussion with study participants as another key community value.

> *Our nurses, we can teach them the skills to get there, but we have a lot of newer nurses that have great work ethic and they're go-getters. And to me, I think that is fabulous because you can't teach work ethic. You can teach the knowledge.* (RN-A)

Frequently the ability of new nurses, even where there appeared to be frustration with competency levels, was somewhat tempered if the same RN was identified as a hard worker. Conversely a competent RN who was not viewed as contributing consistently to the workload of the unit could then suffer in terms of community status. The results of violating shared

community values will be further explored in the theoretical model discussion featured in Chapter 5.

As a key element in the BSP *Developing a Sense of Specialized RN Self, Sharing Passion and Community Values* was a further opportunity for personal reflection and transition in the specialized area for study participants. This element is not easily framed within a specific time period as RNs may recurrently reflect on these as a way to renew their passion for the area, or in response to evolving community values. Lastly, for some participants, while the shared values were identified as being of great importance in terms of community, it was passion for the area that supported the pursuit of the final element of this BSP, life long learning. *"I think they're* [senior RNs] *such a great resource, because they were passionate about this area, so they want to know everything about it"* (RN-J).

4.1.5.1.3 Embracing life-long learning. There are several stages in learning during a specialized RN's career. There are the intense early days where steep learning curves often result in extended extra personal study sessions, and a potentially overwhelming awareness of what is not known. Participants identified an approximate six-month mark as the time where a level of knowledge has been attained that provides an increased sense of comfort and ability. With this, RNs feel they are able to more consistently demonstrate competence and the learning dynamic shifts and they look towards a future on the unit and the additional opportunities for learning and professional development that exist. The importance of learning persists and several of the most senior participants in the study were adamant that without learning, there was little point to continue on with specialized practice. This level of patient care and complexity demands a commitment to learning that extends beyond the classroom hours required to attain a nursing degree.

Even while experiencing the daunting first days in a specialized area, there is recognition of

the richness of the learning environment. *"It's a nice challenging place to work and I get to learn a whole bunch"* (RN-Q). New RNs seem to realize quickly that learning is going to be a key component of their transition.

> *With nursing I guess there's just so much to learn, you want to be so good at it and you want to be able to look at stuff and know it and it's so interesting. And you see things that you've never seen before every day and you just want to know what it is. And everyone else knows what it is, why don't I know what it is.* (RN-I)

As RNs settle in to specialized environments there is a realization of the importance of life-long learning for their personal development and success in this kind of practice. *"You can't be specialized if you're not willing to learn*" (RN-P).

With this comprehension of the need to keep learning throughout their professional practice, and once the stress of early experiences has past, the focus on learning seems to shift to increasing technical or skill capabilities. With so much information and knowledge to sift through, in addition to changes in unit policies and nursing procedures, how do RNs in specialized practice manage their learning needs? Several participants were quick to point out that there are almost as many ways to learn in a specialized unit, as there are learning requirements; one participant summed the opportunities this way:

> *The new information and education, it can be from the newest nurses coming right out of school and they're right up to date with what's being taught at school. It can be from our educators being updated and then providing it back to any of what they would call, maybe more seasoned nurses that are there for a lot of years and so you go to these education days and you try and grasp and update as much as you can in each of those, probably a couple a year. The new information, we have journals that we have right in our coffee room and they're readily available. It's really nice because you could pick up one article and you*

might have a weird question about it so you ask somebody about it and they might have gone to a conference, you know. A lot of education comes from our [doctors] *because they do go to conferences and they bring the info back. Our manager as well you know a lot of her time is spent in meetings and it's purely bringing information to the unit to make it better. So it comes in a variety of ways and then my most favourite is coming from the experienced nurses, the knowledge that they have, it's so much that I think to myself, am I ever going to get there? How much knowledge they have is beyond belief and they are amazing.* (RN-C)

Clearly, specialized nursing areas are a diverse source of both learning challenges and opportunities to learn.

There are benefits from this learning, beyond the obvious elements of supporting ongoing competence; this was noted by several participants in reflecting on their personal transitions in developing their sense of specialized RN self.

I think becoming more and more senior with the new ones coming up, them coming to you and asking you questions, and having the answers, which makes me feel like 'Wow, I'm actually learning something. I actually feel like I can do this', and just being seen as that person that they're comfortable with coming to talk too. (RN-J)

Participants seemed to experience joy in the moment of knowing the answer to a question, be it from someone newer than themselves, or from a doctor or other member of the care team. There was also mention of serving as an expert resource to other nurses and care teams from other acute units. Having their specific expertise sought out was gratifying to those who shared these experiences, and provided them with not only a sense of personal accomplishment but also that of contributing meaningfully beyond even their own practice area.

There was a great deal of recognition from study participants that the demands of learning

would be with them as long they were engaged in the provision of specialized care.

> *Once you've established yourself in those specialties, part of it is continuing to learn. I think that's always, that was the constant and so I guess if you're at a point where you're not interested in doing that, then it's maybe the specialty doesn't quite fit. But, like, to for, someone who fits the specialty and to continue in longevity in the specialty, you have to continue to learn.* (RN-P)

Interestingly, participants did not seem to view these demands as a burden; instead the opportunity for life-long learning was a positive aspect of the specialized RN role. "*And part of another thing that I love about* [unit] *is that I will never be done learning there"* (RN-H). An unwillingness to learn or to accept that life-long learning is necessary part of specialized nursing was a warning sign for RNs engaged in this kind of care. *"When people kind of stop learning or they're at a kind of a standstill, they need to maybe move along and find a place that stimulates them, you know"* (RN-C).

Shutting oneself off to new information and learning opportunities seemed to be viewed as a potential violation to that commitment to quality patient care and safety, as highlighted in this research. It became clear that learning was of great value to these specialized communities and arriving at a point of acceptance, and potentially excitement about the possibility of never being done learning was the final element that stood out as essential in the process of *Developing a Sense of Specialized RN Self.* The personal journey of this sense of development was unique to each participant in terms of timing and cadence of progression, and the transition is strongly influenced by the second BSP outlining integration into specialized areas.

The Findings Component Model (Figure 1) depicts the elements of each BSP as successive to one another, and for some participants, this was indeed a progression that they could identify. However, in transition there are elements of this process that may have to be repeated during the

course of a professional life in specialized practice. There may need to be a reaffirmation to shared community values, for example, or a need to refresh a personal commitment to the demands of life long learning. Perhaps it is the opportunity to return to these elements during the personal development of a sense of specialized RN self that sustains the commitment to the profession, even after many years of practice.

> *I absolutely love being a nurse. I look forward to every day. Even though sometimes I know that it's going to be busy or we're short-staffed, I still enjoy it. So I'm glad, you know, that I still can say that 'cause I think it would suck to work in a job that you hated.* (RN-A)

Several of the most experienced RNs in this study echoed this sentiment, and noted an ongoing passion for their chosen profession and specialized area. It was an inspiring testament to the resilience and dedication of these practitioners who have successfully navigated the challenges of specialized practice for so many years. This personal process, related to transition and sense of self, was a key aspect of competently fulfilling the specialized RN role and was a necessary counterpart to the experience of moving through the second BSP, *Integrating into Specialized Practice.*

4.1.5.2 Integrating into specialized RN practice. Where the first BSP outlined in this research addressed the elements of a personal transition and development of RN sense of self, the second BSP represents the journey of RNs integrating into their specialized practice areas. There was a distinct pattern to the integrative process that emerged with specific key elements present in all three specialized areas featured in this study. There has been a great deal of research and publication in nursing about the process of professional socialization, much of which is summed in a recent concept analysis published on this topic (Dinmohammadi, Peyrovi, & Mehrdad, 2013). The authors identified socialization as a "process during which people learn the roles, statuses, and values necessary for participation in social institutions" (Dinmohammadi et al.,

2013, p. 26). They further noted that the process of socialization is something that spans a person's lifetime, influencing a developing self-concept over time (Dinmohammadi et al., 2013). In the life of an RN, professional socialization is typically considered to begin during the years engaged in nursing education. Again, there have been many definitions of this professional process published in nursing although it has been summed adequately by Dinmohammadi et al. (2013) as "the process of internalizing and developing a professional identity through the acquisition of knowledge, skills, attitudes, beliefs, values, norms, and ethical standards in order to fulfill a professional role" (p. 27).

In this research, a very distinct sense of integration as opposed to solely socialization arose in the stories of the participants. Therefore, within the context of this study, socialization can be viewed as a means of integration. This assertion is supported in a publication from the business discipline by Leroy (n.d.), on socialization during company mergers. Leroy (n.d.) noted that "socialization is not solely a reciprocal acculturation process; it can also be understood as a process of learning and sharing tacit knowledge" (p. 2). The author was particularly interested in socialization processes that occurred within the influence of CoPs (Leroy, n.d.). With this clarification of terminology, the exploration of this second BSP of integration can proceed.

The BSP *Integrating into Specialized RN Practice* has two key components: *Learning the Ropes* and *Settling In*. If successfully navigated, it is this BSP that should afford the RN a sense of having become part of a team within the specialized unit. The participants in this research identified with both a strictly RN team as well as the interprofessional teams within their specialized practice areas; both of these are depicted in the component model featured in Figure 1. A further discussion of teams in these specialized settings is included prior to the conclusion of this chapter. Before there is team, however, there are the first moments RNs experience in their newly chosen specialized practice settings.

4.1.5.2.1 Learning the ropes. There are four aspects to *Learning the Ropes*, the first component of the basic social process *Integrating into Specialized RN Practice*. They are *Orientating*, *Managing Emotions*, *Proving Yourself*, and *Making Connections*. *Learning the Ropes* seemed to sum the experience of this first element of integration and resonated with the participants who viewed the emerging model as it was in development. The importance of learning to the BSP relating to transition has already been outlined, and the pervasiveness of the need for knowledge throughout the entirety of so many aspects of specialized aspects is likely why this title resonated with study participants in representing their early integration experiences.

Entry into specialized practice requires an extensive orientation process, as most nursing degree programs produce what are often termed generalist graduates. This means that although new nursing graduates have an understanding of the basic skills required to begin a safe general practice, their in-depth knowledge into any single specialty area is typically quite limited. Given that the responsibility for specialized nursing education is the responsibility of the specialized practice areas, including the three featured in this study, these units must create extensive orientation programs for their new hires. Typically these orientation programs are a combination of classroom learning and unit tours that culminate in several shifts where new RNs are paired with more senior staff for what are called 'buddy shifts'. The initial phase of orientating is really only the beginning in these specialized areas, where, as has been previously noted there are several levels of certification or training to be achieved in order to reach a full scope of practice. Participants noted their progression through these patient groupings and areas.

> *It's a unit that you end up working like one hallway for about six months and then you might train for another hallway and another hallway and so kind of over about a two-year span you end up finally being fully trained to pick up a shift and walk into the unit assigned anywhere. So you're doing intense learning for all those first couple of years and if you*

don't actually get past the first about six months, you never saw what the other hallway even looked like and you didn't know what other people were doing down there. (RN-C)

Several participants spoke to the intensity of the learning in early orientation days and how difficult it was to absorb all of the material, at least at first. *"Four or five months in, I looked again at the orientation material that we went through and it made ten times more sense than it did at the beginning, which was good"* (RN-O).

Another issue raised several times about orientating was in relation to the who of this process, those nurses responsible for supporting the new RNs entry into the specialized area. In talking about the 'who', participants raised some concerns about their orientation experiences.

I don't think people knew I was new and I could hear, oh I'm orientating again and, you know, they weren't very happy about it. So it wasn't a really good feeling starting off the day where you're kind of burden on somebody else's day. They don't want to be orientating again because there's such high turnover rate there. So you could see it's frustrating for some people. And then it was kind of strange that, like it's not very senior so I get out there and oh how long have you been working here and the nurse that's orientating me has only worked there for maybe a year. So then you're not really getting that experience, they've been there for a year so they do know what they're doing, but you're not getting that experienced nurse. (RN-I)

This participant's experience was echoed by others who shared similar concerns most of which seemed to surface as a result of the *buddy shift* component of the orientating process.

The pairing of new RNs with those already at work in the specialized environment is a long standing orientating method at use in this particular research setting. The issue with the process seems to come down to the amount of protected time for orientating, especially the time promised in the 'buddy' role.

I've been a part of three orientations in the last year. So we have or classroom time, and then we have our hands on time and buddy times. I think that we probably don't get enough time learning. We kind of get thrown in before…just because there is not enough staff and they need you working rather than buddying and learning. So sometimes I feel like I'm kind of learning on the job. (RN-L)

The RNs in specialized practice in this study placed great value on the orientation process. It was a lifeline of sorts, providing them with access to the information and skills they would need to successfully navigate their integration into the challenging practice environments they faced.

It was kind of hard at first, I'm not going to lie. Because you get your classroom time, so you do your three weeks of learning everything basically in a crash course and then you do your buddy shifts. I took full advantage of those buddy shifts. I went in with the nurse and then basically mimicked what she did, like I would pick and choose because you get to buddy six times. So you can buddy with six different nurses. (RN-G)

Having an opportunity to buddy with a variety of nurses was of value not only a means of accessing different knowledge sources but an opening for fostering social connections.

And then when we did the buddy shifts, I got to do them with three different nurses. Three or four, four different nurses, I think. But I'd have a couple of shifts with each of them. So I kind of got to know a few people that way, by doing that. And then by having more than one shift, they could say okay, well this is something you can work on for tomorrow. So I got to have a chance to have a bit of feedback and work on it for like the next couple of shifts. So that was good. (RN-D)

Several participants talked about remaining close with those they orientated with, be that other new RNs or those that they buddied with in their early days. Orientating is typically the first contact for new RNs with their new practice areas. It is during this process, and especially in the

first solo shifts they have to work following the conclusion of their formal orientation time, that *Managing Emotions* seems to be of significance.

The task of *Managing Emotions* for RNs entering into specialized practice was a consistent feature of the stories that were told, especially in the process of integrating, that it seemed necessary to include it as a distinct feature of the BSP outline. This is further supported by the words from the participants that have previously been shared which have already provided a strong sense of the emotional moments and elements that are part of entering into life as a specialized RN. There have been poignant admissions of fearfulness especially for those early days and first solo shifts. Participants spoke of feeling like a "deer in the headlights" and just trying to "stay above water". Some also noted the challenges in navigating an environment complicated by a variety of personalities and established nursing preferences and routines as yet unknown to the new arrivals. *"In the beginning it was like the rough patchy start where you didn't want to step on anybody's toes"* (RN-G).

The integration process does not only feature fear and feelings of inadequacy but these are prominent emotions that need to be managed. This challenge is made more manageable by the attitudes of the more senior staff. "*They're very welcoming. This* [unit] *has the warmest staff you're ever going to meet. I think it's because of the work that we do here…it's like second nature to be kind or something, so it's really nice. They are really nice"* (RN-N). Having a specific contact or friend, or a former preceptor that could provide an opportunity for mentorship also seemed to be a positive factor in managing early emotions. *"I had a mentor for sure. And so that really helped for me. So even right off the bat I felt welcomed. Like, I was appreciated to be there and it's been a good experience"* (RN-L).

Managing Emotions was made more difficult with challenging beginnings. Several participants reported early encounters with more senior RN or medical staff that were negative

experiences. Raised voices or a sense of being made to feel stupid were the most common reports, and understandably when this occurred early on, it influenced the ability of the new RN to make positive progress in emotional management. It appears many things are felt more intensely in the beginning as emotions run high and RNs are hyper vigilant regarding both their own performance and potential unexpected changes in patients' conditions or situations. However, after enough shifts have passed, this initial intensity dissipates and a feeling of a burgeoning competence slowly replaces those fearful sensations of being overwhelmed and underprepared. Still some senior staff have suggested that a little fear isn't necessarily a bad thing. *"You know what, I think the people that come that are terrified, good for you, because this is a terrifying place and there's lots to learn"* (RN-A). The managing of emotions is an essential step if an RN is going to be able to succeed at the work of proving themselves.

Proving Yourself was another very common theme that arose from the participant interviews in all three specialized areas. This seemed to be a characteristic of advanced practice in general as opposed to any one particular specialty. There are two questions of note in *Proving Yourself*, the first being what proof is it that a new RN needs to provide and second, to whom do they need to provide it? The short answer for each of these respectively is competence and the existing care team. In exploring these questions further, consideration of one of the key roles of the RN in all areas of acute practice, even those that are not specialized may be warranted. From some of the earliest moments in nursing education, RNs are informed that they are the guardians, so to speak, of their patients. The reasons behind this status are related to the function of RNs in double checking orders, delivering appropriate medications, ordering and carrying out tests and other interventions and, questioning or advocating when any element of care seems to be in violation of the best interest of the patient. It is a heavy responsibility, many details of which are actually outlined in the Code of Ethics for Registered Nurses practicing in Canada. This is yet

another example of the value that RNs place on patient safety and care.

Given this guardian status, when new, and as yet untested RNs, enter into a specialty practice area, it should not be surprising that experienced RNs will be wary of these arrivals whose skills and competence are unknown to them. With this consideration, it is easier to comprehend why *Proving Yourself* is a crucial part of the integration process for new RNs entering specialized practice and why new RNs feel such pressure anytime they enter a new practice area.

> *I don't know what it would be to integrate nurses more efficiently but I think no matter what in any situation if you're new, you have to gain people's respect. Like you can't go into a situation expecting to know everything and expecting everything to be wonderful because it's not. Everything new is scary, you know what I mean. I've never had a situation where it's new and I'm just expecting it to be this perfect transition.* (RN-I)

For many areas in this study, it was not just to RNs that new staff had to prove themselves, but to members of the medical team as well. Although initial instances of *Proving Yourself* seemed to be most noteworthy in the details provided by the study participants, these specialized communities appeared to require a sustained demonstration of competence. More than one narrative was communicated about RNs inserting themselves between patients and those RNs who were deemed to have become unsafe. This seemed to be further support for the critical importance of the Main Concern. Clearly, the RN community will not tolerate ongoing violations of competence and disregard for, or an inability to protect, patient safety and quality of care.

RNs new to a specialized area reported great satisfaction by as they recalled moments where they felt they had been successful in proving themselves.

> *People kind of want to watch you kind of closely, see what you're about, can she handle this, is she safely working. And then once people realize okay she's doing all right, she*

knows what she's doing, she'll ask questions if she needs help or if she's confused. You know, then they…I just think that you gain a little bit of respect and so the pressure starts to kind of go off. (RN-I)

It was in these moments, with the easing of that pressure that the participants seemed to find the room and perhaps the emotional space to begin making progress in terms of their workplace connections.

There are several milestones in an integrative process and making connections within the specialized practice environment was one of these for the participants in this study. The demands of the environment are too intense to successfully manage alone for a sustained period of time. To cope daily, to advance, and to be able to make positive steps in the professional development process, there is a need to "not feel alone". Not surprisingly, RNs new to specialized practice often begin to make these connections in their earliest orientation days. These initial peer connections were often reported as meaningful and enduring relationships. *"I even feel closer to some of the people I started with because you're going through the same experiences at the same time and, you know, you kind of bond in a certain way"* (RN-H). Specialized practice life seemed to be that much easier with someone to share both the stress and success of integration.

Two of us got hired from the fast track program from the last class and yeah, like at school we didn't talk once. We knew we were in the class together, but now like we're great friends just because we're going through the exact same experience of trying to integrate, trying to learn, trying to do our best. And yeah, I love working with her and it makes it that much easier for me to work when she's around. (RN-O)

Simply connecting with other new RNs within a hiring cohort is not enough, however, and eventually wider connections must be made.

Several participants spoke about the challenges of navigating the social landscapes of their

new work environments. Some noted their particular area attracted similar personality types which could increase the difficulty of integration. For brand new nurses, this seemed to be even a more intimidating challenge and there was an urgency to feel like progress was being made in *Making Connections*.

> *Other staff members know my name now. When I come to work in the morning they're like oh, hey* [name], *or I haven't worked with you for a few shifts, how was few days off? And at the start, you know, people don't really know you so they just say hi and don't really know what to ask you about anything. So now I'm starting to get to know people and that makes it nicer because when you work with people who know you and you know how they work and they know how you work, that makes it a lot easier to get things done.* (RN-D)

This sense of comfort from having been able to make connections in the new environment was repeated several times. Even for experienced nurses, entering a new specialized environment didn't appear to be any easier than it was for new graduates, despite their possession of a greater amount of professional experiences. Beginning a new practice left everyone searching for the same thing.

> *Coming to a new area was very nerve wracking for me because I didn't know anybody. I didn't know what they were capable of, I didn't know if they knew what they were doing, I didn't know what I was doing half the time. So that was a really stressful part about it. But now that I've been here for a while, it's great, I love it*. (RN-H)

How long is a while? There is no clear universal timeline associated with *Making Connections*. This social process contains a great number of variables, including individual personalities, the number of new nurses in a hiring cohort, the number of RN staff members on the unit, unit turnover, and supporting social structures. There was a strong sense from the participants that these connections are needed to support a positive and sustaining work experience.

The last challenge in *Making Connections* is often seen as relationship building or even just more opportunities to begin to connect with existing senior staff members.

> *I think it is being more comfortable with the people and the people being more comfortable with you. Also you get to know the senior staff more as you work because the senior staff is always on; you know the higher risk areas and the newer staff are on the low risk areas. So the more you get orientated the more you get to know these different people and the more they are willing to mentor you a little bit more I guess.* (RN-B)

This opportunity to develop mentoring relationships is a critical piece as well.

Learning the Ropes is a complex set of experiences, emotions, and early integration processes. It can take a great deal of personal fortitude to endure the early days of integrating into an existing practice community. This participant seemed to capture the essence of this phase of *Integrating into Specialized RN Practice*.

> *At first everybody was kind of, not standoffish, but they don't know you…And at the beginning, you can feel that sort of like do we get along, like how do we communicate with each other? There's just a feeling-out period. For the first while, I was as quiet as could be, just getting my bearings type thing. But once they start trusting you more, I guess, with your work, then there's more things you can talk about and you just get to know everybody a lot better. And then they integrate you, everybody. Everybody is inviting you out to things.* (RN-O)

These words highlight the importance of ongoing social connections in the specialized practice environment. Moving out of the *Learning the Ropes* Phase and into *Settling In* may take a slightly different amount of time for each RN, but participants noted that this transition does occur for everyone who will remain part of the practice group. Where *Learning the Ropes* has more of an element of survival with high intensity learning and emotional demands, *Settling In*, is

more about just that, settling into to a routine and more comfortable practice.

