Being, Becoming, and Belonging: A Constructivist Grounded Theory Study Describing the Process of Social Norm Formation of Nurses Working in Groups

Catherine Schoales

Lakehead University

Department of Psychology

Dissertation Supervisor: Dr. Mirella Stroink

Committee Members:

Dr. Rupert Klein

Dr. Idevania Costa

Abstract

Background: COVID-19 exacerbated the worldwide shortage of nurses. The Registered Nurses Association of Ontario reported that the number of vacancies among registered nurses in the province has more than quadrupled since the beginning of 2016 and has more than doubled since the start of the pandemic. Reasons identified by researchers contributing to nurses leaving the profession have included lack of support from peers and management, little input from nurses into their practices, increasingly heavy patient loads, and increasing patient acuity. The purpose of this constructivist grounded theory study was to develop a theory to explain the process of social norm formation of nurses working in groups and to identify the factors limiting or facilitating their development. Group social norms, or rules, contribute to the environment in which nurses practice.

Methods: A constructivist grounded theory (Charmaz, 2014) guided the study design. Theoretical sampling and intensive semistructured interviews were conducted from January to March 2022 with 19 nurses practicing in the health care setting in northwestern Ontario, Canada.

Results: The process of social norm formation of nurses working in groups in the health care setting involves three transitions/processes and their concepts: (a) being, or identifying, as a nurse; (b) becoming a part of the group; and (c) belonging to the group and the profession. The processes are influenced by contextual elements that include personal attributes, work environment, relationships, and communication. The three transitions of being, becoming, and belonging formed the new theory.

Conclusion: This study provided a theoretical model explaining the development of the social norms of nurses working in groups in health care. The results identified the elements of context that impact the social norms of nurses and their groups. This knowledge will contribute to

informing nursing practice, education, and organizations in their efforts to support nurses and encourage them to remain in the profession.

Coauthorship

This dissertation is the work of Catherine Schoales in collaboration with:

Mirella Stroink, PhD, Dean of Health and Behavioural Sciences, Lakehead University

Rupert Klein, PhD, Chair of Psychology, Lakehead University

Idevania Costa, PhD, Professor, School of Nursing, Lakehead University

Expert Consultants in Qualitative Research

Kristen Jones-Bonofiglio, PhD, Director, School of Nursing, Lakehead University

Michelle Spandoni, DNP, Professor, School of Nursing, Lakehead University

Patricia Savean, PhD, Professor Emeriti, School of Nursing, Lakehead University

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Table of Contents

List of Tables

List of Figures

CHAPTER 1: INTRODUCTION

Introduction to the Study

There were 300,669 registered nurses (RNs) in Canada in 2019 and 312,382 in 2021, an increase of 11,713 nurses with active licenses within a 2-year span. Approximately 180,401 (60%) RNs were working in the hospital setting in 2019 and 178,540 (64%) in 2021, meaning that almost 40% are continuing to work in other health care settings (Canadian Institute for Health Information [CIHI], 2022). According to statistics from CIHI (2022), 91.6% of RNs are women, indicating that nursing remains a predominately female profession. CIHI collects data on sex, not gender, so it does not have information related to different gender expressions. A report from the Canadian Federation of Nurses Unions (CFNU, 2022) indicated that 50% of nurses in the workforce wished to change jobs, 94% were experiencing burnout, and 83% were worried about the quality of patient care because of understaffing. Nursing vacancies in the last 5 years have tripled, according to Statistics Canada's (2022, March) survey on the labour force. Nurses under the age of 50 years comprise 66% of the current nursing workforce in Canada. A policy brief from the International Council of Nurses in 2020 estimated that 13 million nurses would be needed to address the worldwide shortage of nurses.