4.1.5.2.2 Settling in. Similar to first component of this BSP, the second also has four aspects that further define the parameters of what it meant to the study participants to be *Settling In*. These include *Living Shift-by-Shift*, *Navigating Relationships*, *Mentoring and Support*, and *Giving and Receiving Help*. In many ways, each of these aspects builds upon the four aspects introduced in *Learning the Ropes*. Although there are similarities to these aspects, there are also distinctions that are a function of having progressed beyond the earlier experiences. *Settling In* includes elements that will support successful professional development in specialized practice over the long term.

Living Shift-by-Shift encapsulates two distinct entities describing this part of the integration process, the first the passage of time itself. Although there is a great deal of learning that can be done through extra studying during personal time, and efforts which can be made in socializing and networking, one of the critical factors which cultivates competence and practice skill is simply the passage of time and accompanying experiences. As an RN progresses, shift-by-shift in a specialized area, they are exposed to different patient situations and care experiences. Be these positive or negative experiences, they are all learning opportunities. Some participants also highlighted this stage as a means to get through the early days in specialized practice, just taking things day-by-day, or in this case, shift-by-shift.

Secondly, many RN participants, even those much more senior, had a tendency to speak about life in specialized practice in these time-blocked terms. There are a great number of daily unknowns in a specialized acute environment and so things have a tendency to change and evolve shift-by-shift. A common instance of this change is working with different patients; in two of the three practice areas in this study, it would be unusual to have the same patients for more than one or two shifts. Even in the unit with a more stable patient census, there would still typically be a

great deal of variety and instability in the conditions of the patients. Such is the nature of specialized care. Combined with the variety of staffing configurations that can present for any given shift, the potential for a sense of perpetual uncertainty is easy to imagine. Many participants reported a regular routine they employed to take a quick reading on the unit situation at the beginning of shift.

> *In* [unit]*, one of the first things I think most people look at is how full we are. And we're always full. So how overfull are we? How many people are sitting in the hallway? How big is the line-up at triage? And that really sets the tone for at least the start of the shift. Because if you have a big line-up at triage, you have a full waiting room and you have people in the hallways, it's going to be busy and disorganized and it's going to challenge you a lot. The next one is, I think, at least from my experience, is who you're taking over from. So who was in the area that you're getting report from. There are individuals you don't maybe trust or you feel you're going to have to go back and make sure things were done properly. That sets a tone that makes you a little less pleased to start your day. I think the underlying thing especially with* [unit] *is that we rarely can ease in, we hit the ground running almost on a daily basis.* (RN-P)

Once the 12 hours is over, it simply begins again the next time with the same kind of uncertainty; who will the patients be, what situations will present, and which other RNs will be involved. *Living Shift-by-Shift* is a series of unique experiences, typically in 12-hour blocks, each offering differing opportunities for advancing knowledge, team connection, and the development of entire group of specialized practitioners.

Relationships are a reality of nursing practice and they serve a key role within this specialized context, especially in terms of a new RN attempting to successfully navigate the process of *Settling In*. There were reports of both positive and negative relationships in this study.

There are many opportunities for these kinds of connections, between RN peers, or unit nurses and their administrative leaders, and finally between RNs and members of other allied healthcare teams, including physicians. Study participants highlighted the social connections cultivated in specialized nursing practice as being of great importance. "*I'm still in some of that getting to know people but definitely, even from two months ago when I first was there to now, like I'm definitely feeling like it's more like I'm part of it now too"* (RN-D). Developing peer relationships in the specialized workplace takes effort; however, when it pays off, RNs noted the benefits extended beyond the work environment.

> *With the first group of people that came on, I put a lot of energy into getting to know them. And you get to know them and you get to know how they work and it just creates good things at work and at home, you know, because you can finally develop relationships in both places.* (RN-B)

Many participants reported social relationships that began in the workplace, but extended beyond into other aspects of their lives. The depth of influence of these relationships was meaningful to many of the study participants.

Study participants highlighted a feeling of not knowing anyone as a key contributor to the anxiety associated with arriving in a new working environment. Not being sure how to navigate the social side of an existing community provoked an equal amount of tension. Given the demands of the specialized area, the prospect of trying to meet such challenges alone appears particularly daunting. Participants that reported feeling isolated or without support typically were either working to change that or evaluating other options. *"I'd only been in [unit] for about six months and…I was actually looking at going somewhere else because I was just like, you know it's just not quite gelling and the staff there and I just aren't really getting along"* (RN-Q). Among those participants committed to trying to navigate workplace relationships there were

observations made which highlighted that the process was not the same for all new RNs.

> *One girl, I felt whenever I saw her she was just integrated right away and I think it is because she was a better communicator than I was even in just telling stories and socially and things like that. She was able to get in a lot quicker. For me it took some time and calculated steps…I think that is your easiest 'in' to be honest. I think if you can get someone on the social side, then you can get someone on the work side.* (RN-B)

Creating peer relationships with other new, or junior RNs is a primary goal in *Navigating Relationships*, but it did not seem to be the ultimate end.

Creating connection with senior staff members was important to many participants; however, these were the most difficult relationships to navigate.

> *I find it's the older ones that are like nitpicking and checking your charting and making sure you're doing what you're supposed to be doing. Which makes you on edge…People that have a lot of experience you do, you want them to, I don't know, trust you. You strive for that so hard for them to trust you.* (RN-G)

Several senior participants noted that they, and their experienced colleagues, should try to invest more time in remembering what it was like to be new. However, they also stressed that new RNs had to arrive with the right attitude.

> *They ask questions and they're respectful of what other people have to say, they learn, you know those are the kids who do well, and they need to mix socially…The people who don't do great are ones who often have experience and they aren't willing to listen to what people have to say, and they don't want to…they know it all. Good luck to you if you have that attitude because if you walk in here with an attitude that 'I know this', and 'you have nothing to offer me' oh they will eat you alive. All you have to do is be respectful of what other people bring, acknowledge that they have that…and be smart, and have a good work*

ethic. (RN-M)

The issue of work ethic was previously raised in the discussion of *Proving Yourself*, and it has repeated as a key theme throughout much of this research.

The power of good peer relationships within specialized practice cannot be overemphasized. Participants persistently highlighted good relationships as a critical component that influenced engagement and satisfaction in the work environment, as well as ongoing intention to stay in the specialized setting. *"I don't care how heavy the job is, I don't care how demanding the job is because that's what I'm here for to work. As long as I get along with the people, I will stay"* (RN-N). Strong RN peer relationships made it easier for participants to navigate potential challenges in other relationships such as those with physicians or administrative staff. The specialized areas examined in this research each featured a large concentration of RNs relative to other disciplines within the care team, often a much larger number than would be typical in general nursing practice. This meant there was a strongly identifiable peer group present in these communities, and new RNs seemed aware of the importance of building new relationships upon their arrival.

> *Moving over to* [unit] *I was just so worried of like not fitting in. I wanted to be friendly but I didn't want to be too friendly and I've developed lots of good relationships with nurses that, we visit on days off. It's super nice to have somebody that I feel confident and comfortable with asking them questions. And when it's like time to get serious, it's time to get serious and I really enjoy that, because it makes me want to come to work.* (RN-G)

There was a definite retention factor reported in relation to the successful navigation of relationships in these practice settings, and although there were many other benefits reported by participants, this factor alone makes this part of the integration process worthy of careful attention. There were stories of less successful relational attempts and with the potential for these

navigational missteps to cause new RNs to quit the practice setting, it is informative to understand what tools can support nurses in their relationship building. In this research, mentoring emerged as just such a tool.

The navigation of workplace relationships is reportedly made easier by the opportunity to develop and engage in mentoring relationships. Although not the focus of this research, the topic of mentoring was raised by many study participants. Some participants noted the value of having previously been a student on the specialized area in which they were currently practicing, and utilizing connections of previous preceptors to help navigate the creation of current relationships. Regardless of how the mentoring relationship was established, it was highly prized by those who felt they benefited from it.

> O*ne nurse kind of took me in under her wing who had been there a lot of years…just took me in right under wing and totally mothered me and it was like, wow thank goodness, because there were a few others that were very harsh. I even remember crying on shift one time* (RN-C).

Mentoring offered not only emotional support for managing the stress of integrating into specialized practice, but also access to a highly valuable source of experiential knowledge coupled with support for skill development.

> *It was always the senior nursing mentors. When it boiled down to, 'how do I treat how do I physically care for this patient that needs a gastric tube or I have to hang blood, how do I do that, or this patient needs to be turned and we need skin care, I've got to, you know, do a procedure', it was always with the the senior nurses.* (RN-R)

Not everyone felt they had access to such mentoring, however, as participants have previously noted. The staged nature of specialized practice often places a majority of senior staff in areas which new RNs are not certified to practice in. This creates what is likely an unintentional divide,

but it is a separation that many participants noted and lamented.

The health region in which this research was conducted had a mentorship program for new RNs, and although the program had not been functioning for some years, many RNs spoke strongly in favour of it. *"If you asked me in one sentence how we could make things better, I would say bring back the mentorship program"* (RN-S). There is a strong recognition of the value of senior RNs in a specialized area. Beyond what is taught in the classroom during orientation sessions, RNs who are new to the area are eager to gain access to the tacit knowledge of their senior RN peers. This access is not always easily accomplished, due to proximity issues and relational barriers. Mentoring and other collaborative work opportunities with experienced RN staff seemed closely tied to the sense of teamwork present in the specialized area and to another indicator: perceived access to support.

The topic of helping emerged as an interesting feature in the study data. The act of help, be it giving or receiving, appeared to be a barometer for study participants either for how much support was available to them, or conversely, how well they felt they were managing and able to offer help. These new RNs in specialized practice attributed a high value to offers of help. Aside from the sense of relief it must provide in their first days, it also seemed to serve as an indicator of the supportiveness of the community they had entered into.

> *The situations that I've been in when I've been overwhelmed, I didn't have to ask for help. Like I had one day where I had send two people to home hospital, got two admissions within a half an hour of each other, and a patient who was tanking on me, and the nurse that was on the unit with me, he just pitched in. And someone came over from* [another area] *she wasn't very busy, and so she came over for like an hour and a half and just did all my orders for me. And I didn't even have to ask for any of that, so that was really nice.* (RN-D)

Many participants talked about the satisfaction and sense of support that resulted in receiving help without have to ask for it. Some new RNs said they were fearful of asking for help, especially those in throes of the proving themselves. These RNs said they were reluctant to ask for help or give up any work assigned to them lest that be interpreted as an inability to complete tasks on their part. New RNs worried if they did not finish their assigned work, not only might an experienced nurse take notice, but they might tell others, thereby diminishing progress made in demonstrating competence and increasing capabilities.

More than one of the senior nursing participants commented on the phenomenon of help, and particularly not wanting to ask, and summed things nicely within a teamwork perspective.

> *Sometimes you do take on a little bit more workload because you see somebody else really feeling like they're sinking but they're not, they just need that little extra hand and you hope that then on a day where they're having a lot more energy they do that back for somebody else and that's you know pulling the team together. It's sharing the workload, you know making people feel like they're not alone, that they're together with the group even if you might be that nurse who's alone down a hallway, you're not alone. Somebody else knows about you, someone else can do a few extra things for you and also teaching them to ask for help because sometimes people feel like they have the stress and it's showing but they don't want to ask and they need to know that it's okay to ask for a little bit extra here or there help because that's what we all want. You know someone else to help us out here or there.* (RN-C)

New RNs also spoke about reaching the point where they were able to offer help and noted this as a milestone achievement, not just as an indicator of their increasing competence, but as a means to start giving back to their coworkers and increasing their value to the community.

The final element that arose with regard to help was the connection of these acts of

assistance with the social relationships established within the RN community. *"I definitely think my social connections with a lot of my coworkers, and my eagerness to work and things like that has made it so people are more willing to help me out if they see I'm really busy"* (RN-Q). There was an undeniable sense of help between those with social connections that extended beyond merely work relationships.

> *I know I can count on my whole unit in an emergent situation. I can count on anybody. But in the day-to-day things, it's my peer group that I know will have my back, no matter what, to help me out. And that's what makes my day better, because they make it more fun.* (RN-L)

In such a demanding environment, it was not surprising to discover that friendships and the ability for there to be moments of levity and humour in the workplace were of great value.

> *When you're having a really crappy day, it makes it easier to kind of lighten the mood if you're working with people that you socialize with and you can have a laugh with. Maybe you have more inside jokes about stuff that has gone on outside of work too. It just can lighten the mood when things are crappy. Then it also gives you something to look forward to if you're having a really bad day. It's like okay guys we're going out for drinks on Friday. We've just got to hang in for two more shifts*. (RN-D)

This sense of connection and support was highly influential for study participants in terms of predicting the quality of an upcoming shift, in determining whether they wanted to work an extra shift, and in the general sense of wanting to remain in the practice area.

Having access to support and assistance from friends also seemed to allow for a clear delineation of those that were not included within the applicable social sphere.

> *It's definitely a pick me up when you know that you're working with somebody that you trust and you rely on and you know that they're going to help me out, if stuff starts getting*

really sticky. I have this person to have my back, whereas there are certain people when you work with them, it will be, like, well those are your patients, I'm, not helping you. I have my own. (RN-J)

All participants were clear that in times of urgency on the units, social connections were no longer relevant. Patient care and safety remained the ultimate equalizer in these practice areas. There were no relationships positive or negative that would supersede the need to provide the highest quality of care possible. The importance of social connection, however, in day-to-day practice in specialized environments was considerable. The giving and receiving of help concludes the elements in the integration phase of *Settling In*. Completing this phase successfully seemed to provide participants a sense of having 'made-it' as a member of the team in the specialized area.

4.1.5.2.3 Becoming team. Seen more as a destination as opposed to a specific element of this BSP, the RN and Interprofessional teams present in specialized practice are nonetheless an key component of the foundational model as presented in Figure 1. Team as identified by the study participants included a distinction between RN teams and Interprofessional teams. Both were essential, and the intersection of the two is demonstrated in the model that has been shared in this chapter. "*Initially when there's something going on you go to your RN team first and you like 'Am I reading this right?, Am I managing this okay?' And…then you go to your docs"* (RN-B). There was also a need for integration into both of these teams that was distinct, although there was a great deal of overlap in the process. Some participants noted that entry into the RN team was achieved first and that facilitated entry into the Interprofessional team. However, some RNs built on strong relationships with physicians and then used that to secure a position in the RN team. Regardless of which entry was achieved first, participants agreed that involvement in both teams was vital to success in the specialized practice area.

Participants praised the teamwork capabilities in their specialized areas, noting the sense of team was very clear in urgent patient situations when all nurses participated fully.

> *When things go wrong actually is when you kind of get that feeling because when things go wrong, everyone rushes in, you work as a team and you get done what you need to get done and the outcome is good. And that's when you know that you've got it. Because when you pull your emergency bell you have six nurses or eight or ten or however many nurses are available, they come running in. You're never alone. And you each just do what needs to be done and you deal with the situation and you make it happen.* (RN-H)

These teams and emergency routines have become so well-honed on some units that there is little need for verbal communication and instead the team moves fluidly managing the urgent event.

> *Whoever's in the* [unit], *they kind of know who does what and nobody has said anything. They just know, you know,* [name] *usually does this and* [name] *usually does this. And then the one nurse was on a different shift, must have done a trade and there was an* [emergency] *and she said it was kind of an eye-opener. Not that anybody did anything wrong or nobody was bossy. It's just that you're used to your group. It doesn't require a half hour of explaining or 15 minutes of explaining. People are already in motion*. (RN-A)

There appears to be deep professional connections in specialized nursing practice; however, in reference to the social connections participants also elaborated on, it was made clear that in emergent situations, no relationships positive or negative would influence the care provided. Every RN available worked as hard as possible for the best patient outcome.

In these intensive environments RNs, although clearly demonstrating bonds within their professional peer group, recognized the other players comprising the larger team.

> *The team is amazing, when it goes crazy on the ward, you pull a call bell or you yell down the hall and you've got five people there, and you know like you look around and I'm like*

okay so there's five nurses here and there's only five on, who's running the ward, you have the other two nurses out there and the care aides, and the unit clerks, anybody, they're pulling up the slack, they're answering phones, they're…family members are amazing because they'll see that we're running and they become family to us, like they know us so they are helping people to the bathroom, or they are alerting somebody that a pump is beeping, you know getting their own linens, doing things like that, it's just an amazing team environment, not only with nurses with family members, with care aides, it's huge. (RN-J)

The interprofessional team is of critical importance in these specialized areas.

RNs reported extremely close working relationships with numerous other professional groups, interacting on a daily basis. *"I don't think nurses and doctors could function on this ward by themselves, I think you need the clinical nurse specialist, you need the pharmacists, we need the nutritionist up there all the time. So it's a huge interprofessional team"* (RN-J). These partnerships are extensive and also include other groups such as social work and spiritual support personnel. There was no role deemed unimportant in the specialized area; this seemed to inspire a enduring sense of togetherness.

It's a good team because you work really closely with each other and that's everybody though. Everyone from housekeeping to lab and ECG and everything. Like you know those people by name there cause we're all in the same little space all day. (RN-I)

Given the number of staff members serving in any one specialized area it is certain that there is some element of transience in these teams shift by shift. Although the specific membership is not permanent, the necessity of each member is. Some study participants aptly described meeting the demands of their specialized care areas as the workings of *well-oiled machine* with a multitude of cogs needed to move care forward. The team cannot afford to have any single part of this mechanism disengaged or malfunctioning, a realization that is not lost on specialized care team

members. Some RN participants, in noting the influence of social connections in strengthening their RN team, also shared anecdotes from their units about the increasing inclusion of non-RN team members in social functions and events. Although this seemed to be a recent development in some areas, it was reported as having a very positive effect on the larger interprofessional team.

There is another point of terminology to clarify: the distinction between team and community. In this research, it was the CoP that emerged as the all-encompassing social context in the specialized practice setting as depicted in Figure 1. The teams reside within this larger community context. There is a key learning element situated within the larger community context as team members are exchanged back and forth per shift and knowledge moves from the community through teams to individuals or vice versa. Social connections formed within the community have the power to influence teams, either positively or negatively.

The study participants did not always make a distinction between team and community. "*There's an obvious sense of community, like they have each other's backs, the doctors have the nurses' backs. The nurses have most of the doctors' backs. Yeah, no, it's a good team"* (RN-I). There were some participants who did note a distinction between the two entities. *"I think community gives a sense of belonging whereas team gives you a sense of duty"* (RN-B). This seemed a particularly astute comment especially in the context of the team working together in the best interest of a patient in an emergent situation. It demonstrated not only the nature of the team boundary within a particular shift and specific situation, but also highlighted what the ultimate driver in the environment is a duty to patients. The social element of community was noted by another participant who said *"when I think 'team', I think of people working together. And community I think of more like laughing and the social aspect of it"* (RN-D). There is a distinction between team and community as has been introduced here and which will be featured

further in the discussion in Chapter 5. Prior to moving to that chapter and an examination of the theoretical model, and a final summary of the component model will be provided.

4.1.6 Summary of the Findings Component Model

The impetus for RNs entering intensive practice areas to achieve the Main Concern of *Competently Fulfilling the Specialized RN Role* is founded in their connection to patients, and a strong sense of duty to provide safe and quality care. This theme of patient connection and sense of RN duty was confirmed numerous times in the words of the study participants, and was reported by most as the single driving force for the collective work done in their specialized unit. RNs are further bound to this standard of care by a Code of Ethics for Registered Nurses authored by the CNA, and enforced by provincial regulatory nursing bodies as a function of the license and registration process for nurses at this level of practice.

There are two BSPs illustrated in the constituent model, *Developing a Sense of Specialized RN Self* and *Integrating into Specialized RN Practice*, each incorporating additional distinct phases. The process of transition was deemed to be a personal and self-reflective journey, with new RNs contemplating *Finding RN Fit, Sharing Passion and Community Values,* and *Embracing Life-Long Learning.* Although participants seemed able to quantify a more specific time element and resolution to *Finding RN Fit*, it is likely that during any lengthy professional stay in a specialized area, RNs would need to periodically reflect on *Sharing Passion and Community Values,* and *Embracing Life-Long Learning.* It should be considered that a shift could occur in RN fit as well, even after several years in the specialized area, which could possibly instigate an RNs decision to seek employment elsewhere. The participants in this study, even those with decades of experience in specialized areas, still reported a passion for the work and a corresponding belief in the importance of learning to their own continuing development within the specialty.

The second BSP detailed *Integrating into Specialized RN Practice.* There were two phases in this BSP: *Learning the Ropes* and *Settling In,* as well as the inclusion of *Becoming Team* as the integrative destination for new RNs. The participants frequently spoke of integration in their reflections of entering into specialized practice. The phases in this BSP, and the distinct elements contained within each resonated with participants who reviewed the early renderings of the constituent model. The work of *Learning the Ropes* included *Orientating*, *Managing Emotions*, *Proving Yourself*, and *Making Connections*. The participant reflections on these elements served to demonstrate the distinct nature of each, and illustrated the complex and demanding nature of specialized nursing practice. This first phase of the integrating BSP was foundational for future success in the process. The aspects of *Settling In* built upon the initial work done by participants while *Learning the Ropes.*

There were also four aspects of the *Settling In* phase: *Living Shift-by-Shift*, *Navigating Relationships*, *Learning the Ropes*, and *Giving and Receiving Help*. There are several opportunities for pivotal moments in the integrative process to occur within this phase. Participants articulated some of these, reflecting on crucial instances of positive relationship development, key mentoring moments, and arriving at a point of competence that allowed them to give and not only receive help. The work of *Settling In* typically led participants to declare a sense of belonging within the specialized practice team. The team element was further delineated to include an RN only, as well as an Interprofessional team. Participants described differing experiences in terms of achieving a sense of team belonging, with some entering through the RN team, while others first aligned with healthcare team members, such as physicians. There was a clear message regarding the importance of team membership and in the necessity of the team itself in successfully meeting the care demands existing in any shift in their environment.

The larger social context in which the achievement of the Main Concern is pursued through

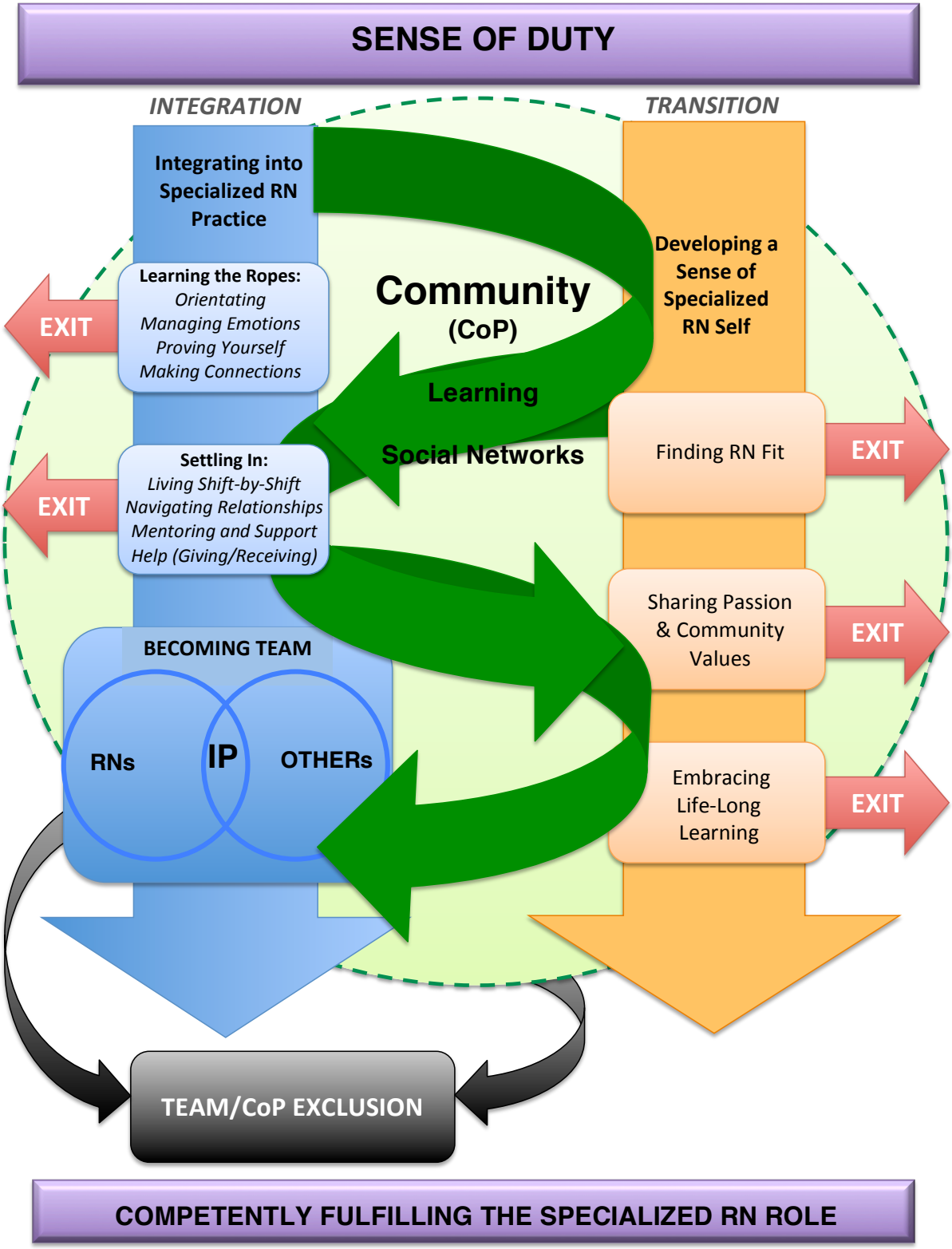
the two BSPs is the community, or in this case, the CoP present in each specialized area utilized for this research. Even though study participants did not specifically identify their community groups as CoPs, their descriptions of these groups was more closely aligned with the defined parameters of a CoP as opposed to simply a community. There were two key elements in the participants' community descriptors that supported an initial consideration of these entities as CoPs: learning and social networking.

When Lave and Wenger (1991) introduced the CoP concept, it was viewed as a marked departure from previous cognition focused learning approaches (Contu & Willmott, 2003; Handley et al., 2006). It questioned "the pedagogic assumption that classroom-based 'learning' (as a discrete and decontextualized activity) is as effective as learning with the communities in which what is 'practiced' is learnt [*sic*] and vice versa" (Handley et al., 2006, p. 641). One key aspect of the CoP concept is legitimate peripheral participation (LPP), a key part of the process by which members are able to join a CoP (Lave & Wenger, 1991). Through LPP " a person's intentions to learn are engaged and the meaning of learning is configured through the process of becoming a full participant in a sociocultural practice. This social process includes, indeed it subsumes, the learning of knowledgeable skills" (Lave & Wenger, 1991, p. 29). The elements of learning and social connectivity were pervasive in discussions with study participants. A considerable amount of learning in the specialized practice environment was driven by the social networks present in the community context, thereby providing a strong initial foundation for the classification of this context as a CoP as illustrated in Figure 1.

4.1.7 Theoretical Model

Adding to the information presented in a summary of the Findings Component Model, a theoretical model (Figure 2) is also proposed, and is presented on the following page.

Figure 2. Theoretical Model



This theoretical model is proposed in order to further explicate the influence of the identified BSPs upon one another, the role of the CoP as the key context for this interaction, and the potential points in the process at which an RN might terminate their employment in the specialized practice area. Additionally, the theoretical model highlights the experience of those RNs that are not successful in integrating into the existing practice team or community. The shared experiences of the participants are also included here in support of the theoretical conclusions that have emerged.

4.1.7.1 Interaction of the identified BSPs. It has already been highlighted that although the two identified BSPs in this research are distinct entities, they do exert an influence upon one another. This connectivity is indicated in the Theoretical Model by the spiral connecting the BSPs, through the larger context of the CoP. The significance of the spiral travelling through the CoP will be explored in further detail later. Although *Developing a Sense of RN Self* was deemed to be a more personal and reflective process, it is not something that occurs in a void. Of all the phases of this BSP, the most personal is likely *Finding RN Fit*, but even this is influenced by events experienced in *Learning the Ropes*. How well *Orientating* proceeds, and how successful a new RN is in managing anxiety, and other intense emotions that participants reported dealing with in their first shifts in specialized practice, must surely feedback into the reflection about fit. Evolving from, what one participant reported as, that *deer in the headlights* feeling to the moment where a senior RN provides some positive feedback is meaningful for new RNs.

> *When I was first starting out there was this lady who...she doesn't work there anymore, and not a lot of people liked her because she was very vocal. And I didn't work a lot with her but as we were passing each other in the hallway she'd be like 'You know I heard about your* [patient] *yesterday and the things that you did and you did a great job' and that was after I probably went home and cried because I thought I did a terrible job. Words of*

encouragement helped. (RN-B)

How might the perspective of this participant's fit within their newly chosen specialty been altered by this encounter? Making positive progress in integrating seems to allow RNs some much needed reflective space and the emotional restoration to be able to further contemplate their place within the specialty.

Making Connections and *Navigating Relationships* successfully is another component of integration that can influence the transition experience.

> *I think that all had to come together before I could be accepted into the* [unit] *community which I think is kind of a hard community to break. Because there's a lot of similar personalities that kind of click automatically so, if you're not that person, it takes a little bit more effort.* (RN-I)

Participants might have a personal passion for their chosen area of specialized practice, but being able to engage with community values would be easier in the context of relationships with those RNs who share the same. Conversely sharing a passion and deep commitment to not only the work of the unit, but also the specialty, was reported by some participants as an *in* in terms of *Making Connections* with RN peers. Participants were consistently compelled by their sense of duty and a profound patient connection to provide safe and quality care. Several participants spoke of feeling like a bad nurse when not able to deliver the level of care they perceived as necessary on any given shift. Even when they recognized that the situation had more to do with adverse circumstances in the care environment rather than themselves, several nurses still reported a sense of personal responsibility, and/or a sense of failed duty.

RNs also noted a strong preference for teamwork and mutual support, again an understandable sentiment when reflecting on the daily demands of specialized care. With so many factors out of the control of practicing nurses on the unit, such as administrative decisions

about patient admissions and staffing, a sense of team seemed a means of coping with the demands that specialized environments foster.

> *I was in charge the other weekend and I was basically told you have to work short all weekend, even though we shouldn't have, so that has pulled us all together. When it's something that affects all of us as nurses and it affects our patient care, that's when we completely bond, that's when we're the nurse group at that point*. (RN-J)

The unifying influence of a shared sense of duty and commitment to patient care and safety was a frequently repeating theme in the participant interviews across all units in the study. Clearly there was great benefit realized by identifying with the team and community.

There were some participants who felt as though their integration into the team was hampered by their social skill. If one considers the influence of the social networking done within the context of the community and how that influences team structure and function, the importance of social connectivity is apparent.

> *I started looking back at how things have changed in the last year with respect to how integrated I feel within the unit. At first I was so quiet that I think that really stifled the relationships I could have built on the unit. On slower night shifts, a few would be engaged in a conversation and instead of going beyond my comfort zone and talking to them, I read until it got busier. I wonder what would have happened if I would have put more energy into getting to know my coworkers better.* (Journal Excerpt RN-B)

This participant reported a delayed sense of transition and ability to reconcile her own sense of RN fit or engage in shared community values in a meaningful way which included the accompanying social connections. There is no question that the larger community context in which these BSPs interact with one another is a key element of the progression of the processes as a whole.

4.1.7.2 CoP as social context. In developing the CoP concept, Wenger (1998) defined community alone as "a way of talking about the social configurations in which our enterprises are defined as worth pursuing and our participation is recognizable as competence" (p. 5). It has already been suggested that the community contexts in these research settings are CoPs. Wenger's definition of community is helpful here as means to reflect on the role of competence in community engagement. As competence is the key component of the Main Concern and also a factor in integration elements such as *Proving Yourself* and *Giving and Receiving Help*, it is interesting to have an opportunity to reflect on its role in community building. Lack of competence was one of the most noteworthy factors that could lead to community exclusion, as will be explored prior to the conclusion of this theoretical discussion.

Wenger (1998) stated that the primary focus of his theory was on "learning as social participation" (p. 4). Through such participation, Wenger envisioned that individuals would construct identities as they engaged in the "practices of social communities" (p. 4). The *Social Networks* identified as a part of the community context for this study are a large part of what aid in making a CoP determination. In this context, social connectivity serves as a bridge between team and community. The social features of a CoP are essential, and participants identified social connectivity to be of great importance. The social network identified in this study serves as a conduit through which information, tacit knowledge, and other experiential learning is exchanged. There are social bonds created within a CoP, and these bonds are notable here in these contexts, fuelled by shared experiences and values. For many participants, it was an identifiable milieu where essential friendships were initiated and developed.

> *I think it is the best thing in the world when you can have community at work because it makes you love your job that much more and makes you want to go to your job and probably prevents a lot of burnout too because you have all of that support that you need.*

It is a note of working together and being a part of something together. (RN-B)

There is a great sense of spirit and fortitude, of being able to meet all adversity, that resides within the unified strength of this group. "*Once the community needs to do something together, it gets done"* (RN-N). It is not surprising that this cohesive approach to work also inspires close relationships.

It's like a whole other social circle that I have now. And those are some of my closest friends now because I spend so much time with lots of them. And I think it makes going to work so much more enjoyable. And even when things are crappy like they are right now, it's still like okay. There's all these people that I like to spend time with that are there that I enjoy being around, and we can make the bad shifts good still. Nightshift you go for breakfast a lot. We do lots of things, and I'm very social. I don't like just sitting around or being by myself. (RN-D).

The depth of influence of these social connections is not to be underestimated. Several participants acknowledged having different work relationships and patterns with colleagues they considered to be friends.

When we help each other out with these things, it makes everyone's job easier. I had mentioned previously in our interview that my peer group (co-workers that I spend time with socially) often do extra things to help each other out. In general, I feel that I can count on these few people to have my back regardless of the situation. They make my workplace a more enjoyable place to be. I know that ultimately I could count on any one of my co-workers in an emergent situation, but when it comes to day-to-day operations; it is the people I consider friends to be the positive and collaborative team that I count on and want to be a part of. (Journal excerpt RN-L).

Clearly the social networks that emerged in this study are of great importance, not only in terms

of aiding in distinguishing between a community and a CoP but as a key contextual influence on the BSPs of transition and integration. There may be other aspects to these networks that should be researched further, the influence on issues of retention, for example.

When one considers the definition of a CoP identified for this research, "groups of people who share a concern, a set of problems, or passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis" (Wenger et al., 2002, p. 4), the reflections shared by the participants here strongly support the supposition of CoP as context. It is also another indicator of how the identified BSPs interact with one another, through the CoP context. Discussion of shared passion and community values for example, might aid a new RN in furthering their personal development of their sense of specialized RN self, but when those discussions are held within the social network it also strengthens the CoP.

A strong CoP then supports the knowledge exchange that occurs as members switch through differing team configurations shift by shift. The underlying social connectivity is the force that inspires the continued feedback of new knowledge or discussion from those experiences back into the CoP. While RNs may have issue with the structure of their team for any given shift, or even prefer teams with more members of their personal social network, the social bonds that are of value maintain their connection to the CoP. Now consider the experience of RNs who are not able to establish these social or community connections.

4.1.7.3 No I in team: Being separated from existing community. When Wenger (1998) spoke of community as a social configuration in which participation would be recognizable as competence, he provided a definition that aligns with a fundamental necessity in specialized practice. The ability to competently fulfill the specialized RN role emerged as the Main Concern in this research, not only as a priority focus for nurses new to these areas, but for all RNs in every specialized unit that participated in this study.

Although some participants felt that attitude or work ethic were potentially divisive matters for RNs trying to engage in their new social context, ongoing competency issues were almost universally acknowledged as the most powerful ostracizing force.

> *She just wasn't catching on well and doing her job very well and people were getting frustrated with that and maybe didn't give her as much of a chance. I mean, she was brand new, she had never worked in that area before and it takes a while in such a specialised area to catch on to what you need to do, but it's pretty quickly evident if you are going to be able to keep up to the pace, to think on your feet critically and to make the right decisions…and some people have that and some people maybe don't have that to work in that area*. (RN-L)

With a sense of duty driving an unrelenting commitment to patient safety and quality care, there is little opportunity for sustained competency challenges when entering into specialized practice.

> *I don't know how to say this. If you are not good, let's say your assessment skills, it's actually, not attitude, it is skills. If you're not good at your job, then we don't want you here. But the thing is, we give them a chance. You're not going to be good at your job the first time. It will take time, but if you don't, get better at what you're doing, then we don't want to work with you.* (RN-N)

The anxiety new RNs arriving in specialized practice report is understandable given the pressure they face to perform.

As was discussed in *Navigating Relationships*, there is real value in the demonstration of an exemplary work ethic while striving to develop the necessary specialized skill set. "*If people want to learn and want to be a part of our group, our team, we give them every opportunity. But if you're just there to slack, or you're not safe, you won't last"* (RN-D). It appears there is a necessary value component to sustained community acceptance from two perspectives. There has

to be a perceived contribution of value on the part of the new RN at some point in their integration journey in addition to the sharing of community values that is part of the transition process. There is also a practical need to be able to excel in the team-nursing environment that has been shown to a prominent feature of many of these specialized units.

> *You can be good at what you do and you can be a really nice person but if you can't be a team player in* [unit] *you're screwed. And I think even though I'm kind of quiet, I was fortunate enough coming out of* [unit]*, we did team nursing there.* (RN-I)

Without the ability to work through these issues of team integration and ultimately community connectivity, the risk of isolation from both of these entities is substantial.

The theoretical model shows the separation of those individuals that have been excluded from the CoP in the specialized unit. Although these acts of exclusion would likely require more intensively focused research to fully articulate, within the context of this study, it appeared that the isolation began from the Team. If an RN had persistent and repeated Team issues through the *Living Shift-by-Shift* experience, then exclusion was a likely result. There also seemed to be a path to exclusion directly from the CoP, typically due to social missteps. In a worst case scenario, issues arising from the Team were reinforced with those from the CoP, or vice versa, and exclusion became a part of a damaging feedback system from which it appeared reintegration would be extremely difficult. *"As soon as you work with somebody that you know is not capable, it just makes your life so much harder and you don't want to work with that person and then they're on the outs*" (RN-O). Once RN peers began to develop a resistance to working with a new RN, things tended to turn quickly. *"When you go for a break, you want to know that this person is caring for your patient the way you would…There's some, the odd nurse, that you really don't want to relieve you"* (RN-A). Again, a loss of value is perceived and integration into the team and CoP is made much more difficult.

There were some issues that RNs new to a specialized area could overcome, perhaps reversing a previous exclusionary status, either with a dramatic skill acquisition improvement or perhaps through a substantial gain in social capital. However, it should be asserted again, that when it came to competence and patient safety, it seemed there was little that could be done to resolve an earned reputation for not meeting standards held by the CoP.

> *I mean if there are competency issues, people will cover because they care about the patients, but they deeply resent that…The RN's deeply resent that, and they will put up with things for a while, but then it gets to be ugly…They just want them gone.* (RN-M).

Specialized RNs are not reserved in their opinions on this topic. There is strong support that the chiefly held shared passion in these units is the competent fulfillment of the specialized RN role. "*You had to know your shit or you were done"* (RN-E). There is little time for coddling in acute care specialized nursing practice. The pace and demands are simply too high. None of the participants in this research felt that they were excluded from their unit CoP, although several did note they never wanted to be the nurse that was. The view of excluded RNs on life in specialized practice without the support of a community would also be an interesting consideration for future research, especially in terms of length of tenure under such circumstances.

4.1.7.4 Potential departure points in transition and integration. For the most part, the RNs that the participants felt were excluded from their units were reportedly still employed and working in the area, although in two cases some of the RNs in the unit had requested action on the part of their administrators in removing the parties in question. The path of exclusion and eventual exit, either directed by an RN, or through a formal dismissal process, is one avenue of departure from a specialized practice area, but there are also other natural exit points as shown in the theoretical model.

There are less traumatic ways to exit from a specialized practice area as opposed to the

isolating experience that has just been reviewed. There are some natural exit points at which an RN working through the transition and integration processes may decide that the area is not ideally suited to them. In fact, each of the phases of the two BSPs provides a potential opportunity for this. The first of these is the transition phase of *Finding RN Fit*. "*I can remember when I first came here. I wondered what the hell I'd done, really, because it is tough"* (RN-E). Participants did report that they had observed a few RNs that realized fairly early on that the area was not going to work for them. However, as was highlighted by one participant earlier, a substantial period of time has to have passed in order to have an informed and comprehensive view about any area. The staged levels of RN practice in these units often meant that it would take more than a year in order to have fully experienced all that the area had to offer.

Some RNs may feel that the specialized area is an adequate fit for them, but perhaps they do not have, or develop, a true passion for the type of care provided. One experienced member of a specialized RN care team had this to say sharing passion for the area: *"I don't think you need to love it. I think you should love it"* (RN-H). A passion for the area and type of specialized care provided, is often a shared community value in these units, and not being able to demonstrate such can be problematic.

> *You want them to have some passion, and we talk a lot about passion for our job, and you want them to because you know they can do really good work, and you just want them to care enough to do it. And most of them do, and it's when they don't care, that's what makes us crazy, the eye rollers.* (RN-M)

This phase is yet another natural exit point for RNs from a specialized practice setting, a decision perhaps preferable to risking isolation from the CoP due to lack of commitment to the demonstrated shared values.

The final phase of the transition process that may elicit an exit is an inability to commit to

the life-long learning demands of speciality nursing care provision. This was an interesting exit point, in that several participants highlighted it as the one where very senior RNs in the area could potentially decide to move on from, or even retire from nursing altogether. *"It's a complete learning process all the time and like I said when people stop learning or they're at a kind of standstill they need to maybe move along and find out a place that stimulates them you know"* (RN-C). The learning demands in the life of any RN are incessant and this is often heightened for nurses in specialized practice. Even ongoing certification in these areas, through the CNA, requires additional review and demonstration of ongoing engagement and development in the specialty.

As in the transition BSP, there are similar opportunities for exit illustrated in the integration process. The first of these comes in *Learning the Ropes*. The aspect of this phase that appears to be a critical juncture is *Proving Yourself*. New RNs may reconsider continued employment in the unit if they are not able to successfully prove their worth to the existing CoP.

> *For you to do a good job, you need to say what you don't know and hopefully other people you are working with understand that and are willing to help you out. I can think of a few examples where people didn't admit that they were doing something wrong or didn't understand what they were doing and there were bad outcomes and that also takes you further from the group…Sometimes you can see people really try really hard but it doesn't change people's minds until you prove yourself on the unit.* (RN-B)

It may not even be a clear case of incompetence that creates a division between the new arrival and the other RNs. It can simply be not adapting quickly enough.

> *Some people come in and they can't prioritize. So the two people that I'm thinking of, they just couldn't prioritize. They asked the same questions for two years. Like, you look and you think, really? So unfortunately, they just don't get brought in and work well with the*

team. (RN-A)

It is noteworthy that the individuals in this instance were still on the unit after a period of two years, an indication of the potential longevity of RNs to continue working even after being excluded from the team and/or CoP.

Finally, there is a natural exit point from the integration phase from *Settling In*. The aspect of this phase that seems to be most troublesome in terms of retention of new RNs to the unit is *Navigating Relationships*.

> *People don't usually want to accept people who are floundering and they either get left in the dust or you have the people who will build you up. Hopefully the group that you are in are the people who want to build everyone up. I think I was fortunate enough to have a few of those people who would do that for me, especially being a new nurse, and that absolutely helped me integrate into the group a little bit more.* (RN-B)

This is another potential misstep that, if left unattended to by the new RN, could lead to isolation from the CoP. Social connection is a key element of CoP membership, and also has been highlighted as a critical means of coping in these intensely demanding care areas.

This theoretical model adds three key components to the foundational Findings Component Model. First is the connection of the two BSPs that is depicted by the spiraled line moving through the center of the model. This demonstrates both the influence of these BSPs on one another and the interaction of the processes through the highly influential CoP context. Second is the exclusion of RN members from their Team and/or CoP. An exclusion from either of these has a tendency to create a negative feedback cycle that can result in an almost complete isolation from the peer group. Finally, there are several departure points, from each phase in the BSPs, where an RN, either through self-reflection or peer or administrative feedback, may decide to leave the unit and seek employment elsewhere. The theoretical model, like the previous view

of the finding components, reinforces the Main Concern of *Competently Fulfilling the Specialized RN Role* as well as demonstrating the serious consequences that can result from RN peers assessing a violation of duty in a new RN, especially one that encroaches on patient safety or quality of care.