According to NSI Nursing Solutions (2022), the average cost of replacing a bedside RN was $46,100 and ranged from $33,900 to $58,300, resulting in the average hospital losing $5.2m to $9.0m annually. These statistics pointed out not only the high cost to organizations to train new nurses but also the loss of experience, mentorship, and support that nurses can offer to each other as they work in groups in hospitals. Staff turnover also has resulted in a shortage of nurses that has had an ongoing impact on the provision of care to patients in hospitals, long-term care facilities, and communities that was exacerbated by the COVID-19 pandemic (Canadian Nurses

Association [CNA], 2020). The CNA (2020) estimated that Canada will have a nursing shortfall of 60,000 RNs by 2022. The Registered Nurses Association of Ontario (RNAO, 2021) released the results of its 2021 Work and Well-being Survey, which showed that there would be an additional increase to 15.6% of nurses planning to leave the profession in the first-year postpandemic. This increase was linked to several factors: stress during the pandemic, poor employer support, lack of mental health support, and poor coping skills of early-career nurses.

During the COVID-19 pandemic, nurses' psychological and physiological stress levels became worse (CNA, 2020). The result was an even greater exodus of nurses from the profession as indicated by the RNAO (2021) adding to an already critical shortage of nurses in the Canadian health care system. For decades, studies focusing on the factors contributing to nurses leaving the profession have highlighted the increased workload leading to burnout; inability to complete all care for clients; lack of job satisfaction; conflicts in the workplace; little leadership support and inter- and intraprofessional collaboration; little input regarding patient loads and policies; and a lack of support (e.g., help with the workload, mentoring, emotional support) from colleagues and management (Kornhaber & Wilson, 2011; Kox et al., 2020; Kutney-Lee et al., 2016; Lewis et al., 1990; J. J. Moreland et al., 2015; Wendsche et al., 2016; White et al., 2019).

During my more than 40 years of experience as an RN in a variety of settings (e.g., frontline nurse, clinical instructor working in the hospital and long-term care settings, and nurse educator at the local university), I have witnessed similar reasons for nurses leaving the profession: signs of burnout, job dissatisfaction, and difficulty getting leadership support. These reasons intrigued me, so I chose to conduct a study to explore ways that the profession and employers could better support nurses to stay in the profession. The CFNU's (2022) report

indicated that 94% of nurses reported felt burned out and 83% were concerned that they could not provide the quality of care that they wanted to.

Research focusing on nursing practice through the lens of social identity theory (SIT) has been scant. Nurses who work in groups are influenced not only by their own ideas of nursing but also those of other members of their groups, the society in which they are embedded, the organizations' expectations of what nurses should do, as well as their friends and families. These influences on the social norms of nursing practice are not always identified by nurses in their day-to-day practices. Examining nursing from this perspective may contribute to a better understanding of the process of social norm formation of nurses working in groups. I followed a constructivist grounded theory approach to understand the process of social norm formation of nurses and the factors facilitating or limiting their social norm development while working in groups in the health care setting. The following section provides support linking the use of SIT, social norms, and communication as possible concepts on which to base the research question (RQ), aim of the study and the RQ, my reflexivity statement, and the dissertation outline.

Linking SIT, Social Norms, and Communication

By connecting the knowledge acquired from my nursing experience and doctoral course work, I came to realize that SIT and social norms could expand current understanding of the reasons nurses chose to remain in the profession. The nursing profession relies on experienced RNs who identify strongly with the profession to mentor and support novice nurses in developing the values, beliefs, and work ethic of the profession. This mentorship is supported by statements from the CNA (2020) and the RNAO (2022) that experienced nurses play a significant role in the socialization of novice nurses and that novice nurses bring new knowledge and innovative approaches to care. Nurses in Canada have a professional obligation to support

the practices of the nurses with whom they work (CNA, 2020). Mentorship continues to play an important role in supporting nurses as they navigate the profession and develop their own identities to gain a sense of belonging to the profession.

Along with SIT and social norms, group communication has a strong influence on the development of salient group social identities and social norms. Social norms are the implicit (i.e., unconscious) and explicit (i.e., conscious) rules of groups (Cialdini, 2007; Cialdini et al., 1991; Postmes, 2014). Members of groups come to learn group social norms as they watch the behaviours of others (e.g., during mentorship programs); are praised or sanctioned for their behaviours; come to feel that they belong to the groups; learn the best way to communicate with other group members; and develop a common social identity (Cialdini, 2007; Cialdini et al., 1991; Postmes, 2014).