4.1.8 Conclusion

The RN participants in this study shared detailed accounts of their experiences, both arriving and practicing in acute specialized care areas. Their words guided the researcher in meeting the primary purpose of this research which was to explore nursing specific processes associated with CoPs in specialized acute care settings with a focus on their potential role in RN integration and professional development. As should be expected with a grounded theory methodology, the use of constant comparative analysis, and the words of the participants, led the research in a somewhat unexpected direction. The processes of transition and integration began to emerge very early in this study. This unexpected development was somewhat distressing for the novice researcher; however, the data was not forced back to a strict examination of CoPs. The researcher came to realize that the analysis of the data was providing insight into the social processes that were essential to the integration of nurses into their chosen specialized acute care settings, and through this integration, the role of CoPs in this journey.

The two identified BSPs contributed to a clearer definition of the larger social context of the research. This was fundamental in defining the key features of the CoP within a specialized acute care practice setting. It was anticipated that the findings from this study would contribute to the development of a substantive CoP theory for specialized acute-care nursing practice. The application of a constructivist grounded theory methodology has resulted in a theorectical model depicting the transition and integration of RNs into acute specialized practice and highlighting the crucial role of CoPs within this process.

Chapter Five

5.1 Discussion

In this chapter, findings from this research will be discussed in relation to relevant extant literature. A further review of the theoretical model presented in Chapter 4 with specific consideration regarding the effects of the two identified BSPs upon one another, as well as the role of the encompassing context of the CoP, is included in this discussion. The intricacies of CoPs in acute care specialized settings will be compared and contrasted with the seminal work, and definitions of the concept, by Wenger (1998). The role of transition, integration, and teams in nursing will be explored within the current literature along with an examination of the most current CoP literature pertaining to nursing practice. The CoP concept has faced considerable critique in its more than 20 year history, and an overview of some of these challenges is also incorporated into this chapter prior to a reflection on the potential worth of CoPs in the professional development journey of specialized RNs.

Although more research is needed in this area, there are some actions that can be recommended now for administrators and practitioners looking to improve upon the transition and integration processes of new RNs arriving in acute care specialized practice settings. This chapter includes recommendations regarding said improvements for administrators, practicing RNs, nurse educators, and researchers. There are concrete steps that can be taken to strengthen integration and transition processes and CoPs in specialized nursing today. The use of these findings and recommendations can support nurses to be better prepared for future practice. Additional research is also recommended in this area, study that ultimately could benefit patients as well as RNs. A discussion on the limitations of this research is also shared in this chapter along with some relevant reflections from the researcher, prior to the chapter conclusion.

5.1.1 Overview

The findings of this study have contributed to a theoretical model depicting the pursuit of competence in specialized RN roles in acute care settings. The use of a constructivist grounded theory methodology has supported an emerging theory of transition and integration into acute care specialized nursing practice within the context of existing CoPs. Study participants identified their practice communities as being of great value, especially in their demanding environments. The view of a CoP as the key context for the successful transition and integration of RNs into specialized practice settings has not previously been shared in nursing literature. The emerging theory uniting transition, integration, and the role of CoPs in specialized nursing contains unique elements also not previously explored.

5.1.2 Theoretical Model Discussion

The theoretical model, along with the words of the participants, depicted the influence of the BSPs upon one another, the role of the CoP as the key context for this interaction, and potential points from both BSPs at which an RN might conclude their employment in a particular specialized practice area. The theoretical model also highlighted the experience of those RNs who are not successful in integrating into the existing practice team or community. This discussion supports those theoretical assertions through further consideration including relevant literature sources.

5.1.2.1 Interaction of the identified BSPs. The curved line travelling through the middle of the theoretical model rendering in Figure 2 is a representation of the influence of each of the main BSPs on one another. There has been a transposition of the terms *transition* and *integration* in publications detailing the experiences of RNs entering into professional practice. Perhaps this interchange is understandable given the elements commonly expressed by these terms. This research however, revealed two distinct entities as were denoted in the previously shared BSPs:

Developing a Sense of Specialized RN Self, a personally driven process of transition, and *Integrating into Specialized Practice*, the more socially collaborative process of integration. These BSPs were undertaken by RNs, new to specialized practice settings, seeking to achieve an identified Main Concern of *Competently Fulfilling the Specialized RN Role.*

More recently in the nursing literature, there have been articles that do distinctively address both transition and integration (Chernomas et al., 2010; Walker et al., 2013). These publications included an examination of these processes from the point of view of Nurse Managers; however disappointingly, there were still not strongly definitive distinctions made between transition and integration. Walker et al. (2013) spoke of "successful integration into the workplace" and "transition into the workplace" in an interchangeable fashion without having clearly articulated what they viewed to be the difference between the two (p. 295). Chernomas et al. (2010) similarly summed their work identifying the "critical time of transition and integration into the workplace" again without a previous distinction of the terms. These authors did expand their discussion of transition to a broader exploration of role transition, which has a strong foundation in existing nursing literature (Chernomas et al., 2010).

There seems to be a much more prominent focus in nursing literature on transition, as opposed to the integration process, especially when further defined as role transition or other similarly termed socialization experiences. (Duchscher, 2008; Duchscher, 2009; Guhde, 2005; Rush et al., 2013; Young, Stuenkel, & Bawel-Brinkley, 2008). Transition has also been explored, from the perspective of new graduate nurses (Hinds & Harley, 2001; Malouf & West, 2011). There is a foundation within existing nursing literature to support the researcher's distinction of the processes of integration and transition, although these have not previously been clearly delineated. Events occurring within each of the BSPs identified in this study have the potential to feedback and influence the other through the context of the CoP. There was only one other article

found in the current nursing literature that shared some of the same elements of this argument (Thrysoe, Hounsgaard, Dohn, & Wagner, 2012). In examining the experiences of newly qualified nurses, Thrysoe et al. (2012) also proposed that interactions within a CoP were influential in transition processes. Although these authors also did not distinguish transition and integration, they did speak of transition and full participation within a CoP as separate entities (Thrysoe et al., 2012).

Examining the literature on transition and integration into professional nursing show that there is a precedent for a further exploration of the distinct natures of these processes. The participants in this study were eloquent in detailing their personal transition reflections and in relaying how events that transpired in their integration experiences influenced personal views regarding competence, for example. A self-reported lack of social dexterity was noted by more than one participant as a perceived barrier to full acceptance, or as the researcher would assert, CoP membership in their new specialized areas. The relationship between social skill and belonging or team membership is also supported in current nursing literature (Hinds & Harley, 2001; Malouf & West, 2011). In their recent work, Malouf and West (2011) have also argued that a distinction needs to be made between orientation and transition, and they spoke further to the confusion that can arise when those terms are used interchangeably. A similar problem persists in nursing literature with regards to transition and integration. This study has provided further clarity in delineating some of the specifics associated with these distinct processes as well as how they can influence one another.

The participants in this study had differing reflections on specific timelines associated with their transition and integration processes. There was some consensus that a minimum of six-months was required in order to make any substantial progress in the achievement of the Main Concern regarding competently fulfilling their specialized RN roles. This finding is echoed in the

work of Duchscher and Cowin (2004) who detailed the experience of new nurses existing between two worlds for the first six months of their practice, transitioning between student nurse and RN. Others made the argument that a full year was a more realistic timeline for transition and/or integration to occur (Chernomas et al., 2010; Valdez, 2008; Walker et al., 2013).

The findings of this research suggested that *Developing a Sense of Specialized RN Self* incorporated elements that could have to be revisited periodically such as recommitting to shared community values and the need for life-long learning and professional development. A complete sense of transition could be achieved in the initial consideration and resolution of each of the proposed phases of this transition process. Consideration of the need to revisit transition reflections could provide insight into the decision making process of senior nurses who leave their specialized areas after lengthy periods of employment.

There is a final distinction that should be made, between the findings of this study, and existing nursing literature. All of the work on transition and integration that has been highlighted thus far from publication is focused on the experiences of new graduate nurses (NGNs). Participants in this study have shared that entry into a specialized practice area resets their feelings of competency. While experienced nurses acknowledged that their past practice was a support for them in moving through the transition and integration processes of specialized practice, it did not appear to nullify a necessary participation in the identified BSPs. These occurrences of more senior nurses experiencing the same processes as NGNs entering into practice for the first time, highlights yet another opportunity for further research.

There are clearly unique demands inherent in entering acute care specialized practice settings that provide an opportunity for comparing and contrasting transition and integration experiences of NGNs and experienced nurses. The processes cannot be circumvented by experience, but perhaps there are other key factors that would be revealed in further examination.

A potential ease of social connection for example, for experienced nurses, with the specialized CoP conceivably through a valuing of their previous nursing experience by the new community. The existing literature on the NGN experience of transition does provide insight into the unique circumstances these new professionals face, especially when attempting to integrate directly into a specialized area (Valdez, 2008). For new and experienced nurses alike, the CoP appears to be an essential element in their sustained success in the demanding environment of specialized care.

5.1.2.2 CoP as social context. Although there has been further publication regarding CoPs and use in nursing (Carmel & Baker-McClearn, 2012; Lin & Ringdal, 2013; Nesbitt, 2013; Risling & Ferguson, 2013; Thrysoe et al., 2012), there has been little discussion of the CoP as the social context for the processes of transition and integration. Thrysoe et al. (2012) have authored the only other article that examines interaction with a CoP as a key factor in NGN transition. The role of CoPs in supporting all RNs, be they newly graduated or experienced, seeking to achieve competence through successful transition and integration into specialized nursing practice, has not previously been explored in the current literature.

The purpose of this doctoral research was to explore nursing specific processes associated with CoPs in specialized acute care settings with a focus on their potential role in RN integration and professional development. There were moments of apprehension for the researcher when, through the application of a constructivist grounded theory methodology, a focus on transition and integration initially arose as opposed to more specifically focused CoP elements. The words of the participants and the use of constant comparative analysis continued to direct the research process and eventually, in delineating the BSPs, the critical elements of the social context for the findings were revealed. These are the elements that aided the researcher in identifying and defining the aspects of the CoP present in the studied specialized care settings.

Wenger's (1998) reflections on social communities and "learning as social participation"

(p. 4) is a principal support for the assertion of the CoP as the social context in this research. As was proposed in Chapter 4, a CoP in a specialized practice setting serves as a conduit between the two BSPs experienced by new RNs entering the unit. Reflections and experiences from transition and integration moments are filtered through the CoP and can influence, and be influenced by it, simultaneously. The elements of *Learning* and the *Social Networks* that emerged as key aspects of the context in these nursing units framed a further consideration of the same as CoPs. In their work Thrysoe et al. (2012) have also identified nursing personnel groupings within units to be a CoP. The authors examined how NGNs, or as they identified them Newly Qualified Nurses (NQNs), became fully engaged members of these existing CoPs. Learning and knowledge exchange opportunities were a key feature of their findings as well (Thrysoe et al., 2012). Thrysoe et al. (2012) noted that:

> interest in how NQNs could contribute in terms of knowledge and experience, seemed to increase NQNs' feeling [sic] of being important and was an incentive for increased participation. Being able to contribute with knowledge and experience signaled a shift from primarily learning from colleagues to also being able to teach them something new. (p. 553)

Participants in this study also indicated great satisfaction in relaying moments where they felt they had made a contribution to the CoP, not simply taken knowledge from it. This seemed to not only be an advantage in terms of increasing personal social capital, it was also a further indicator of developing competence in the specialty.

Although these research participants did not identify their communities as a CoP, there is sufficient support to warrant the claim that there are, in fact, CoPs in acute care specialized practice. Even the value attributed to *belonging* on the unit can serve as a further indicator of CoP presence. The study participants were clear about the personal value of community in their

workplaces. They did not want to be involved in a workplace without community, nor did they want to become ostracized from the existing community structure.

Working from Wenger's (1998) definition of a CoP, the shared passion and concern of this RN group can be identified as the provision of competent, safe, and quality care for patients. Reflecting on the definition further, it is likely that sharing knowledge and expertise through ongoing interactions is the element of utmost value to new RNs arriving on the unit. CoP membership may be desirable for specialized RNs both in the early days when arrivals have an acute need of the knowledge and support that can come from a CoP, and later, as RNs are seeking to contribute knowledge to the CoP as an indicator of their own value.

The other element of relevance in this research was the presence of strong social networks underlying the CoP. Not only did social connectivity seem to have a persuasive influence on the aspect of *Giving and Receiving Help*, these kinds of connections were also of importance to participants, who fervently indicated that they had no wish to be one of the 'those nurses'; referring to those that had been isolated from the CoP.

5.1.2.3 No I in team: Being separated from existing community. Study participants were steadfast in their support for the communities they perceived to be the core of their specialized units. It appeared these groups were extremely valuable, both personally and professionally, and several participants noted they would not want to work in their settings without a secure membership in these groups. These findings are supported by the work of Malouf and West (2011) who examined the desire of NGNs to fit-in when arriving in their new practice settings. "In their transition to practice within the acute care workplace these NGNs instinctively understood the benefit of establishing solid social relationships and actively tried to avoid the ill effects of not having at least minimal social ties within the workplace" (Malouf & West, 2011, p. 492).

Although they appeared to be quite few in number, in each unit participants were able to identify RNs they felt were separated from what they viewed as their teams or community. The most common reason for this separation was a perceived lack of competence or sense of duty, as demonstrated through a lack of care and commitment to the patient group. In the theoretical model presented in Figure 2, the isolation from the CoP is depicted as originating from the Team or from the larger community context. It is plausible that this isolation could originate from persistent team issues noted over the course of several shifts or through a social conflict or lack of social skill resulting in an inability to move into the CoP. The participants noted an identified grace period for misstep and lack of skill in the earliest days in specialized practice, but there was a definite time constraint with regards to the demonstration of improvement. Without being able to achieve a minimally accepted level of competence, as well as substantial exhibition of a commitment to the safe and quality care of the patient group, there was an ongoing risk of isolation.

Many study participants viewed an existence with an isolated status as intolerable. They felt it would greatly influence both their personal enjoyment of their RN role as well as jeopardize their ability to effectively provide care. Thrysoe et al. (2012) have stated that "lack of support from colleagues, and less frequent dialogue between NGN and members of the CoP seemed to put the NQNs in a more or less marginalized position" (Thrysoe et al., 2012, p. 554). The authors further explained that this isolation increased the risk of an RN moving along an outward going path that could ultimately result in a decision to leave the CoP altogether. A marginalized status was an ongoing burden in terms of attempting to achieve full participation within the CoP (Thrysoe et al., 2012).

Duchscher and Cowin (2004) examined the issue of marginalization with NGNs. The authors defined marginality as life between either two hierarchical levels, or between two

cultures with differing power (Duchscher & Cowin, 2004). This was what they felt the experience of many NGNs was equivalent to. There were two instances of marginalization of note in the work of these authors, marginalizing situation and marginalized personality (Duchscher & Cowin, 2004). NGNs could typically expect to experience moments of a marginalized situation as they transitioned from their student group to their new professional peer group, but these would not be lengthy (Duchscher & Cowin, 2004). A marginalized personality however was said to result "from the longstanding misappropriation of individuals into a binding subordinate social or economic stratum within which the realization of their full sense of self is prohibited, and from which they are unable to ascend" (Duchscher & Cowin, 2004, p. 290). Thrysoe et al. (2012) noted that it was the later of these that was more damning in terms of trying to achieve entry into a CoP, and declared NGNs so unfortunate as to obtain a permanent marginalized personality would likely leave their job within a few months.

Wenger (1998) also included the concept of marginality in his work, noting it to be "a form of non-participation" (p. 166). This situation could result, the author noted, in a permanent marginal position or non-membership in a CoP (Wenger, 1998). In the presented theoretical model, the exclusion of an RN from either the Team or CoP is depicted as a potential negative-feedback scenario. Meaning that an initial exclusion may be fortified by the very experience of being isolated and the experiences or behaviour that may result. This supposition is supported by the work of Thrysoe et al. (2012) who stated "from a marginalized position newcomers do not have sufficient access to resources in the CoP which would allow them to gain relevant competence and act as a valued member" (p. 554). This situation appears to be a vicious cycle from which positive extrication could be extremely difficult. Although participants in this study noted that some RNs seemed to persist in these isolated states for months or years, the majority of those observed reportedly did seek other employment eventually. The importance of the need for

acceptance and a sense of belonging or fitting-in for RNs entering into specialized practice cannot be overemphasized, and these findings are supported by previous nursing research (Hinds & Harley, 2001; Malouf & West, 2011). It would be a much more positive experience for RNs to be able to leave their specialized practice setting of their own accord, as opposed to a decision fuelled by their inability to gain membership within the CoP.

5.1.2.4 Potential departure points in transition and integration. In a recent literature review examining the cost of nursing turnover, Li and Jones (2013) referred to data identifying a RN turnover rate of 28% in the United States and approximately 20% in Canada in the first year of employment. These moderate to high rates are a costly enterprise not just for health-care organizations, but potentially for patient care. "Health-care organizations also lose the intellectual capital of nurses who leave and incur potential productivity losses associated with nurse turnover" (Li & Jones, 2013, p. 406). Although the focus of this study was not on why RNs leave specialized practice, there are some insights offered in the theoretical model about where in their engagement in the identified BSPs, they might make a decision to do so. Moving to a position of isolation from the CoP on the specialized unit can create the conditions to support an eventual exit from a particular practice area. The theoretical rendering proposed in Chapter 4 details other possible exit points for the RN in specialized practice related to each phase in each of two identified BSPs. Beginning with transition, it is worth examining further why RNs might choose to leave specialized practice.

The three phases of the BSP *Developing a Sense of Specialized RN Self* are about transition, personal self-reflection, and professional growth. Each of these is also a natural place to include reflection on whether or not continued employment in the area is desired. The first phase *Finding RN Fit* may be the most likely of the three where a nurse may decide that the specialized area they have entered is not a good personal fit. There is a dearth of publication on the particular

experiences of RNs entering specialized practice. Although there is a great deal of research on the intentions and experiences of NGNs entering into professional practice, there are fewer, if any, specific publications on RNs acclimating to a new acute care specialized practice setting. Valdez (2008) examined the experience of NGNs transitioning into Emergency care practice in a literature review and synthesis and found there were no other articles focused on the transition experience of RNs into this specialized practice. In their integrative review of expert nursing practice, Morrison and Symes (2011) also noted a need to know more about how expertise was developed across a number of nursing specialties. Both of these publications identified an overall lack of data and study on the experiences of RN development in specialized practice.

A potential departure related to RN fit is likely to be tied to experiences in the integration phase *Learning the Ropes*. Although there is little research in this area, participants in this study did note that RNs who departed early from their specialized units likely did not allow adequate time to evaluate and adjust to the practice. In order to reflect on the fit of a specialized area, RNs have to have sufficient emotional capacity and support. It is plausible that negative experiences in *Learning the Ropes* while attempting to integrate into the specialized area feedback through the CoP context and influence the personal reflections of RNs determining their RN fit. One participant in this study reflected on a number of new RNs she had observed leaving her specialized unit after only a few months. While it is possible that those nurses had adequate time within a few dozen shifts to determine the area was not a fit for them, the participant suggested instead that they had not given themselves enough time to ascertain the complete experience of RN life on the unit. Due to the leveling of nursing skills and tasks in the specialized areas in this study, a time period of one to two years is actually necessary to move into a full range of specialized practice. Given this, the researcher concurs with the participant that a conclusion of unsuitable fit by an RN new to the area after only a few months is likely premature, providing

that there has not been a strong negative reaction to working with the patient population to which care is provided on the unit.

The second and third phases of the transition BSP: *Sharing Passion and Community Values* and *Embracing Life-Long Learning*, are areas that the researcher has proposed an RN may need to revisit more than once during an extended career in specialized practice. With the rapid pace of change in today's healthcare environments, it would be expected for the shared values in a specialized unit CoP to evolve. As RNs face issues of burnout in demanding care environments, they might also have a need to revisit their personal passion for the specialized area in which they have chosen to practice.

This ever progressing and evolving environment also necessitates a strong commitment to the life-long learning and professional development needed to retain the skill and knowledge necessary for competent care in a specialized area. Participants in this study identified a lack of commitment to ongoing learning and development as a serious warning sign for RNs to reflect upon whether or not continued practice in the area was right for them. There were no existing studies or publications found that examined these particular factors and their relationship to a specific intent to leave nursing practice. However, there is relevance to be found in looking at other closely aligned factors that may influence nursing turnover, such as empowerment which has been shown to influence the intent of RN exodus (Hayes et al., 2012). "Certain structural determinants within an organization are theorized to promote growth of empowerment, including having access to information, support, necessary resources and the opportunity to learn and grow (Kanter, 1993)" (Hayes et al., 2012, p. 890). In reviewing expert nursing practice, Morrison and Symes (2011) also stressed the importance of supportive learning environments for nurses actively engaged in ongoing professional development. Strong membership in the CoP would also likely be essential for sustaining passion for the specialized area and remaining engaged in

learning over a lengthy career.

The impetus to leave an area of specialized practice could also be strongly tied to experiences occurring within an RN's integration process. In this study, the second BSP *Integrating into Specialized RN Practice***,** had two phases where a decision to depart could occur. Although limited, there is literature to support an assertion of overwhelming emotional experiences while integrating into specialized nursing practice. In this study, these experiences were identified as an aspect of the phase *Learning the Ropes* and were similar to the work of Valdez (2008):

> Rapid immersion into the modern-day acute care work environment and feelings of inadequacy lead many new graduates to feel overwhelmed, unsupported, and disillusioned. Known stressors that accompany entry into practice, coupled with the high-stress, fast-paced, life-and-death environment of the emergency setting, place the new graduate at increased risk for failure to thrive in clinical practice. (p. 435)

The time of *Learning the Ropes* is incredibly demanding for an RN entering into specialized practice, be they a new graduate or a nurse with years of experience in another area. Within these emotionally charged early experiences falls the burden of successfully navigating orientation and getting through the aspect of *Proving Yourself*. Participants in this study frequently commented on a specific phase of their integration where they felt their actions and decision making were being closely scrutinized by more experienced RNs in the unit. The new RNs felt an ongoing demonstration of their competence was essential during this time. Participants in this research often equated how well they were able to perform during the time of *Proving Yourself* with the strength of some of the initial social connections they were able to make.

The need for substantial social connection in specialized practice has already been articulated in reviewing the study findings. What begins in *Making Connections* is furthered in

Navigating Relationships as RNs move on to the *Settling In* phase of their integration process. Social networks and connection are also a key element in the CoP context. Malouf and West (2011) addressed the intense need of new nurses to have a sense of connection. "For these NGNs, fitting in and the achievement of some degree of attunement with colleagues was an integral part of being able to function in the clinical environment during their transition to practice" (Malouf & West, 2011, p. 491). Hinds and Harley (2001) observed that acceptance of new nurses by their RN peers was a factor in gaining, and sustaining, feelings of confidence in the new workplace.

It appears it would be difficult for RNs to advance their skills and create rich learning and professional development environments for themselves without social connections. Morrison and Symes (2011) stressed the critical importance of such connection in their work on expert nursing practice. "Expert practice develops as nurses gain experience in a specialized practice setting, reflect on and learn from their experience, and develop meaningful relationships with their patients, families, and colleagues" (Morrison & Symes, 2011, p.163). Without these connections, which would ideally be forged early on in the integration process and then deepened as RNs accumulated more time in their specialized area, retention issues would not be surprising.

The RNs in this study had a clear predilection for collaborative work environments. For some, the strength of their social networks seemed to have a direct influence on the amount of collaboration that resulted in any given shift, with urgent situations and care needs exempt from this. This finding is a strong indicator of the importance of these social connections. Whether deemed a team, group, community, or CoP, there is no denying that a key element to the process lies in understanding more about the social aspect that underlies the identified BSPs. In the case of this research that is the particular aspects of the CoPs serving as the context for transition and integration in specialized acute care nursing.

5.1.3 CoP in Specialized Nursing Practice in Comparison with Wenger's COP

The researcher began this study with an understanding of the CoP concept which Wenger developed both in his initial work (Lave & Wenger, 1991; Wenger, 1998) and in later publications (Wenger et al., 2002; Wenger, White, & Smith, 2009; Wenger & Snyder, 2000). There was interest in determining if a CoP in acute care nursing had the same parameters and membership function as suggested by this seminal work. Wenger was a computer scientist when he initially teamed with Lave, an anthropologist, to develop the CoP concept. Using processes associated with the apprenticeship experience, the pair put forth their initial work on the CoP concept. This work however, was not developed with RN practice in mind, nor was it a specific tool created to serve nursing science. The identification of the two BSPs in this research also revealed information about the social context in which RNs were pursuing transition and integration; that context was then deemed by the researcher to be a CoP. This discussion is an opportunity to compare and contrast the study findings and the particular aspects that comprise a CoP in acute care specialized nursing practice with Wenger's seminal work on the concept.

In the models representing the findings of this research, the community context is identified along with two key additional elements that emerged from the study data: *Learning* and *Social Networks*. These components were key aspects of the communities, as the study participants identified. Consequently, *Learning* and *Social Networks* became the elements for further reflection on the research context and the researcher returned to Wenger's work to examine the fundamentals of his early CoP conceptualization.

When Wenger (1998) introduced the concept of CoP, it was meant to be an integrative element of a new social theory of learning he was proposing. For Wenger, learning was about more than being casually present in an enterprise. It was an "encompassing process of being active participants in the practices of social communities and constructing identities in relation to

these communities" (Wenger, 1998, p. 4). From this, Wenger (1998) identified four components of his social theory of learning:

> *1) Meaning*: a way of talking about our (changing) ability – individually and collectively, to experience our life and the world as meaningful.
>
> *2) Practice*: a way of talking about the shared historical and social resources, frameworks, and perspectives that can sustain mutual engagement in action.
>
> *3) Community*: a way of talking about the social configurations in which our enterprises are defined as worth pursuing and our participation is recognizable as competence.
>
> *4) Identity*: a way of talking about how learning changes who we are and creates personal histories of becoming in the context of our communities. (p. 5)

When RNs complete basic undergraduate programs they are typically referred to as generalists, meaning that they have a beginning foundation of skill and knowledge so that they are capable of safely engaging in basic practice safely. Although there is often some exposure to specialized areas during their education, nurses do not have the in-depth knowledge for full competence in any one acute area of specialized practice. They must learn and develop these skills once in practice. Many elements of Wenger's social theory of learning are discernible in the shared experiences of the study participants. A meaningful approach to the job, shared resources, mutual engagement in action, the recognition of competence, and personal histories of becoming, are all recognizable themes from participant data.

Social theories of learning could be valuable to the nursing profession, especially since much of RNs' professional development occurs outside of the formal nursing education system, in specific practice areas. Wenger (1998) felt that for individuals, learning was an act "of engaging in and contributing to the practices of their communities" (p. 7). Communities could also learn by "refining their practice and ensuring new generation of members" (Wenger, 1998, p.

7). Finally, organizations could maximize learning potential by "sustaining the interconnected CoPs through which an organization knows what it knows and thus becomes effective and valuable" (Wenger, 1998, p. 8). This multi-level approach to learning seems particularly valuable to the complex and ever evolving healthcare milieu. In this study, learning is a heavily featured aspect of the findings. There are specific learning phases in both the integration and transition BSPs in addition to the identification of learning as part of the defined social context. This aspect of Wenger's CoP work seems well aligned with the research done on these specialized nursing units.

The second specific aspect of the CoP, as it was identified in this research, was the importance of social networks and relationships. Wenger's (1998) initial pursuit of the CoP concept as part of a social theory of learning is an explicit indicator of the relationship between learning and social connection. Learning "takes place through our engagement in actions and interactions, but it embeds this engagement in culture and history. Through these local actions and interactions, learning reproduces and transforms the social structure in which it takes place" (Wenger, 1998, p. 13). This essential social element of Wenger's work also supports the contextual aspect of professional learning specific to the needs and situation of the setting, in this case, specialized nursing units. The social element further contextualizes the CoP itself, as was the case in the findings of this research. Participants outlined the importance of their social relationships not just in their learning, but also in their day-to-day pursuit of excellence in their professional practice. It became clear that this was a key contextual element of these specialized practice environments, just as it was to Wenger's social theory of learning.

Once he had identified the elements of his social theory of learning, Wenger (1998) laid out the essential components he felt were needed to unite community and practice, bringing forth the concept of CoP. Wenger noted three essential dimensions of practice needed to serve as a source

of coherence for the community, "mutual engagement, a joint enterprise, and a shared repertoire" (p. 73). Wenger felt that negotiating meaning and mutual engagement were what defined a community. Joint enterprise was noted to be the "result of a collective process of negotiation that reflects the full complexity of mutual engagement" (p. 77). Wenger added that participants in a CoP also developed "mutual accountability" as a result of engaging in the joint enterprise. Finally, Wenger stated that over time, as members of a CoP interacted with one another, a shared repertoire would develop. These "resources for negotiating meaning" could include "routines, words, tools, ways of doing things, stories, gestures, symbols, genres, actions, or concepts that the community has produced or adopted in the course of its existence, and which have become a part of its practice" (p. 83). Once again there are several similarities between this seminal CoP work and these study findings.

Wenger's (1998) concept of mutual engagement as a key to CoP membership is represented in this research by the engagement of RNs in specialized practice in the achievement of the Main Concern from the study: *Competently Fulfilling the Specialized RN Role*. In this research, participants were compelled to maximize the competence of their practice to satisfy an inherent sense of duty to provide the safest and highest quality of care for their patients. These RNs were extremely unified in their pursuit of this goal, their joint enterprise, and therefore had a strong underlying force driving their mutual engagement in achieving the same.

A further examination the element of joint enterprise provides additional support for the identification of the provision of safe and quality care for patients as the negotiated joint pursuit in specialized nursing units. Wenger (1998) noted joint enterprise to be a factor in maintaining CoP unification. Joint enterprise reflects the complexity of the mutual engagement of a group and is negotiated by participants even as they pursue it (Wenger, 1998). "It is their negotiated response to their situation and thus belongs to them in a profound sense, in spite of all the forces

and influences beyond their control" (Wenger, 1998, p. 77). This assertion has a particular connection to the study findings, as participants often reflected on coming together to try and make things work when they were forced to proceed in a shift without adequate staffing, an overage in their patient census, or through a series of urgent situations that depleted the resources of the unit. The RNs in this study had a profound connection to their pursuit of practice that did not erode their sense of duty. This correspondence was another convincing correlation between the CoPs delineated in these specialized nursing units and Wenger's seminal work.

Finally, a shared repertoire was the third element Wenger (1998) identified as a distinct component of how practice served as a source of coherence for community. As time progresses, a CoP develops resources associated with the pursuit of their joint enterprise (Wenger, 1998). "The repertoire of a community of practice includes routines, words, tools, ways of doing things, stories, gestures, symbols, genres, actions, or concepts that the community has produced or adopted in the course of its existence, and which have become part of its practice" (Wenger, 1998, p. 83). There is an argument to be made that the core of specialized nursing practice communities are reflected in this definition of repertoire. *Learning the Ropes* in integration and *Sharing Passion and Community Values* in transition particularly highlight the areas from this research that align with these assertions from Wenger.

There is extensive literature on the work of nurses and their creation of these types of repertoire elements. In this study in particular, there was a pervasive representation of these elements in the stories of participants working to orientate, settle in, and eventually become a functioning part of the team in these specialized areas. Behind these pursuits was the socially networked learning environment in which they learned of, and eventually contributed to, the shared repertoire of the CoP present in their specialty unit.

According to Wenger (1998), members of a CoP may not even identify their collaboration

as a CoP, nor do they need to for it to be so. The participants in this research did not identify their communities as CoPs. As the existence of a CoP was not deemed dependent on membership pronouncement, Wenger compiled a set of characteristics to aid in identifying a CoP, whether group participants identified it as such or not. The presence of these characteristics denotes three essential dimensions of practice: mutual engagement, a joint enterprise, and a shared repertoire. Wenger's characteristics of a CoP include:

> Sustained mutual relationships – harmonious or conflictual; Shared ways of engaging in doing things together; The rapid flow of information and propagation of innovation; Absence of introductory preambles, as if conversations and interactions were merely the continuation of an ongoing process; Very quick setup of a problem to be discussed; Substantial overlap in participants' descriptions of who belongs; Knowing what others know, what they can do, and how they can contribute to an enterprise; Mutually defining identities; The ability to assess the appropriateness of actions and products; Specific tools, representations, and other artifacts; Local lore, shared stories, inside jokes, knowing laughter; Jargon and shortcuts to communication as well as the ease of producing new ones; Certain styles recognized as displaying membership; A shared discourse reflecting a certain perspective on the world. (p. 125)

This is a lengthy and extremely comprehensive inventory, much of which has already been reflected upon within the context of the research findings. There are however, a few additional parallels of note.

The shared experiences of the study participants contain many of the characteristics that Wenger has identified in this CoP checklist, the most prominent of these likely being the presence of sustained mutual relationships. Participants were quick to highlight the importance of their relationships and reported both positive and more challenging relationships within their

communities. The rapid flow of information is another characteristic that many participants identified, especially in detailing the management of emergency situations. There were several reports of *unspoken action* in these situations where every member of the team on that shift knew what needed to be done and things simply progressed as needed.

The ability to work as a cohesive unit in an urgent care situation led participants to further explicate the need to understand the particular strengths and abilities of all of their team members on any given shift. The participants noted it was not unusual for roles to be assigned to certain nurses such as those most suited to start intravenous lines, assess a rhythm strip, administer emergent medications, or manage the anxiety of family members. It was these situations in which there was an abundance of jargon and shortcuts employed that were only useable by CoP members. Finally, in the midst of the stress and demanding nature of their specialized environments, several participants reported the importance of humour and shared stories in their communities or teams. The demands of these units seemed to require a counter camaraderie and humour and shared experiences seemed to strengthen these ties. Unit specific lore and jokes were an identifiable element of these communities. A review of this extensive CoP characteristic listing, along with the three key factors uniting practice and community, provided further support for the existence of CoPs in these specialized areas as well as the key elements that comprised them.

5.1.4 Transition

Transition emerged as a key finding in this research. Much of the nursing transition literature is focused on the experience of the NGN with very little publication found about experienced nurses that move into a new specialty area. In her work on NGNs transitioning directly into emergency practice, Valdez (2008) used the work of Benner as a theoretical foundation. Although typically applied to NGNs, Benner (1984) herself did acknowledge the

potential of the novice to expert transition to apply to experienced nurses entering a new practice area. Elements of the journey through the stages of novice, advanced beginner, competent, proficient, and expert (Benner, 1984) are found in the stories of the study participants from the newly graduated, to those who entered their specialized areas with considerable experience. Although it is likely that the time spent in each stage is lessened with previous nursing experience and skill development, most participants arriving in these specialized areas felt they were novices. A novice nurse is typically defined as not having previous experience with, or knowledge of, the nursing skills they are required to perform (Benner, 1984). "This [novice] level of proficiency is frequently seen in the prelicensure nursing student, although even an experienced nurse entering a new specialty role may function at this proficiency level" (Valdez, 2008, p. 436).

More research is needed on how nurses with experience in other areas might progress along the novice to expert continuum as opposed to their newly graduated counterparts. In terms of *Developing a Sense of Specialized RN Self*, although an assumption could be made that experienced nurses might have an advantage in moving through this process in reflecting on RN fit, for example, within their own historical professional context. Some experienced nurse participants did report a sense of ease in establishing social connection within the existing community, but again, more study would be needed to determine how much of that might be attributable to an established nursing history as opposed to personality, for example.

Duchscher (2008) also developed a transition theory for NGNs, founded, in part, on the seminal work of Kramer (1974) done decades earlier. During their initial 12 months in practice, Duchscher (2008) proposed that NGNs would move through three stages in a process of becoming: doing, being, and knowing. In doing, these nurses would struggle with high anxiety trying to manage unexpected heavy workloads and the realization that their skills sets were not

completely developed (Duchscher, 2008). Duchscher (2008) found that for NGNs:

> understanding what was expected of them, doing it well, and completing their tasks on time were their primary concerns…Uncertain who they could trust and driven by a need to belong, these graduates went to great lengths to disguise their emotions from colleagues and worked to conceal any feelings of inadequacy. (p. 444)

These findings are closely aligned with aspects of *Learning the Ropes* in this study. However, as the researcher has stated, the experiences in this integration process have a direct influence on the development of the sense of specialized RN self that is evolving in the transition process.

After the first several months the NGN transitions into Being, and this phase is one of rapid development in how they critically think and perform in their practice (Duchscher, 2008). Finally in Knowing, the nurse works to distinguish themselves from their peers and also seeks to join with practitioners in the larger community (Duchscher, 2008). "Being able to answer questions rather than simply ask them, and assist others with their workloads were both identified as notable signs of their progress" (Duchscher, 2008, p. 447). Participants in this study also highlighted these occurrences as noteworthy experiences.

Since Kramer (1974) first introduced the term *reality shock* into the nursing literature there has been a considerable amount of publication about the transition or integration of nurses into professional practice. Based on the two subsequent views of transition experiences reviewed here, the seminal work of Benner and the more recent theory of Duchscher, is appears there is still a need for further research and discussion regarding nursing transition and integration. The experiences of arriving in specialized nursing practice relayed by the participants in this study supported a very clear distinction between a personally reflective transition process, in contrast with the environmental and socially influenced integration experience.

While the events of integration can have a substantial bearing on transition, only each RN

themselves can reflect upon their RN fit, and whether or not they share a passion for the area they have chosen and can commit to the values shared by the community. There will likely be a need to recommit to community values and the necessity of life-long learning in these demanding care areas as the career of the specialized RN progress, and again, these are personal reflections and decisions that must be made. In their article on professional socialization in nursing, Dinmohammadi et al. (2013) noted that the view of socialization "should no longer be seen as a reactive and linear process, but as a dynamic, ever-changing process. Nurses, at any point in their career development, can change the way they view themselves and their role" (p. 32). *Developing a Sense of Specialized RN Self*, is a personal journey, one in which the RN is influenced by many external factors that may sway their internal evaluations and reflections, but ultimately this sense of self is something that every RN must determine, create, and sustain for themselves.

5.1.5 Integration

Unlike transition, integration is a process more directly influenced by external forces. While ultimately it is the RN who must successfully navigate this experience, there are many factors and influences along the way that can help or hinder a successful journey. For new graduates, entering directly into specialized practice seems an especially challenging venture. Consider this recommendation for NGNs: "Graduates require consistency, predictability, stability, and familiarity in their initial clinical practice situations for at least the first 4 months" (Duchscher, 2008, p. 448). This kind of environment would be difficult to locate even in general nursing practice and it was not the experience of arriving in specialized units, as shared by the study participants. The previous discussion on transition included publication that supported some of the findings of this research in the integration phase *Learning the Ropes*, such as *Managing Emotions* and *Proving Yourself*. There is additional literature on the integration of nurses that addresses some of the other aspects of the proposed BSP.

In what has been determined to be a highly emotional and anxiety filled experience, the importance of *Making Connections* and *Navigating Relationships* during the integration process cannot be overemphasized. Again, although this research was not particularly focused on mentoring or other supportive structures at use in acute care nursing practice, these were aspects of their experiences entering specialized practice that were of great importance to the study participants. Much of the literature on integration and transition in nursing practice also addresses the need for some sort of formal support for new nurses, be that mentors, preceptors, buddies, or other orientation program supports (Chernomas et al., 2010; Duchscher & Cowin, 2004; Ferguson & Day, 2007; Guhde, 2005; Malouf & West, 2011; Rush et al., 2013; Thrysoe et al., 2012; Valdez, 2008). Be it through a CoP, a mentorship program, or another type of structured peer relationship, the critical importance of social connection and support is well documented.

In research on the need of NGNs to acquire a sense of fitting in, Malouf and West (2011) noted their "participants quickly recognized the importance of secure social bonds and the need to connect with those with whom they were working" (p. 491). Hinds and Harley (2001) also found that NGNs had a powerful need for acceptance. These authors viewed this need as creating a potentially problematic power differential between new arrivals and already established nurses (Hinds & Harley, 2001). In their work on the risk of marginalization for NGNs, Duchscher and Cowin (2004) noted that stigmatization of NGNs, being referred to as "kids" or "novices" by senior staff was a potentially damaging way of distinguishing this group. This was another example of a hierarchical power issue. It was in the aspect of *Proving Yourself* that participants in this study recounted their experiences with these kinds of power struggles. Being told that they would have to *pay their dues* and desperately trying to avoid any appearance of incompetence in front of senior staff were repeated themes. Perhaps it was these kinds of experiences that led participants to identify their social connections and developing relationships as one of the most

essential elements in their ability to settle in and for their ongoing job satisfaction.

Study participants highlighted *Making Connections* and *Navigating Relationships* as central to their success. This is also what creates the strong social element in the CoPs in these units. Of course, the drive to create these social connections goes beyond simply relational support; it is a means to access the experience and tacit knowledge of the community. "New nurses have difficulty with independent decision-making and autonomous practice in the first 3-6 months of practice and because of their focus on procedural and organizational skills, a preceptored relationship is beneficial" (Ferguson & Day, 2007, p. 112). Valdez (2008) also noted that the role of preceptors for NGNs transitioning into emergency practice was profound.

It was not just NGNs who reported novice-like anxiety and competency issues in this study; even nurses with previous experience reported feeling overwhelmed upon arrival in the specialized unit. Although the participants noted they did have an opportunity for some paired buddy shifts with more senior staff members, these were only provided for a few shifts, six at most, as noted in this research. The brevity of these paired opportunities was not the only issue; often participants reported that their senior buddies had only been in the unit several months to one year longer than they had been.

There is research support for the assertion that experienced nurses have a critical role to play in the transition of new nurses in their practice areas (Chernomas et al., 2010). "New nurses need to work closely with experienced nurses to hone their skills, develop clinical judgment and build their confidence" (Chernomas et al., 2010, p. 81). However, what happens when senior nurses are not willing to provide this support? Almost equal to the call in the literature for this kind of formal support for new nurses, is the caution that senior staff can become over burdened with mentor or preceptor roles and experience burn-out with these roles (Chernomas et al., 2010; Guhde, 2005).

Nurses entering into specialized practice do not relish their role as a drain upon the resources and support of existing RNs. It is a noteworthy moment for RNs in these settings to be able to provide competent help to a peer. New RNs will voluntarily substitute extremely hard work for what they perceive to be a lack of competence. Better than providing help, is the moment that a new RN can answer, instead of ask, a question. Be it for someone newer than themselves, or the often celebrated provision of an answer to a senior peer, these are notable markers in the progression of these nurses through their integration process. Although they may view themselves as a drain, there were several experienced nurses in this study who noted the valuable resources that new nurses could provide. These nurses said they welcomed the fresh approaches and new knowledge that these nurses brought, either from their nursing education programs or experiences elsewhere.

This acknowledgement of the potential for give and take in the learning relationships in specialized practice is another positive indicator for the further development and use of the CoPs in these units. Given the need for supportive structures for RNs arriving in these areas, and in the face of ongoing challenges in sustaining formal mentorship and preceptoring relationships, perhaps a new approach is needed. There is mounting evidence to suggest that recognizing and supporting the further development of strong CoPs may be an answer.

5.1.6 Teams, Communities, and CoPs in Nursing

Terminology usage difficulties are not new to the nursing discipline and this research has also highlighted some challenging nomenclature issues. The need to differentiate and specifically explicate the processes of *transition* and *integration* has already been presented. In light of the findings of this study, the researcher would argue that it would be a disservice for new RNs entering into specialized acute practice areas to have these terms used interchangeably. Doing so confounds issues of importance in these distinct processes, and increases the risk for the

assumption that one could be subsumed by the other. New RNs entering these practice areas will not have the luxury of attending to only one of these required journeys.

The second challenge lies in providing distinctions between the use of the terms *teams*, *communities*, and *CoPs* in nursing. The study participants often used these terms interchangeably an issue that is also apparent in the nursing literature, as well as other disciplines. Wenger recognized this nomenclature challenge in his early work and provided the following guidance, "a community of practice is not just an aggregate of people defined by some characteristic. The term is not a synonym for group, team or network" (Wenger, 1998, p. 74). If a CoP is going to be an identifiable intervention for supporting transition and RN professional development, it needs to be a distinguishable entity from other groupings commonly considered as part of nursing practice.

The word *team* has a long history in nursing practice. The application of team nursing in practice has been in use since the 1950s (Ferguson & Cioffi, 2011). The impetus for care provision done by teams was an opportunity to provide a better standard of care than could be delivered by practitioners working alone (Ferguson & Cioffi, 2011). Ferguson and Cioffi (2011) found that RNs often led these teams, directing the work of a variety other care providers. While historically these teams were comprised of a majority of members with at least some nursing education or training, there is now a greater diversity of staff in many acute care settings (Hand, Evans, Grainger, Lloyd Jones, & Peate, 2013). In this study, as has been noted, the majority of nursing staff on these units were RNs, due to the demanding and specialized care required. There was one unit that also employed special care aides (SCAs), and one that employed an official team nursing approach. Other than these exceptions, when participants spoke of team, they typically meant their RN team, or else the interprofessional team in their specialty area.