Members share a common language that encompasses implicit and explicit understandings of group social norms (Hogg, 2018; Holmes & Woodhams, 2013). They also construct a common social language that shapes the social reality of the group based on the work context (Postmes, 2014). For instance, the common language, expressions, and behaviours used by members of the same group may be the ways that they communicate concerns, feelings, and messages such as nurse charting and reports on patients with other members of their professional group.

Informal communication and the development of group social norms among nurses in the workplace may contribute to the decision to stay in the profession. For example, my extensive experience as a nurse has allowed me to identify that colleagues who have felt comfortable sharing their feelings and concerns (e.g., frustrations, successes, and fears) with peers through informal communication during shifts and breaks have developed more self-confidence and the

ability to face daily nursing challenges. The support that they have received from peers also has contributed to the development of a sense of belonging and may have strengthened their professional identity and attachment to the nursing profession. As a result, I have witnessed nurses in my group sharing the satisfaction that they have felt during interactions with peers who have supported them during challenging times at work that has contributed to the development of social group norms (e.g., support from peers) and intentions to stay in the nursing profession.

J. J. Moreland et al. (2015) studied the ability of nurses to interact with others and to confront conflict, learned helplessness, and intention to stay concerning professional identity. The results of their study indicated that having higher levels of professional and group identity lead to nurses being more interactive, able to confront conflict, and stay on the units and in the profession. Researchers who have examined the outcomes of group interactions and peer support in the nursing workplace have identified these strategies as essential to helping nurses to cope more effectively with stress (Carvello et al., 2019; Mealer et al., 2012) and possibly stay in the profession.

Participants in a qualitative study on the development of resilience among nurses who cared for patients in a burn unit shared that without team support, they would not have been able to meet the emotional and physical demands necessary when providing care to patients with severe burn injuries (Kornhaber & Wilson, 2011). In another study by Lewis et al. (1990), the participants highlighted the impact of team interactions and support on their ability to cope emotionally and physically while working on a burn unit. The burn unit nurses whom Lewis et al. surveyed identified interactions with coworkers and experienced staff, humor, timeout, teamwork, and support as effective coping strategies.

I believe that informal intragroup communication and peer support also may influence the development of group social norms, that is, the implicit (unconscious) and explicit (conscious) rules of the group, as well as the expected behaviours of members of social groups that are considered appropriate or inappropriate in different situations (Bartholomew et al., 2006; Cialdini, 2007; Cialdini et al., 1991; Hogg, 2018; Postmes, 2014). The ability of nurses to use supportive communication in their practices and build relationships with each other has many benefits to the nursing profession: improved patient outcomes; the development of nurses' independent practice (Deppoliti, 2008); a sense of belongingness; increased collaboration; and stronger collegial relationships (Galuska et al., 2018). The many demands of nursing practice require that individual nurses have not only knowledge and skills related to medical-biological needs but also the ability to support patients and families through emotional challenges (Galuska et al., 2018). However, to be able to provide biological and emotional support to patients, nurses also need to meet their own needs. I believe that one way to meet these needs could be by developing social norms that support strong relationships with other nurses. Another way could be by demonstrating supportive behaviour in nursing groups to build capacity to confront professional challenges without allowing negative emotions to affect personal well-being.

Based on my experience in the nursing profession, it has become clear to me that the process of social norm formation of nurses working in groups and manifesting supportive behaviours is paramount for nurses to develop their identities in practice and feel that they belong to the group, which may increase nurses' professional satisfaction and influence their decision to stay in the profession. Researchers have discussed social norms as the adhesive that holds groups together, that is, the unwritten rules that direct group behaviour (Legros & Cislaghi, 2020; Maltseva, 2018). For example, in my nursing practice, nurses who were willing to share

knowledge and support each other were always included during conversations and were offered more support by other nurses when they were struggling with patient loads, which seemed to help them to remain satisfied with their profession and achieve better patient outcomes. Other nurses who were not always willing to share information or provide support to members of the group often withdrew from group interactions and did not seek advice or provide help during patient workloads, which had a negative impact on the work environment and group cohesiveness. Although these situations were not declared or made explicit in the group, they seemed to be a part of the social norms developed within the nursing group.

Being part of a group contributes to the human sense of belongingness (Willetts & Clarke, 2014) and self-esteem (Turner, 1982). Group social norms contribute to group behaviours and outcomes (Hogg & Terry, 2012; Postmes, 2014) and have been defined as implicit (unconscious) and explicit (conscious) rules of the group that are driven by the need to belong (Cotterill et al., 2019; Legros & Cislaghi, 2020; Shulman et al., 2017). For individuals to identify as belonging to the nursing profession, they must be able to identify group social norms to exhibit the behaviours that others consider to be representative of the group members.

Simmonds et al. (2020) conducted a scoping review related to the formation of students' professional identity during nursing education. They asserted that the development of professional identity influenced the ability of nursing students to understand the significance of their roles and responsibilities in practice. Although social norms guide the behaviours of nursing practice, several articles in the scoping review did not classify these behaviours as social norms and did not explicate how social norms are communicated and formed in nurses' professional practice (Simmonds et al., 2020).

To date, research on the combination of informal communication, social identity, and social norms has been scant. The gap has reduced current understanding of the ways that nurses develop supportive group social norms so that they can thrive in their day-to-day practices, feel part of the group, and develop a sense of belongingness and social identity as nurses. Identifying the process of group social norm formation will broaden the understanding of how to better support nurses as they develop supportive behaviours that contribute to their sense of belongingness and connection to their group and profession.

Considering the lack of a theoretical model explaining the process of group social norm formation, I identified a need to develop a theory based on nurses' unique experiences that will facilitate an understanding of the process of group social norm formation of nurses working in groups in their day-to-day practices and determine the factors influencing this development. In response to this gap in the research, I conducted a study following a constructivist grounded theory methodology to explain the process of group social norm formation by nursing groups and examine the factors influencing the ability of nurses to develop positive social norms that will help to retain nurses in the profession. This study allowed me to obtain the perceptions of a sample of nurses regarding the development of group social norms and the relationship of these norms to their social identity and sense of belonging. This study provided insight into the ways that social norms are formed in nursing groups and their impact on the work and workplace environment of nurses.

Study Aim and Research Questions

The overall aim of this study was to explain the process of group social norm formation in nurses' day-to-day practices working in groups in the health care setting. Factors facilitating or limiting the process of group social norm formation in nursing groups were examined through

the unique experiences of nurses working in groups to develop a substantive theory. Use of a constructivist grounded theory methodology allowed me to obtain rich and detailed data from the participants on the ways that social norms are developed and their impact on the decision of nurses to stay in the profession. This methodology also gave the participating nurses the opportunity to reflect on their day-to-day practices to identify implicit factors (e.g., informal communication, observations of peer behaviors) in the workplace environment affecting the development of group social norms.

In grounded theory, the central RQ is developed to guide the formulation of subquestions that anticipate the information required to explore the central RQ (Charmaz, 2009; Strauss & Corbin, 1990). SIT, the social cognitive process of social norms, and communication theories were the foundation for my study, which was grounded in social psychology. My extensive experience as a clinical nurse and an educator nurse has impacted my worldview and brought an added dimension to this research.

Researchers' preexisting knowledge and life experiences give them an understanding of the research concepts that they can use to develop questions before, during, and after data collection and analysis to add depth to their research endeavours (Charmaz, 1990, 2014, 2017, 2020). The caveat to having a priori understanding of theoretical concepts is that it requires researchers to be aware of their influence on the development of the RQs, theories, and data analysis. Researchers must continually reflect on their worldviews, positions, privileges, and priorities while developing and conducting their studies (Charmaz, 2017). Researchers also must reflect on their relationships with their study participants and the influence of the relationships on data analysis.

My experience in nursing practice has led me to question how behaviours in nursing practice can be developed so that they consistently support colleagues and contribute to a sense of belongingness and an improved workplace environment so that nurses stay in the profession. The knowledge that I gained as a doctoral student gave me a more in-depth understanding of the ways that the concepts in SIT, social cognitive process of social norms, and organizational communication impact the work of nurses in the group health care setting (e.g., hospital). There has been little research not only on the process of group social norm formation in nursing practice but also on the factors (e.g., informal communication) that facilitate or limit its development, thus impacting the social identity of nurses, their professional satisfaction, and their decision to stay in the profession.