The value of effective teamwork was indicated in several discussions, but it is essential to

note, given the large staff numbers in these units, that these teams were transient. There were numerous combinations of RN team members that could present for any single 12-hour shift, in addition to fluctuating physician staff as well as other healthcare team members. Participants often reported that their routine when beginning a shift was to check and see what the team looked like for that day. Newcomers to the units also noted that a large number of RN staff made it difficult to get to know everyone, or to have consistent shifts with the same people. Of the three units, only one was still using a line scheduling format, meaning that for the most part, the same groups (lines) of RNs would rotate through a schedule. While this did make it easier for new RNs to get to know team members, it was also problematic for new hires who felt their line was not a good personality fit for them. The presence of colleagues on shift with whom participants felt they had strong social bonds also seemed to alter the perception of the team for that shift, in that these socially bound groups were more likely to work closely and collaboratively together. Sometimes, this collaboration may have been at the exclusion of others, although all participants did note the power of the team in working cohesively as one unit in the face of any urgent patient need or situation.

Several study participants stressed the importance of the interprofessional team in these units. The nature of specialized nursing work necessitates a close working relationship, not only with physicians, but other healthcare professionals as well, such as pharmacists, nutritionists, respiratory technicians, and others. Many of the participants in this study noted that without this interprofessional team, they would not be able to provide quality care to their patients. Strong working relationships were reported among team members. There were even reports from some units of social outings being expanded to include more representation from this interprofessional group. This was seen as a positive development for ongoing team relationships. Having a sense of belonging within the team context of any shift was important to study participants. RNs

reported a dread of feeling alone in these care environments. Teams, and more often teamwork, seemed to play a key role in specialized units.

Many participants were able to distinguish a difference between team and community. Often team was viewed as the smaller of the two entities, where community was how participants regarded the larger RN or complete staff group employed in the unit. For the researcher, it appeared that team was strongly associated with teamwork, so was bound by the moments or shifts upon which a participant reflected. Community was a more all-encompassing term that seemed to capture the entirety of the RN staff on the unit, as well as any other regular employees viewed as part of this grouping. When participants spoke of community, they often alluded to supports being accessible, or provided for life events faced by community members, such as births, serious illnesses, or deaths. Study members consistently reported a sense of community in their specialized care area, even if they could not define it further.

For this study, the researcher chose Wenger's (1998) definition of community as the reference point for distinguishing between groupings. As noted previously, community was defined in this study as "a way of talking about the social configurations in which our enterprises are defined as worth pursuing and our participation is recognizable as competence" (Wenger, 1998, p. 5). The words of Wenger seem fitting for these nursing communities so engaged in an unified enterprise, with newcomers even keenly aware that not just anyone will be permitted admission. Perhaps the drive to achieve competence in the setting is not just for the necessary benefit to the patients, but also for the RN as means of entry into the peer group of which they are seeking to be a part of.

Finally, there comes a need to distinguish between *community* and *CoP*. A CoP is "groups of people who share a concern, a set of problems, or passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis" (p. 4). Ideally, a CoP

will contain experts, novices, and a range of members whose expertise lies somewhere in between (Kerno, 2008). With this mix of experience in a CoP, all members stand to benefit from belonging in some way (Kerno, 2008). The novices have opportunity to access both the formal and informal knowledge that the group holds; the experts have the satisfaction of sharing that knowledge and perhaps learning something new themselves; and all have members an opportunity for belonging and ongoing growth and development.

Wenger (1998) has stated that a CoP "is a living context that can give newcomers access to competence and also invite a personal experience of engagement by which to incorporate that competence into an identity of participation" (p. 214). This seems to comprehensively express the experience of the study participants in what the researcher has deemed to be their own CoPs. Although the researcher had anticipated there would be differences between the parameters of a CoP as identified by Wenger, and what emerged from the study findings, the opposite outcome resulted. With further research, it is likely that not every minute aspect of Wenger's extensive CoP work would be deemed an exact match for the RN experience in specialized acute care nursing. Nonetheless, the key CoP elements and functions that Wenger (1998) established in his seminal work on the concept and his social theory of learning do capture the essential aspects of the CoPs revealed in these specific acute care specialized nursing units.

CoPs are diverse entities that can present in a multitude of variations. A CoP: may be comprised of a varying number of members; can exist over a few weeks or many years; have members who are co-located or distributed across differing geographic regions; be homogenous or heterogeneous; work inside or across organizational boundaries; form spontaneously or with intention; and can range anywhere from completely unrecognized with an organization to being institutionalized (Wenger, McDermott, & Snyder, 2002). This wide ranging diversity has left the concept open to considerable misuse, the result of which has been a substantial amount of

critique spanning its more than 20 year history.

5.1.7 CoP Critique

Since its introduction in the 1990s, the CoP concept has been enthusiastically embraced by a number of disciplines, perhaps most notably the business community (Li et al., 2009) but also increasingly in the education and health arenas (Ranmuthugala et al., 2010). As the concept has begun to be more widely employed, several criticisms of the theory have been brought forth as well. Even Wenger (2002) himself has noted potential negative CoP ramifications. Wenger (2002) has stated "communities of practice, like all human institutions, also have a downside. They can hoard knowledge, limit innovation, and hold others hostage to their expertise" (p. 139). Wenger (2002) went on to compare a flawed CoP to the exclusive and often indentured nature of medieval guilds. Essentially the author concluded, a CoP may only be as fair, just, and highly functioning as the larger community within which it exists. In this case Wenger has stated that a CoP can be part of an organizational problem; not the solution some would hope it to be. Further issues with power, bureaucracy, community complexity, and boundary conflicts are items that Wenger and others have debated with regards to CoPs.

For Contu and Willmott (2003), a primary issue with the CoP concept is not so much with Lave and Wenger's (1991) initial presentation, but in the ways that it has been selectively applied by others since then. Contu and Willmott (2003) argued that many researchers have failed to fully articulate the entrenched nature of a CoP within larger organizational constructs. It is imperative, the authors have stated, that "learning practices are understood to be enabled and constrained by their embeddedness in relations of power; and, more specifically, by the unstable institutionalization of power relations within capitalist work organizations" (Contu & Willmott, 2003, p. 283). While the authors acknowledged that Lave and Wenger examined the role of power in controlling access to CoP membership, they felt they did not explicate the full scope

and reach of this issue within the concept, nor did others who used the concept after its initial publication (Contu & Willmott, 2003). For Contu and Willmott (2003) the use of the CoP concept, and more specifically a social theory of learning, can only be fully realized "when studies of learning in organizations more fully appreciate and demonstrate how learning processes are inextricably implicated in the social reproduction of wider institutional structures" (p. 294). Roberts (2006) also addressed similar concerns and noted that any CoP "will reflect the wider social structures and institutions, or lack of them, evident in the broader context within which it is situated" (p. 632). Conceivably these considerations would guide future researchers to examine how CoPs could function as a vehicle for the propagation of views of a hierarchal status quo.

Roberts (2006) and Fox (2000) also addressed power issues related to the CoP concept; specifically those that could arise *within* a CoP. Roberts (2006) was concerned about the power of a CoP to essentially hold members at the periphery of a group, thereby creating general trust issues in the community that could ultimately impede its growth and development. The author further noted the potential of a CoP to stagnate, by discouraging members with views in opposition to the community from becoming a part of the group (Roberts, 2006). Fox (2000) noted this problem as well, and detailed the potential for power struggles and tensions to arise within a CoP as a result. Essentially, these critiques have revealed issues with the boundaries of a CoP. This kind of critique raises questions such as how members surmount these boundaries, or what happens to those at fringes of a CoP, especially if they seem unable to move further? Do those members held at the periphery of a group, and those with different or challenging ideas, eventually split off and form their own CoP? Or do the power issues in the CoP even permit this kind of deviation? If a new group is able to form, do the players in it become more open to accepting new members because of their experience, or do they seal off the boundaries of their

own group as well? These are questions that future CoP research should attempt to address.

A second critique from Contu and Willmott (2003) focused on the use of community in a CoP. The authors felt that community was applied in such a way that it implied coherence and consensus in such groups. This was a critique leveled not only at Lave and Wenger, but also, once again, at other researchers that employed the concept. For Contu and Willmott (2003), a community was not necessarily a place of consensus; rather its formation could be viewed as "a fractured, dynamic process of formation and reproduction in which there are often schisms and precarious alignments that are held together and papered over by unreflexive invocations of hegemonic notions including 'community', 'family', 'team', and 'partnership'" (p. 287). As Lave and Wenger applied the term, the authors felt they were "complicit in the reproduction and legitimation of this hegemonic process" (Contu & Willmott, 2003, p. 287). The authors have argued, that future researchers interested in this concept focus more on the practice, and less on the community, and do not forget the critical influence of the institutional structures in which any CoP is embedded.

The need for insight into the internal workings of a CoP has been echoed by Iverson and McPhee (2008). The authors called for further research to be done on the communication processes at work in a CoP, as they deemed these to be integral to understanding the relationships formed in these communities (Iverson & McPhee, 2008). Iverson and McPhee were adamant that researchers stop treating CoPs as black boxes, as if one was the same as another "without differences of processual intensity, mix, or enactment. While we may want to defend the conceptual integrity of the 'CoP', more careful theory-building may reveal significant differences in the ways knowing is enacted in different subtypes of CoP" (2008, p. 177).

A summary of much of this critique has been collected in the work of Murillo (2011). The author has further noted in his review of the CoP literature that the various interpretations and

adaptations of CoPs that have occurred in the last 20 years have included many works where the concept was misused, too casually applied, or where groups were erroneously labeled as a CoP altogether. Murillo (2011) viewed this as substantiation of not only the popularity of the CoP concept, but of its poor and unfocused application without needed continued conceptual development or challenge. Li et al. (2009a) also noted:

> different interpretations of CoP make it challenging for people to apply this concept or take full advantage of the benefits that CoP groups may have to offer. It is also difficult to objectively evaluate the effectiveness of these groups as there is no consensus on what is, or is not, a true CoP group. (Wenger, McDermott, and Snyder section, para. 6)

Some of this critique is addressed by the application of a constructivist grounded theory methodology, where the CoP concept was not a forced element, but rather emerged, and was thusly defined as a contextual element of other processes. The aspects of the CoPs present in the specialized acute care units used for this research arose from the experiences of the study participants and framed the resulting theoretical model.

As the CoP concept has grown in popularity and application, it has also become fodder for academic critique, a valuable process in itself. In examining the principles of the concept, and reflecting critically on how sound these may be, there is an opportunity to expand and refine the concept. The CoP concept has the potential for broad and diverse application; a positive aspect of this is that it may be useful in guiding the exploration of social learning in a variety of disciplines and situations. It is imperative that researchers planning to work with the CoP concept are meticulous in its application, or in the examination of how it has been applied. As with any conceptual exploration, a researcher cannot just include what fits and not attend to what remains. The concept as a whole must be understood and analyzed; and then, if necessary, modifications or alignments for the discipline to which the concept is being applied may be made. Ultimately,

researchers in any field must be able to articulate an opinion about whether or not the CoP concept is of benefit for their discipline.

5.1.8 Benefits of CoP in Specialized Acute Care Nursing Practice

In a recent call for the creation of a CoP in a critical care nursing setting, Lin and Ringdal (2013) noted that in spite of the critique the concept has faced, there was still benefit in pursing its application in healthcare. The authors felt CoPs could be used to develop clinical knowledge, challenge and reshape existent clinical practice, and improve knowledge translation (Lin & Ringdal, 2013). In a systematic review of how and why CoPs are created in healthcare, Ranmuthugala et al. (2011b) found that despite diversity in the terms and purpose of their creation, a commonality of CoP use was to facilitate learning, including knowledge exchange, and/or to improve practice. Li et al. (2009a) noted that key characteristics of a CoP included "support for formal and informal interaction between novices and experts, the emphasis on learning and sharing knowledge, and the investment to foster the sense of belonging among members" (Conclusion section, para. 2). The findings from this research have denoted a great need to support and encourage the proliferation of these very occurrences.

RNs do not graduate from basic undergraduate programs with the skill and knowledge they need to succeed in specialized practice. That learning must occur within the specialized communities. This is one of the strongest arguments to support the interpretation of RN groups in these units as CoPs. There is an intense learning need for all newcomers, and an almost equally strong yearning to be a part of something that even those that are new likely have a burgeoning passion for. In their study on NGNs and CoPs, Thrysoe et al. (2012) determined "that it is specifically mutual professional as well as social interaction with colleagues that strengthen experiences of being valued and accepted members of a CoP and makes the transition to becoming a nurse easier" (p. 554). Many participants in this study talked about their work

colleagues, especially those whom they felt they had a deeper social connection with, as *having their back*. A sense of belonging, of not having to face the demands of this kind of practice alone, was obviously meaningful for these participants.

Nursing is a demanding profession. Through membership in a positive CoP, RNs may take lessons learned from their experiences and evolve them, adding tacit group knowledge and other experiential expertise to potentially advance professional knowledge. There is much more to learn in terms of supporting the ongoing work of CoPs in specialized acute care nursing. However, a positive and well-functioning CoP is a potential avenue, not only for staff retention and successful transition and integration, but in moving nursing agendas forward in the best interest of patients and their care needs.

In their research on expert nurses, Carmel and Baker-McClearn (2012) also highlighted the social aspects involved in the development of expertise, and indicated the value of a CoP in support of said development. "Expertise is a social phenomenon, not only in that it requires to be socially acknowledged, but also that the manner of its use and its effects are themselves social" (Carmel & Baker-McClearn, 2012, p. 293). The authors further noted that this socially fueled expertise development was evidenced in the ways that the nurses developed CoPs (Carmel & Baker-McClearn, 2012). Thrysoe et al. (2012) noted that NGNs were more actively involved in daily work and the shared workplace dialogue "when there was a mutual interest in solving the challenges in the ward. This seemed to boost the way the NQNs [NGNs] regarded themselves as members of the CoP" (p. 553).

Dynamic and positive CoPs have a compelling potential to serve as nurturing systems of learning and competence development. When this potential is realized, it is understandable that nurses entering into particular practice areas would desire CoP membership, be they new graduates or experienced practitioners. RNs seem to have an instinctive recognition of the need to

establish strong social connections in their workplaces. Through these social connections, knowledge is exchanged between novice to expert, and those in between. CoPs may also provide an opportunity to have expert tacit knowledge remain in the community even after individual expert practitioners have retired or moved on. The systematic review by Ranmuthugala et al. (2011b) demonstrated that CoPs can contribute to "a diverse range of outcomes including, but not limited to, gaining competencies following completion of basic training; breaking down professional, geographical and organizational barriers; sharing information; reducing professional isolation; and facilitating the implementation of new processes and technology" (p. 14). There is value in pursuing the use and support of these groups in acute care nursing practice.

There are CoPs in acute care specialized nursing units. More research may provide greater insight into what differentiates a positive CoP from a negative, and the ramifications of the existence of the latter. Since CoPs are already present in acute care nursing practice, it is in the best interest, both of RNs and patients, to determine how best to support and maximize this potential. The findings of this research support an innovative examination of issues of RN retention by identifying not only transition and integration processes, but also how transition and integration are supported by active participation and membership in existing specialized CoPs. It is an opportunity to unite previous study on the practice entry experiences of NGNs, as well as providing further insight into how experienced nurses manage a change in specialty. The successful integration and retention of RNs from both these experiential groups could positively influence nursing turnover rates in specialized units.

The application of Wenger's (1998) social theory of learning and the CoP concept to these nursing areas has provided the ideal lens through which to further examine how successful socialization is tied to ongoing opportunities for learning and meaningful social connection. CoP research is intensifying in healthcare. Nursing should not disregard the potential of this concept

to address persistently challenging issues regarding RN transition and integration. There are indications from this growing body of CoP study "that CoPs, on their own or as part of larger interventions, may have a role in improving healthcare performance" (Ranmuthugala et al., 2011b, p. 14). Nursing researchers should acknowledge the opportunity to further positive advancement in the challenging arena of successful RN development, by expanding examination of CoPs. In addition to ongoing research, concrete interventions should be shared with RNs in areas of practice, administration, education, and research so that RNs and their patients can benefit from strengthened and supportive nursing CoPs.

5.2 Recommendations and Nursing Implications

The findings from this doctoral research support a range of recommendations and specific nursing implications for nursing administration, practice, education, and research. Many of the participants in this study were interested in being informed of the resultant findings and recommendations from this research. This interest from practicing nurses who have taken the time to participate in a research effort is an opportunity to develop closer relationships between academia and practice.

5.2.1 Administration

There has been research in recent years specifically examining the role, and perspective, of nurse managers in regards to NGN transition and integration in the workplace (Chernomas et al., 2010; Walker et al., 2013). When it comes to nursing work environments and day-to-day experience of nursing life on a unit, the nurse manager is a key factor. Nurse managers of specialized care units need appropriate support to effectively assist their new RN staff, be they graduate or experienced nurses. "The introduction of resources that take into account the learning needs of new nurses during the critical time of transition and integration into the workplace and profession hold promise to retain new nurses in the profession" (Chernomas et al., 2010, p. 83).

Although retention is a primary issue, especially given the costs associated with nursing turnover, it is the focus on the learning and competency development that should be considered of utmost importance. This research has highlighted the critical importance of achieving competence in a specialized RN role, as identified by specialized nurses.

In order to be able to achieve the competence that they seek, RNs must be successful in their transition and integration processes. There has been a great deal of time and research effort invested in how best to meet the persistent challenges associated with successfully integrating new RN staff. An increased focus on orientation programming has been suggested (Bowles & Candela, 2005; Young et al., 2008) either accompanied by, or in addition to more preceptored peer support (Ferguson & Day, 2007; Guhde, 2005; Rush et al., 2013). However, there are challenges with these solutions that have been presented in mentorship literature such as senior staff availability and cost. This research has highlighted the role of a unit's CoP in providing an essential context for the transition and integration of new RN members. In order for a CoP to be supported, and potentially strengthened, it first has to be identified and revealed to the appropriate parties. Although CoP use and research is expanding in healthcare the CoP concept still does not seem to be a familiar entity to many RNs.

It has been suggested that a CoP is not something that can be forced to come into existence, nor does simply labeling a group of people a CoP make it so (Li et al., 2009a; Ranmuthugala et al., 2011b; Wenger, 1998). There are steps that can be taken to support developing CoPs (Li et al., 2009a; Ranmuthugala et al., 2011b; Wenger et al., 2002). Nursing administrators must first realize that each CoP will be a unique collective. What might work as a support for one group may not be successful for another (Ranmuthugala et al., 2011b). For example, does the CoP in question prefer face-to-face interactions, technology connection options, or a combination of both? Li et al. (2009a) listed interventions they felt could positively support a CoP, such as

having an identified facilitator to promote group sessions with a specific focus on enhancing member interaction. The use of technological connection tools was also highlighted, as well as the importance of a CoP having some sort of organizational infrastructure, ideally around the uptake and distribution of new knowledge (Li et al., 2009a). The authors also noted that "the functions of these network/groups may be optimized by improving the understanding of the process of negotiating boundaries of emerging CoPs, and the roles and responsibilities of CoP members" (Li et al., 2009a, Conclusion section, para. 2).

Nursing administrators in a nurse manager role or in other positions, can play a role in promoting the use of CoPs in acute care nursing units, and supporting their ongoing success. By using the suggestions that have been shared, administrators can heighten awareness of the benefits of CoPs, and support RN staff in successful membership. The social connectivity, learning, and professional development opportunities in a well-functioning CoP are considerable. Nurse managers may want to begin simply by endorsing more informal social activities among RN staff. A breakfast club, or journal club that has an additional social element could be a good beginning. There is great value in RNs being able to connect with one another beyond the workplace. The findings of this study included the experiences of RN participants who for a variety of personal reasons had not initially pursued strong social connections in their new specialized environments. It was not long before these same nurses realized that making efforts to be socially connected was a necessary component of their long-term job satisfaction. Without exception, these participations felt much more settled and supported in their workplaces after strengthening their social networks. The role of social connectivity cannot be underemphasized. Not only is this an essential CoP component, these connections support the transition and integration of new RNs, but also aid in answering a deeply felt need for belonging and membership.

5.2.2 Practice

The process of transition is a reflective and personal journey. Even though the integration experience is more directly influenced by external forces, ultimately it is RNs who must have the resiliency and resources to successfully navigate both processes. Although this research is bound to the particular context setting in which it was constructed, these findings could potentially be utilized with other new RNs entering specialized practice. There is information here that could support the development of educational sessions on CoPs, how they are structured, the role they may have in a nursing unit, and the function of community members. RNs entering into specialized practice report that they do not want to feel alone. It may be of benefit for them to know that there is a CoP in the unit they are entering, including tips and suggestions on how to successfully navigate full membership in the same.

In the earliest CoP work, Lave and Wenger (1991) also included a discussion on legitimate peripheral participation. This concept summed the way that new arrivals interacted with their experienced colleagues, and identified a process "by which newcomers become part of a CoP. A person's intentions to learn are engaged, and the meaning of learning is configured through the process of becoming a full participant in a sociocultural practice" (Lave & Wenger, 1991, p. 29). The intimate connectivity of learning and social networks is a key element for practicing nurses to understand and utilize to maximize their personal benefits from CoP participation. As was highlighted in the recommendations for nursing administrators, the social component of a CoP is extremely meaningful. Thrysoe et al. (2012) stated "interaction with colleagues as experienced by NQN's [NGNs] has a significant influence on whether the NQNs participated more or less actively in the CoP" (p. 555). Study participants recalled several times the relative ease with which new RNs, whom they deemed to have superior social skills, were able to connect with peers. New RNs should seek opportunities to join with their peers in any social functions offered

by their units. They should take advantage of opportunities in the break room and elsewhere to create connections that are deeper than just having workplace acquaintances. Not only may this facilitate their CoP entry, positive relationships were often reported in this research as a support easing some of the strain and anxiety present during transition and integration.

If the CoP concept is not embraced and promoted by nursing administrators, there is still benefit to practicing RNs to recognize these entities and their roles in them. RNs could advocate for specific networked learning opportunities, as well as additional social connectivity events. A suggestion could be made to the nurse manager that a catered lunch be awarded as a prize for achieving a unit goal relating to hand-washing or chart audits for example. Not only could this support the development of mutual engagement, one of the key characteristics of a CoP, there is a strong social opportunity built into the celebration of the goal achievement.

5.2.3 Nursing Education

There is a role that nursing education could also play related to the findings of this study, and other research, in supporting NGNs in their impending transition and integration journeys. Though this research was not completed with nursing students, previous study has already called on nursing education faculty to be more active in portraying a realistic view of the upcoming professional transition through orientation opportunities in senior years of an education program (Duchscher & Cowin, 2004; Malouf & West, 2011). Introducing students to the CoP concept early in their education, including the role these groups may have in nursing practice, could be beneficial. There has been research done on nursing students interacting with CoPs upon entering into clinical environments (Thrysoe et al., 2010). Students who are informed about the structures and functions of a community of practice would benefit when trying to integrate into the same. Thrysoe et al. (2010) found:

students' courage to participate on their own initiative seemed to be affected by the nurses

> who they interacted with on an everyday basis. The way the students participate was particularly influential in how the students experienced a sense of belonging to the CoP. (p. 364)

An increased sense of belonging was mirrored in the student's motivation for learning (Thrysoe et al., 2010). As was found in the movement of NGNs into a CoP, social connections not merely founded on work commonalities were also for valuable for students in increasing CoP participation (Thrysoe et al., 2010). Nursing students should be equipped with the skills they need to successfully manage these social connectively challenges so that they are able to secure the learning advantages from CoP acceptance.

Allowing students longer practicum sessions in one specific unit, particularly if the student hopes to seek employment there, may also be a positive step nursing educators could support. A participant in this study had both a clinical rotation, and then a lengthy senior practicum in the specialized area she entered directly following graduation. This RN reported her successful preceptorship and previous time spent in the unit as a crucial factor in her rapid integration and social success on the unit. In their research on formal new graduate transition programs, Malouf and West (2011) recommended longer stays in particular units as well, to allow further opportunity for making key social connections.

Finally, the theoretical model from this research could be used by nursing education faculty to represent the processes of transition and integration to nursing students. There is no purpose in attempting to deny the stress and anxiety that will accompany these experiences. It would be of much greater benefit for students to see the phases present in each process, and to understand where they can be proactive in aiding their own transition and integration. The model is clear, and would enable educators to walk students through the processes with specific examples of what could be expected including the chief tasks of each phase.

5.2.4 Research

The recruitment and retention of RNs is still an international concern (Chernomas et al., 2010; De Gieter et al., 2011; Rush et al., 2013). In a recent publication, Rush et al. (2013) noted that the CNA has estimated that Canada could experience an estimated shortage of 60,000 RNs by 2022. Although the nursing shortage issue was seemingly cooled by the global financial crisis, the imminent retirement of the baby boomer generation cannot be ignored. There are also more options than ever for young professionals, both in and out of nursing. Given this, nursing will have to continue to work on its professional drawing power, and secure a reputation for the creation of dynamic learning and professional development opportunities for bright and dedicated young professionals. More research on the role of CoPs as a key context for the processes of transition and integration would be an excellent place to begin.

CoP research in healthcare is only now gaining momentum (Ranmuthugala et al., 2011b). With initial results indicating that CoPs may play a role in improving healthcare performance (Ranmuthugala et al., 2011b), this is an ideal time to deepen nursing research into this concept. There is much more to learn about CoPs in acute care nursing and beyond. Could these same groups be useful in integrating other nursing professionals, for example new faculty members? What are the ramifications of a negative CoP in nursing practice, and how might this influence transition and integration of members? What occurs if there is more than one CoP within a single nursing unit? How can nursing CoPs be supported and encouraged to maximizing their learning and professional development potential? With the knowledge that these groups are unique, it is worth further exploration to determine what specific supports might be useful to CoPs in acute care nursing practice as well as other practice areas.

Finally, with the looming retirement of many senior nurses, it might also be worth exploring how their tacit knowledge can be retained within their CoP. Is it possible for a CoP to

act as a reservoir for the years of experiential knowledge of the record number of RNs on the verge of retirement? From the most senior to the most junior, further research on allowing nursing students full access to nursing CoPs during their clinical learning would also be beneficial, building on the previous work of Thrysoe et al. (2010). The findings of this research could also potentially be applied to the student experience.

5.2.5 Knowledge Dissemination

The topic of knowledge translation (KT) has been well researched in nursing literature. Interestingly, among the social theories that have been considered for use in KT is CoPs (Estabrooks et al., 2006). "The formation of community is thought to be essential for both the production and the transfer of knowledge" (Estabrooks et al., 2006, p. 32). More recently Perrott (2013) also completed research on CoPs and knowledge transmission in health care. The author determined that, in fact, "communities of practice can play a key role in facilitating the flow of knowledge within organizations" (Perrott, 2013, p. 330). The findings of this study contribute to the substantive knowledge of the nursing discipline as well as potentially providing a possible means for disseminating these findings, through specialized nursing CoPs.

The participants in this research will be provided with a summarized version of the study findings, as well as being notified of any subsequent publication that may result from this dissertation. An offer will be made to the nurse managers of each unit involved in the study to hold a short informational session on CoPs and their potential benefits for nursing practice. Publication of these study findings will be pursued in journals with an established readership of practicing RNs. In addition, information can be provided to the provincial professional nursing organization (SRNA) and nursing union (SUN) on the study findings and next steps for practicing nurses. Abstracts will be submitted to at least three relevant national or international nursing conferences, one of which will have a focus on RNs engaged in bedside practice. Finally,

as a nursing faculty member, the researcher will have a unique opportunity to share these findings with her students, providing them with the key knowledge needed to support their own successful transition and integration experiences.

5.3 Factors Influencing the Study

Any research effort, especially those under the direction of novice researchers, provides opportunity not only for the discovery of new knowledge, but for learning and reflection on what might be done differently for the next study. In this doctoral work, the researcher has considered the following factors as having potential influence of the study: methodology, sampling and the resultant sample, and the study context, including geographic consideration. The use of a constructivist grounded theory methodology with a strong interpretive element means that others may have alternate interpretations of these findings and processes.

This grounded theory was carefully and deliberately situated within the specific specialized acute care nursing practice context in which the knowledge was shared. Generalities from grounded theory research must be pursued in further analytic reflection or additional study. It was of great interest to the researcher to discover the work of Thrysoe et al. (2012) who also examined the experience of new nurses, and the role of CoPs in their integration. It was not so much the specific findings that these Denmark researchers had discovered that were especially intriguing; it was the words of their participants that echoed the sentiments shared by RNs in this study. These research participants were thousands of miles and a world of healthcare organizational differences apart and yet some profound similarities emerged in their experiences. This finding alone encourages the pursuit of further study to move the theoretical findings of this research towards a more formal theory.

There were some sampling challenges in this study. The researcher conducted the study at the same institution at which she was still employed as a casual RN. Although the unit in which

the researcher is employed was not used, this is still a particular factor of influence in the study. The recruitment of participants for this study began in February 2012, and initial responses were slow. An amendment was made through the University of Saskatchewan Behavioural Research Ethics Board in April 2012 for the use of a study recruitment poster, as well as the use of further recruiting approaches. These approaches are a potential factor of influence in this study, as is the fact that sampling and participant interviewing was not concluded until September 2013. Although the length of time to recruit study participants and complete the data collection was much longer than the researcher anticipated, it did create an opportunity to follow up with some participants almost a year after their initial interviews. This allowed these participants to share some valuable reflection on their complete transition and integration experiences. Another consequence of the long data collection timeline was that two study participants who had agreed to submit entries misplaced their study journals.

The sample itself was a mix of new and experienced nurses, both male and female, although it seemed to the researcher that the NGN view was strongly represented. Although the majority of the study participants were female the overall sample was a good representation of the professional culture in these settings. All participation in the study was voluntary, and this may have been a factor in the data in terms of the views shared. Each of the participants was willing to take time to engage in a research process, and there may have been some similarity among them that was a factor in facilitating their participation. For the most part, each participant indicated a positive view of their employment in their identified practice area. Although participants spoke of RNs being isolated from their unit communities, they did not identify these RNs to the researcher nor did any of these nurses volunteer to be a part of the study. The researcher made some attempts to learn more about these RNs, but could not pursue them beyond the ethical boundaries in place for participant recruitment.

Finally, this study was conducted with three specialized acute care nursing units at an urban teaching hospital with approximately 300 beds. The study reflects the views of RN participants practicing within these specific settings, as well as in a Western Canadian geographical context.

5.4 Researcher Reflections

At a first glance, grounded theory seems an ideal choice for a novice researcher. The methodology has been reported to be extremely popular and extensively used across many disciplines. Conducting grounded theory research however, requires a veritable 'leap of faith'. I was not very far into this process when I realized that my characteristics as a researcher were very similar to my characteristics in other aspects of my life. I prefer plans, schedules, and certainties. Grounded theory methodology may offer many benefits to novice researchers, but certainties are not one.

My purpose in this research was to discover more about CoPs in acute care nursing; but at first what I found was how transition and integration processes worked for RNs. Where was the CoP data, I coded and interviewed and coded again, and still I could not see it. There was a prolonged period of time where I imagined I would have to go to my supervisor and try to explain how my CoP research had not produced any relevant CoP data. Perhaps this moment of data induced panic is commonplace in grounded theory research, and even if it is not, I share my own experience to encourage other novices not to give in to that anxiety. Instead of trying to force information on CoPs to emerge, I stubbornly pursued the direction my study participants were moving the data to. I engaged in the substantial use of memos in my analysis and I let my fears out there in the form of more questions about what was emerging, asking again and again, what were the participants telling me? Then one day, in one light-bulb moment, it emerged, the social context of the findings was a CoP. I would not be honest if I did not admit a great sense of relief in that moment, but there was also a bit of a sense of wonder at how effectively the research

process had worked. That moment taught me how critical it is to let the data speak, and to not force preconceived ideas upon its movement in a research process. A lesson I feel will serve me well as a further my program of research.

Even after elements of a CoP emerged in the data, I was extremely surprised about how closely these aligned with Wenger's work when I returned to the literature in my final writing. I found the entire process quite exhilarating; to have the words of the study participants serve as the foundation for a theoretical model and to create a meaningful abstraction of their experiences that still resonated with them. These outcomes have cemented my belief in the power of qualitative research to deliver results that are compelling representations of real-life experiences.

5.5 Conclusion

The purpose of this constructivist grounded theory study was to explore nursing specific processes associated with CoPs in specialized acute care settings with a focus on their potential role in RN integration and professional development. In working to meet this purpose, I hoped that the research would provide insight into the social processes integral to the integration of nurses into their chosen specialized acute care settings, and the role of CoPs in this journey. Additionally, I wanted to contribute to the development of a substantive CoP theory for specialized acute-care nursing practice. In the end, I felt my study findings were a genuine glimpse behind the curtain of life in specialized nursing practice, for all who have never experienced it from the RN perspective. The passion these RNs had for their specialized areas, and the deep sense of duty and commitment to their patients that they shared, was an honour to convey in my research findings. I am certain that their words and experiences will stay with me for the entirety of my research career.

Nursing will face ongoing professional development challenges as we work to evolve our discipline. In nursing practice, human resource issues are likely to be paramount. Potential RN

shortages combined with increasing complexity of care in acute practice settings will require improved methods to manage the integration and retention of RN nurses into specialized units. The findings of this research provided insight into the transition and integration processes that RNs experience when entering acute care specialized practice.

The CoP emerged as the key context present in these nursing units in which these processes proceeded. There may be potential in nursing communities that could be realized by encouraging the further development of positive CoPs, especially in acute care specialized practice. The needs of patients in these areas are extensive and although the RNs providing their care are deeply committed to this duty they are also at risk for becoming overwhelmed and disillusioned regarding their abilities to do so. Knowing more about how communities of nurses can come together to support one another in successfully meeting the demands of their practice areas can strengthen current retention and workplace efforts.

This research has added new knowledge to the discipline of nursing, in further delineating fundamental differences in transition and integration. It has also reinforced a newly emerging idea of examining CoPs to further explicate their potential in supporting the transition and integration of RNs. Much of the previous research in this area has been focused only on graduate nurses. This research extends *transition* and *integration* to encompass the experience of nurses, who are not new graduates, but are starting again in new specialized roles. As such, this work affords an expanded view of the importance of support for all RNs entering into specialized practice areas regardless of previous experience. This consideration may also help broaden current thinking on the retention of RNs in these demanding areas.

The theoretical model representing the findings of this research can serve as a useful tool for individuals hoping to gain a better understanding of the transition and integration experience of RNs into specialized practice. With this knowledge, and the practical recommendations that

have been made, nurse administrators, educators, and researchers can collectively pursue an improved experience for specialized RNs. This could not only result in the increased retention and recruitment of these specialists, but improved support for the efficient development of needed specialty skills. Nursing students and practicing nurses could also use these findings, brought forth from the stories and experiences of their own peers, to be more empowered in the management of their transition and integration experiences. The RN participants in this research revealed the importance of community and connection in their specialized practice settings. It is my hope this research can provide any RN, in search of these same connections, some guidance and support as they pursue meaningful membership in their own CoPs.

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Appendix A

Table 2.1 Nursing Specific Community of Practice Research Studies (n=20)

	Source, (Year), Country of Origin	**Purpose and/or Research Questions (RQs)**	**Sample**	**Design**	**Variables or Instrument**	**Findings**
1	Anderson, J. K. (2009) USA	To examine work-role transitions of clinicians to new educator roles. No specifically stated RQs.	n=18 (Nurse Practitioners or Clinical Nurse Specialists in first or second year of teaching full-time)	Descriptive explanatory study	Semi-structured interviews	Metaphor of a mermaid swimming in a "sea of academia" with six patterns emerging. Transition defined as human experience associated when entering a new CoP.
2	Booth, J., Tolson, D., Hotchkiss, R., & Schofield, I. (2007) UK	To use action research in the construction of a national evidence-based nursing care guidance for gerontological nursing. No specifically stated RQs. Objective was to develop and evaluate the Best Practice Statement.	n=30 (Scotland nurses involved in the care of older people formed a community of practice)	Best Practice Statement Construction Methodology (was this phase of the longitudinal action research plan)	CoP Interviews (telephone, focus group) Text analysis from online activity	The CoP members reported the emerging methodology to allowed nurses to create valuable evidence-based best practice statements.

3	Boyd, P., & Lawley, L. (2009) USA	To investigate the experiences of nurses who have recently begun to work as lecturers in higher education. <u>RQ:</u> "How do new lecturers experience their transition as they move from clinical practice roles as nurses to become lecturers in nursing in higher education."	n=9 (new lecturers in nursing)	Modified grounded theory (created a coding framework based on research question)	Semi-structured interviews	Overlapping communities of practice are noted in setting and participants note having to emphasize different elements of themselves for each.
4	Burgess, J., & Sawchenko, L. (2011) Canada	To examine the post-legislation role development for Nurse Practitioners in British Columbia. No specifically stated RQs.	n=11 (Nurse Practitioners)	Participatory action research	Inquiry sessions at monthly CoP meetings (6) Action inquiry sessions (2)	The CoP addressed internal needs of members and external concerns of the organization, contributing to healthcare improvement overall.

5	Cope, P., Cuthbertson, P., & Stoddart, B. (2000) UK	To examine situated learning in practice placements. No specifically stated RQs.	n=30 (nursing students)	Thematic analysis of emerging categories	Interviews	Acceptance into the CoP separated, conceptually, into social acceptance which could be extended to all and professional acceptance which requires displayed competence.
6	Creighton, G., & Oliffe, J. L. (2010) Canada	To examine masculinity in men's health research as a guide for future theorizing re: social constructions of masculinity. No specifically stated RQs.	n=40 (young men who had a friend die within the last three years)	Ethnography Application of a Community of Practice framework	Semi-structured interviews Photo elicitation as a form of participant observation	Application of the community of practice framework to men's health. Found the CoP framework to be a valuable analytic tool for understanding problems and leveraging solutions for men's health issues.
7	Garrow, A., & Tawse, S. (2009) UK	To explore how new academics are introduced to the assessment process in higher education.	n=6 (new nursing academic staff)	Phenomeno-logy	Semi-structured interviews	Highlighted issues with support and guidance for new academics as well as the way experienced academics communicate

		No specifically stated RQs.				with new faculty.
8	Giddens, J., Foff, L., & Carlson-Sabelli, L. (2010) USA	To examine the student perceived benefits and utility of virtual communities. **RQs:** 1. Is there a relationship between the frequency of virtual community use and perceived benefits among students? 2. Is there a difference in utility of the virtual community for learning between white/Asian and URM students?	n=350 (BSN nursing students) Power analysis showed medium effect size, with a power of .99 (significance set at .05), confirming that this was an adequate sample size for data analysis.	Quantitative (nonexperi-mental approach involving surveys, with a descriptive and comparative approach for data analysis) **Survey Tool:** A 19 item exit survey tool was developed from the Current Student Inventory (CSI). "Because the CSI is a test bank, true validity and reliability of individual items are not available."	Surveys **Results:** Q1: "The relationship between program use and perceived benefits was substantial. A correlation analysis between the two revealed a positive relationship (r =.416 (318), p = .001), which is slightly larger than Cohen's medium effect size." Q2: "A t-test comparing utility between the 2 groups revealed a greater perceived benefit among white/Asian students compared with URM students (t = .219, df = 330, p = .03)."	Frequency of virtual community use appeared to be linked to positive learner benefits and engagement. Benefit and utility related to use was also found to be of note for many groups of students.

9	Grealish, L., & Ranse, K. (2009) Australia	To explore how nursing students learn in clinical placements with a focus on social learning. Question for requested participant narrative: "Describe a clinical event that has happened for you, where you believe that you learned about being a nurse or nursing as a professional practice."	n=49 (first year nursing students)	Narrative Inquiry (with development of thematic statements)	Student Clinical Narratives	Three thematic constructs emerged: 1) participation or observation of nursing tasks leads students into a complex reading of nursing work, 2) being emotionally confronted by work is a high challenge situation, 3) encounters with different nurses help students construct images of what they want to be as nurses.
10	Grealish, L., Bail, K., & Ranse, K. (2010) Australia	To explore the implementation of a CoP model of clinical teaching in four residential aged care facilities. No specifically stated RQs.	n=24 (staff from care facilities, nurses and others)	Qualitative thematic analysis (constructivist ontology)	Focus groups (4)	The CoP model was found to have benefits for staff and students and was considered a potential vehicle to help address issues of recruitment and retention in this area.

11	Griffiths. P (2010) UK	To explore the nurses' role on a medical assessment unit. No specifically stated RQs.	n=19 (nurses and others on a medical assessment unit)	Ethnography	Semi-structured interviews Participant observation	The CoP concept helps the exploration of the interplay of the goals of practice and the attendant social relationships developed in nursing teams.
12	Kelly, T. B., Tolson, D., Schofield, I., & Booth, J. (2005) UK	To develop a practitioner-led description of gerontological nursing and the key principles of this practice. No specifically stated RQs.	n=30 (nurses working together in a CoP)	Participatory Action Research Content analysis	CoP Interviews Records of on-line discussions	Gerontolo-gical practice requires an accessible consensus view and description to support develop-ment.
13	Murphy, F., Timmins, F. (2009) UK	To explore current professional teaching practice in nursing. Question used to initiate the Understand-Action-Evaluate Cycle: "How can I improve my teaching methods?"	n=1 (novice nurse educator)	Reflexive Action Research	Reflective Journal (researcher) Informal discussions with nursing students and colleagues	Insight was gained within the community of practice regarding teaching methods.

14	Roberts, D. (2009) UK	To explore the importance of friendships for student nurses in clinical practice. <u>RQs (AIMS):</u> 1. Do nursing students learn from each other and if so when and where does this take place? 2. What processes are used by students while engaging in peer learning?	n=15 (nursing students)	Ethnography	Participant observation Ethnographic interviews	Student nurses exist on the edge of the practicing nurses' CoP and so form their own parallel community. Friendships are used to enable learning.

15	Smedley, A., & Morey, P. (2009) Austraila	To explore ways to improve teaching and learning in the clinical environment. No specifically stated RQs.	n=65 (nursing students) No discussion of power related to sample size.	Quantitative (cross-sectional survey design) **Survey Tool:** Use of the CLEI questionnaire (previously created to measure three basic dimensions of human environ-ments). "The preferred clinical experience CLEI scores for all scales were significantly ($P < 0.05$) greater than the equivalent actual clinical experience scores but still displayed a similar profile to that of the actual clinical experience scores."	Survey (given twice 84.6% and 58.4% response rates respectively) Once immediately following clinical placement and once a few weeks later to allow for reflection on the clinical experience and consideration of what the ideal clinical would be.	Student satisfaction is increased when they feel they are an integral part of the CoP in their clinical nursing placement. **Results:** "The mean value of each of the CLEI scales for the students' actual clinical experience was relatively high, yet still below their preferred values on the respective scales." "The clinical environment factors captured from the CLEI questionnaire accounted for only 51% of the variance in student satisfaction with their actual clinical experience."

16	Thrysoe, L., Hounsgaard, L., Bonderup-Dohn, N., & Wagner, L. (2010) Denmark	To examine the experience of nursing students in their final clinical placement as they participate in nursing communities of practice. No specifically stated RQs.	n=10 (nursing students in final clinical practice)	Phenomenal hermeneutic interpretation methodology	Semi-structured interviews Participant observation	Student participation in the clinical CoP is strengthened by students and nursing showing interest in getting to know each other professional and socially and by students having an opportunity to contribute their knowledge.
17	Tolson, D., Schofield, I., Booth, J., Kelly, T. B., & James, L. (2006) UK	To collaborate with practitioners and older people to develop approaches to promote the attainment of evidence-based nursing care. No specifically stated RQs.	n=30 (initial nursing CoP) n=30 (second group of nurses) n=15 (third group of nurses n=21 (older person-carer community)	Participatory Action Research	CoP Interviews Records of on-line discussions	Membership in the CoP strengthened commitment to the process of reflection during the research. Collectively the CoP could see possibilities and solutions to problems that could have been overwhelming for any one individual.

18	Tolson, D., Booth, J., & Lowndes, A. (2008) UK	To determine the impact of the Caledonian Development Model, designed to promote evidenced-based practice. **RQs(AIMS):** 1. Obtaining objective evidence of impact at the ward/unit level and with individual patients. 2. How did the intervention influence nurses views about their work and to estimate cost.	n=24 (nurses, who formed three communities of practice) No discussion of power related to sample size.	Pre-Post Intervention Design "The intervention was version 2 of the Caledonian Development Model, which focused on implementa-tion of an existing Best Practice Statement, chosen from a selection of five published statements. Each of the three CoPs selected one statement to become the focus of their development al activities." **Survey Tool:** Revised Nursing Working Index was used as a survey tool (no discussion of reliability or validity of same).	CoP Facility audits Older person audits Focus groups **Results:** Analysis of the pre- and post-paired data (n = 14) using a paired samples t-test, with alpha at 5% level ($P < 0.05$) = no statistically significant difference in the two measurement points for full scale scores. Analysis of the four sub-scales revealed statistically significant differences for greater autonomy ($P = 0.019$) and increased organizational support ($P = 0.037$) in the nursing roles after the implementa-tion of the model.	The Caledonian Development Model encapsulates a vision for evidence-based nursing which is negotiated through the CoP. Facilitation through the CoP appeared to be instrumental in promoting the implementa-tion of the care guidance.

19	Uys, L. R., & Middleton, L. (2011) South Africa	To explore the internationalizing of university schools of nursing in South Africa through a CoP. **RQs:** 1. What do the members of the participating universities view as the meaning of the work they have done? 2 .How do the members of the participating universities define the practice they are engaged in, and how do they view the knowledge they have developed?	n=13 (nurse academics) **RQs (cont.):** 3. What is the role of the members of the participating universities in terms of creating a culture of 'community' within the collaborative relationship between the universities? 4 Does the project change the way the members of the participating universities members view themselves, that is within a global context?	Case Study	CoP Interviews Surveys Focus Group	The model of forming a CoP across universities seems to be a viable one for internationalizing nursing education within African universities and in revitalizing these institutions.

20	Valaitis, R. K., Akhtar-Danesh, N., Brooks, F., Binks, S., & Semogas, D. (2011) Canada	To explore the views of community health nurses regarding an on-line CoP to support their practice with homeless or under-housed populations. No specifically stated RQs.	n=16 (community health nurses)	Q-methodology (combined quantitative and qualitative approach)	Survey Focus Groups Q-sort concourse	Online communities of practice can be valuable to nurses in specialized fields with limited peer support and access to information resources. Tacit knowledge development is key for nurses working with homeless populations.

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Appendix B

Ethical Approval University of Saskatchewan

UNIVERSITY OF SASKATCHEWAN

Behavioural Research Ethics Board (Beh-REB)

Certificate of Approval

INTERNALLY FUNDED

TITLE
Communities of Practice in Nursing: A Grounded Theory Exploration

ORIGINAL REVIEW DATE	APPROVAL ON	APPROVAL OF:	EXPIRY DATE
23-Dec-2011	09-Feb-2012	Ethics Application Consent Protocol	08-Feb-2013

Full Board Meeting ☐ Date of Full Board Meeting:

Delegated Review ☒

CERTIFICATION
The University of Saskatchewan Behavioural Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol or consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

ONGOING REVIEW REQUIREMENTS
In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month of the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for further instructions: *http://www.usask.ca/research/ethics_review/*

Please send all correspondence to:

Research Ethics Office
University of Saskatchewan
Box 5000 RPO University, 1602-110 Gymnasium Place
Saskatoon SK S7N 4J8
Telephone: (306) 966-2975 Fax: (306) 966-2069

UNIVERSITY OF SASKATCHEWAN

Behavioural Research Ethics Board (Beh-REB)

Certificate of Approval Study Amendment

PRINCIPAL INVESTIGATOR DEPARTMENT

TITLE
Communities of Practice in Nursing: A Grounded Theory Exploration

APPROVAL OF	APPROVED ON	CURRENT EXPIRY DATE
Amendment to Recruitment Recruitment Poster	18-Apr-2012	08-Feb-2013

Full Board Meeting ☐

Delegated Review ☒

CERTIFICATION

The University of Saskatchewan Behavioural Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol or consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

ONGOING REVIEW REQUIREMENTS

In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month of the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for further instructions: *http://www.usask.ca/research/ethics_review/*

Please send all correspondence to:

Research Ethics Office
University of Saskatchewan
Box 5000 RPO University, 1602-110 Gymnasium Place
Saskatoon SK S7N 4J8
Telephone: (306) 966-2975 Fax: (306) 966-2069

UNIVERSITY OF SASKATCHEWAN

Behavioural Research Ethics Board (Beh-REB)

Certificate of Re-Approval

PRINCIPAL INVESTIGATOR DEPARTMENT

INTERNALLY FUNDED

TITLE:

Communities of Practice in Nursing: A Grounded Theory Exploration

RE-APPROVED ON	EXPIRY DATE
27-Mar-2014	26-Mar-2015

Full Board Meeting

Delegated Review ✔

CERTIFICATION

The University of Saskatchewan Behavioural Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol or consent process or documents.

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Please send all correspondence to

Research Ethics Office
University of Saskatchewan
Box 5000 RPO University, 1607 - 110 Gymnasium Place
Saskatoon, SK S7N 4J8
Phone (306) 966-2975 Fax (306) 966-2069

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Appendix C

Operational Approval from Saskatoon Health Region

Saskatoon Health Region is pleased to provide you with operational approval of the above-mentioned research project.

Kindly inform us when the data collection phase of the research project is completed. We would also appreciate receiving a copy of any publications related to this research. As well, any publications or presentations that result from this research should include a statement acknowledging the assistance of Saskatoon Health Region.

Catalyzing Health Research and Innovation Together

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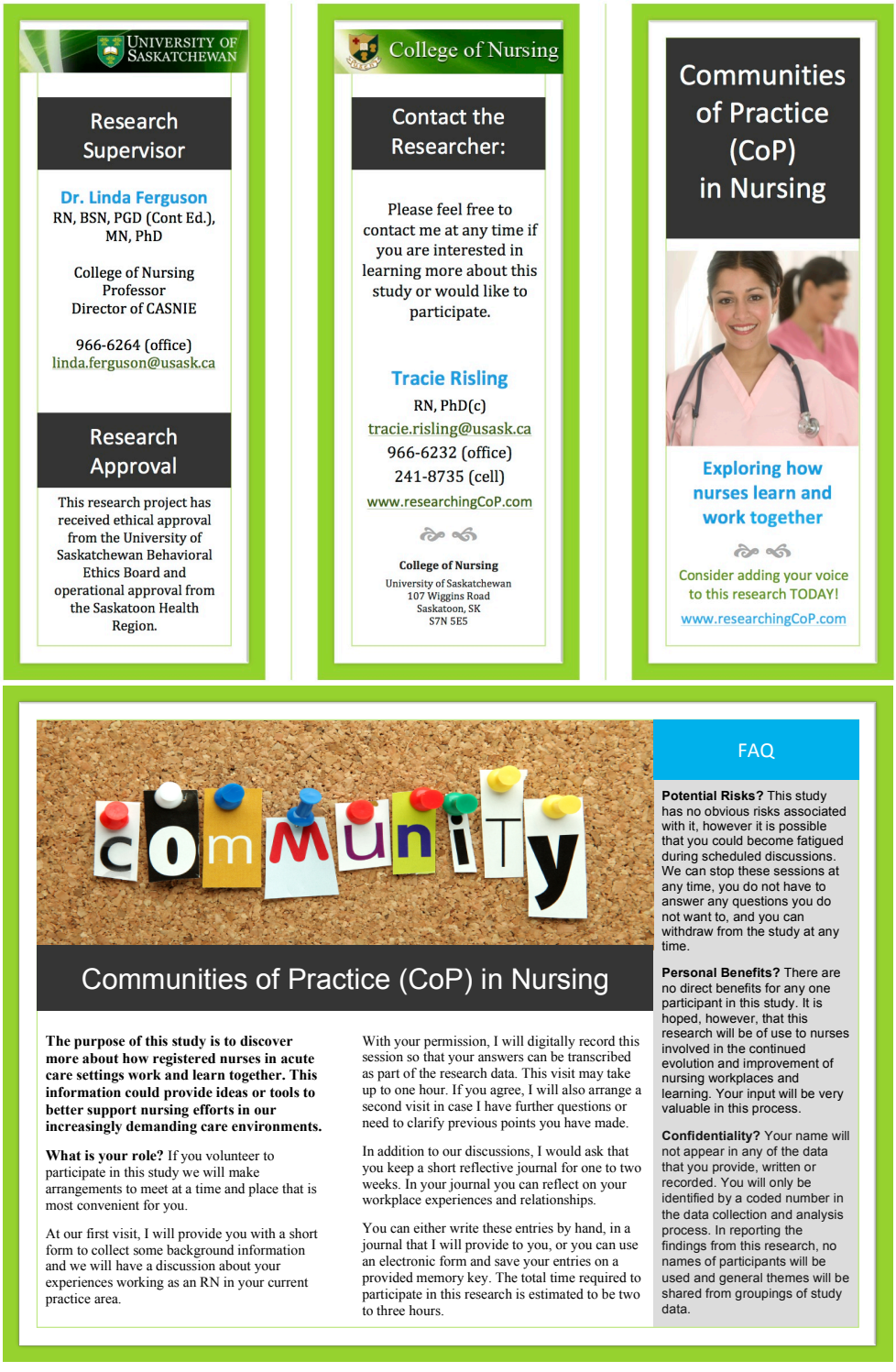
Appendix D

Research Pamphlet



UNIVERSITY OF SASKATCHEWAN

Research Supervisor

Dr. Linda Ferguson
RN, BSN, PGD (Cont Ed.), MN, PhD

College of Nursing
Professor
Director of CASNIE

966-6264 (office)
linda.ferguson@usask.ca

Research Approval

This research project has received ethical approval from the University of Saskatchewan Behavioral Ethics Board and operational approval from the Saskatoon Health Region.

College of Nursing

Contact the Researcher:

Please feel free to contact me at any time if you are interested in learning more about this study or would like to participate.

Tracie Risling
RN, PhD(c)
tracie.risling@usask.ca
966-6232 (office)
241-8735 (cell)
www.researchingCoP.com

College of Nursing
University of Saskatchewan
107 Wiggins Road
Saskatoon, SK
S7N 5E5

Communities of Practice (CoP) in Nursing

Exploring how nurses learn and work together

Consider adding your voice to this research TODAY!
www.researchingCoP.com

Communities of Practice (CoP) in Nursing

The purpose of this study is to discover more about how registered nurses in acute care settings work and learn together. This information could provide ideas or tools to better support nursing efforts in our increasingly demanding care environments.

What is your role? If you volunteer to participate in this study we will make arrangements to meet at a time and place that is most convenient for you.

At our first visit, I will provide you with a short form to collect some background information and we will have a discussion about your experiences working as an RN in your current practice area.

With your permission, I will digitally record this session so that your answers can be transcribed as part of the research data. This visit may take up to one hour. If you agree, I will also arrange a second visit in case I have further questions or need to clarify previous points you have made.

In addition to our discussions, I would ask that you keep a short reflective journal for one to two weeks. In your journal you can reflect on your workplace experiences and relationships.

You can either write these entries by hand, in a journal that I will provide to you, or you can use an electronic form and save your entries on a provided memory key. The total time required to participate in this research is estimated to be two to three hours.

FAQ

Potential Risks? This study has no obvious risks associated with it, however it is possible that you could become fatigued during scheduled discussions. We can stop these sessions at any time, you do not have to answer any questions you do not want to, and you can withdraw from the study at any time.

Personal Benefits? There are no direct benefits for any one participant in this study. It is hoped, however, that this research will be of use to nurses involved in the continued evolution and improvement of nursing workplaces and learning. Your input will be very valuable in this process.

Confidentiality? Your name will not appear in any of the data that you provide, written or recorded. You will only be identified by a coded number in the data collection and analysis process. In reporting the findings from this research, no names of participants will be used and general themes will be shared from groupings of study data.

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Appendix E

Research Poster

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Appendix F

Demographic Form

Date: _____ Employer: _____

2) Primary Department of Employment: _____

3) How many years have you worked in the area noted above: _____
(note months for incomplete years – e.g. 6 years 4 months)

4) Average hours worked on identified ward per week: _____

5) How many years have you been licensed to practice as an RN: _____
(note months for incomplete years)

6) Educational Background (please check all that apply):

Diploma in Nursing _____
Bachelor's Degree in Nursing _____
Master's Degree in Nursing _____
Doctoral Degree in Nursing _____
Bachelor's Degree in another field _____
Master's Degree in another field _____
Doctoral Degree in another field _____
Advanced Nurse Specialist _____
Licensed Nurse Practitioner _____
Other Certification () _____
(please specify) _____

7) Age: _____ 8) Gender: M _____ F _____

9) Ethnicity (please specify): _____

10) Marital Status:

Single _____ Married _____ Common-Law _____ Divorced _____Widowed _____

For Researcher Use:

Code Number: _____

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Appendix G

Interview Guide

Opening Questions:

Tell me about your workplace?

How do you feel people relate to one another in your workplace?

How is the overall communication in your workplace?

What kind of communication tools are used in your workplace?

Do you feel engaged in your workplace?

Additional Questions:

How do you feel you acquire knowledge in your workplace?

How is work distributed in your workplace?

What is it like when things are very busy in your workplace?

What do you recall about your experience of first arriving in your workplace?

What do you think the experience is like for new staff arriving in your workplace now?

Do you feel a sense of community in your workplace?

Closing Questions:

Is there anything you would like to tell me that we have not talked about?

Is there anything you would like to ask me?

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Appendix H

Reflective Journaling Guide

Guidelines for Reflective Journaling

In order to provide you with further opportunity to reflect on what is discussed during the interview process, I hope you will engage in a reflective journaling process for the next two weeks.

You can choose to complete this reflection electronically and save your entries on a provided memory key, or in a paper journal that will also be provided to you should you choose that option.

If you have a daily time that works for you to spend a few minutes engaged in this reflection that would be ideal, but any amount that you feel comfortable completing will add important data to this research. It might work best to complete your journaling after having recently worked a shift.

Possible Workplace Reflections

What stands out from your experience in your workplace today?

What, if anything, was challenging today in your workplace?

What was a positive or negative moment today in your workplace?

Can you recall a moment of teamwork or collaboration in your workplace today?

Did you learn anything new in your workplace today? If so, how?

Remember

The format of your journal entries is not restricted, you may note your thoughts in any way that works for you, including point form, and please do not worry about grammar or spelling. At the end of the two weeks, I will collect your journal to add to the research data. The original copy can be returned to you if you would like.

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Appendix I

Table 3.1 Coding Process Example

Quotations	**Incidents**	**Categories**	**Concepts**
"You know you see the transition, they might be here for the employment the first time, but then they work with these people and all of a sudden the concern you develop working with these people it's just amazing."	Developing a deeper connection to the work	Finding my place	Finding RN Fit
"I am very much an organizer. Let's figure out where we can do what and how many people we need on the floor and that type of thing. So I like that I can start getting involved in that more now."	Getting more involved in unit organization		
"At the start when I didn't understand the language or what different treatments that were there, and when I was just kind of getting my place, I think I felt a little bit on the outside, because I didn't understand all the stuff that was going on there." "I remember the day where I said I feel like I'm part of the team now" "I ended up slowly finding my place and my piece of the puzzle fitting."	Getting your place		
"I think it is being more comfortable with the people and the people (senior staff) being more comfortable with you."	Increasing level of comfort	Experiencing expanded role responsibility	
"I'm pretty confident in a lot of the things now like I never bring my iPod anywhere even, like I don't need it anymore which is kind of nice cause I'm not constantly looking up things anymore, it's nice."	Giving up the IPod (not looking things up)		
"I started seeing others enjoy having me co-working with them and enjoy what I had to bring, whether it was knowledge or some humour or some leadership, you could feel the enjoyment was now reciprocal."	Knowing others want to work with you		

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Appendix J

Researcher Memo Examples

Researcher Memo: June 20/13

Work today has taken me into the literature of integration of new nurses into the workplace.

I want to create a conceptual category. Originally tagged *First Experiences in a New Unit* to become a more comprehensive and further encompassing category entitled:

Integrating into a Specialized Practice Setting

Although I do wonder about the wording perhaps environment instead of setting. I think this a category that explicates an important process in this research.

Is it conceptual? Does it have analytic direction? I am not sure on this. **?**

I think another potential category from today is:

Seeking Community

I think this one does have some abstract power. It is a telling, short and to the point. And I can feel in the data….this sense of seeking.

Codes that indicate such:

Wanting community

I want to incorporate the belonging and connectedness of category 5 into this….But it is with sense of team now….I need to resolve the differentiation of team and community! This is critical point…..especially if considered a linear type of transition.

Team = getting the work of the day done – can be confined to the 12 hour shift? Who is there – good and bad members – making the best of it and moving forward with the team and the work of that shift.

Community = the bigger sense of belonging, connectedness, family, importance. Overall sense of looking out for one another.

Both has aspects of the RN not feeling alone.

Are social connections the bridge between a fleeting sense of team and lasting sense of community?

Researcher Memo: July 23/13

Working again on the use of Transition versus Integration (review definitions from earlier memo):

Still feel both have a role here….in fact they are the two key processes at play I think.

Transition is strongly related to the personal sense of specialized RN self and Integration to the process of joining the specialized practice team or community.

Does the CoP…. strongly influence both of these processes….???

Learning + Socialization, perhaps both are key factors in moving these forward.

Seems clear now that parallel processes are at work for RNs….no wonder that is stressful. Finding yourself and finding your place!

How about considering Benner + Workplace Researchers, would this literature add something here ???

[Benner's work on Intuition has value in this discussion as well]

A strong community of practice should be able to help…..but a negative community must be very damaging to these processes….potentially more so transition. Find more data on this.

Do we really want RNs integrating into bad or negative communities of practice??

RNs seem to feel this transition and that is a life-long process… "I will never be done developing my RN self"

Integration take a minimum of 6 months….can by a year or longer dependent on social connection perhaps?

SO WHAT DOES IT LOOK LIKE???

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Appendix K

Participant Consent Form

You are invited to participate in a research project entitled *Communities of Practice in Nursing: A Grounded Theory Exploration*. Please read this form carefully, and feel free to ask questions you might have.

Researcher(s):
Tracie Risling, RN, PhD(c), College of Nursing, University of Saskatchewan
Phone: (306) 966-6232 Email: tracie.risling@usask.ca

Dr. Linda Ferguson, RN, PhD **Supervisor** College of Nursing, University of Saskatchewan
Phone: (306) 966-6264 Email: linda.ferguson@usask.ca

Purpose and Procedure: The purpose of this study is to discover more about how nurses work and learn together in practice communities. This information may provide ideas or tools to better support nursing efforts in increasingly demanding care environments.

If you volunteer to participate in this study we will make arrangements to meet at a time and place that is most convenient for you. At our first visit, I will provide you with a short form to collect some background information about your work experience, age, numbers of years in practice, etc. We will also have a discussion about your experiences working as an RN in your current practice area. With your permission, I will digitally record this session so that your answers can be transcribed as part of the research data. This visit may take up to one hour. If you agree, I will also arrange a second visit in case I have further questions or need to clarify previous points you have made.

In addition to our discussions, I would ask that you write a short reflective journal entry daily during a two week period. In your journal you can reflect on your workplace experiences and relationships using the journaling guidelines and questions provided to you. If you have a daily time that works to spend a few minutes engaged in this reflection that would be ideal, but any amount you feel comfortable completing will add important data to this research. You can either write these entries by hand, in a journal that I will provide to you, or you can complete them electronically and save them on a provided memory key. With your permission, I will copy these journal entries and they will also be included as research data. The time required to participate in this research, including the two discussions and the reflective journaling, could be anywhere from three to four hours total.

Potential Benefits: There are no direct benefits for any one participant in this study. It is hoped, however, that this research will be of use to nurses involved in the continued evolution and improvement of nursing workplaces and learning. Your input will be very valuable in this process. A thank-you card a $10.00 gift card from a coffee vendor located in Royal University hospital will be provided to you following the completion of the study.

Potential Risks: This study has no obvious risks associated with it, however it is possible that you could become fatigued during the scheduled discussions. We can stop these sessions at any time, you do not have to answer any questions you do not want to, and you can withdraw from the study at any time. If anything arises in our discussion that is upsetting to you, I can provide you with information for contacting the appropriate supports through your workplace employee assistance program.

Storage of Data: Your answers to the questions, and copies of your journal entries, will be stored in a locked drawer at the College of Nursing, University of Saskatchewan, for at least five years. Only the research team will be able to access the information. If the researcher decides to discard the data after the five year period it will be destroyed beyond recovery.

Confidentiality: Your name will not appear in any of the data that you provide, written or recorded. You will only be identified by a coded number in the data collection process. During the transcription of recorded conversations any reference to your name will be excluded. The consent forms associated with this study will be stored separately from this data. In reporting the findings from this research, no names of participants will be used and general themes will be shared from groupings of study data. When direct quotations are used in the research reporting, they will be chosen so that they do not identify any one person.

Right to Withdraw: Your participation is voluntary, and you can answer only those questions that you are comfortable with. You may withdraw from the research project for any reason, at any time, without penalty of any sort simply by letting me know that you wish to discontinue. Your right to withdraw data from the study will apply until the data has been coded in the analysis phase. After this time your data may have influenced the theory development and it will not be possible to withdraw it. All of the information that you share will be held in strict confidence and discussed only with the research team.

Questions: If you have any questions concerning the research project, please feel free to ask at any point; you are also free to contact the researchers at the numbers provided if you have other questions. This research project has been approved on ethical grounds by the University of Saskatchewan Behavioural Research Ethics Board on (insert date). Any questions regarding your rights as a participant may be addressed to that committee through the Ethics Office (966-2084). Out of town participants may call collect.

Follow-Up or Debriefing: I will leave you with my contact information should you have any further questions or wish to contact me about the final results of the study.

Consent to Participate

I have read and understood the description provided; I have had an opportunity to ask questions and my questions have been answered. I consent to participate in the research project, understanding that I may withdraw my consent at any time. A copy of this consent form has been given to me for my records.

Name of Participant: _____

Signature of Participant: _____ Date: _____

Signature of Researcher: _____ Date: _____

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Appendix L

Table 4.1 Participant Characteristics Summary

Participant Characteristics (n=19)	
Age **Mean (34 years)** **Range (23-53 years)**	20-25: 5 26-30: 1 30-35: 6 36-40: 3 40-45: 1 46-55: 3
Gender	F: 15 M: 4
Educational Background (Nursing) **(highest attained)**	Diploma in Nursing: 1 BSN: 17 Masters of Nursing: 1
Marital Status	Single: 3 Married/Common-Law: 15 Divorced: 1
Length of time licensed to practice as an RN **Mean (8.4 years)**	6 months to 1 year: 4 1-2 years: 4 3-6 years: 3 7-10 years: 2 11-13 years: 2 20-23 years: 1 27-31 years: 3
Length of time employed in the specialized unit **Mean (7.3 years)**	Less than 6 months: 1 6 months-1 year: 4 1-3 years: 4 3-6 years: 3 9-12 years: 3 13-16 years: 1 20-23 years: 2 27-30 years: 1
Average hours worked on the specialized unit per week	20-25: 2 30-35: 4 36-40: 13

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