One central RQ guided this study: What theory explains the process of social norm formation and the factors facilitating or limiting social norm development in nursing groups working in health care settings? Nursing groups referred to nurses working in groups on units in the health care setting. The following subquestions supported the central RQ:

1. What are the components, or the systems of the rules and observations, that comprise the social norms of a group of nurses?
2. How do the social norms of a group of nurses develop?
    a. What factors contribute to or constrain the development of social norms?
    b. What is the role of informal and formal communication in the development of group social norms?
3. What are the impacts of the group's social norms at various levels?
    a. How do the group's social norms shape nurses' social identity?
    b. How do the group's social norms impact the work environment?

c. How do social norms affect how nurses perceive the profession as a whole and their decision to remain in the profession?

Reflexivity Statement

My reflexivity statement allows the individuals reading this study to understand how my professional, personal, and educational experiences informed and contributed to the development of a theory explaining the process of social norm formation and the factors facilitating or limiting its development within nursing groups. I have been a nurse for more than 40 years and have had many career opportunities. I have worked as a nurse on a burn unit and an intensive care unit. I have been a staff educator and have developed programs to support nurses in attaining the knowledge and skills to work in intensive care units with critically ill clients. Over the past 16 years, my career has involved my working with nursing students and clinical instructors in labs, clinical placements, and education.

My educational background has been diverse. I have a bachelor of science degree in nursing, a bachelor of education degree, and a master of science in nursing degree. Upon completion of this dissertation, I will have a doctoral degree in psychological sciences. I believe that the opportunity to navigate through different educational areas has helped to shape my view of nursing practice; how students learn to be nurses; and how they are affected by the context and individuals with whom they learn and practice with, as seen through the theories of nursing, education, and psychology.

Throughout my experiences in nursing and education, I have become more cognizant of my epistemology and belief that we are all connected to the outcomes that we see around us, that we develop meanings and connections with others, that our actions and meanings are built upon how we interpret what is occurring around us, and that we learn from the behaviours of others.

Having worked in various groups of nurses and in many different roles, I have seen that some groups work well and are supportive of the people with whom they work, but I also have worked in difficult groups that made me feel as if I did not belong. I have seen nurses treat others in noncaring ways and not have anyone try to influence changes in their behaviours. I have always been an advocate for other nurses and have spoken up about unfair behaviours, but I also have wondered about ways to better understand the behaviours of groups to improve nurses' support of each other and their sense of belonging to the group. I recognize that I come from a position of privilege, meaning that I have been able to reach a level of academic achievement that many nurses have not had the opportunity to even consider.

Pursuing a doctoral degree in psychology gave me the opportunity to examine group behaviour through SIT and social cognitive processes, social norms in particular. I began to question how nurses develop the social norms of their nursing groups in practice. Social norms are implicit as well as explicit. Sometimes they are followed, but other times, they are not. Some nurses may agree with them, and other nurses may not, but regardless, they are the rules of the group and impact all nurses in the group. What is it about the nurse, the group, and the organization that supports the development of social norms of the group, and can nurses change the norms? Are they aware of the social norms in their groups? How do social norms influence the decisions of nurses to stay in or withdraw from the profession? I brought all these questions and personal experiences with me as a researcher, so I had to be aware of their influence on my interactions with the participants and the data, the RQ and subquestions, the analysis, and the development of the final theory. As Charmaz (2014) pointed out, researchers must be reflexive, develop methodological self-consciousness, continuously go back and forth between the collected data and analysis of the data, ask the "why" and "how" questions, and look for the

actions and meanings of the participants as expressed in their interview responses. We as researchers take part in the social world, and as we interact with the research participants and data, we construct our findings based on these experiences. Charmaz (2006) stated that "constructing and writing research are not neutral acts" (p. 130).

The purpose of writing this reflexivity statement is to allow the readers of this study to know what my experiences have been and what my own beliefs about the profession of nursing are. As a researcher, I had to question my decisions to determine how my perspectives, privileges, social location, and experiences would impact the research. These questions included reflecting on how my nursing experiences might have affected the way in which I interpreted the participants' comments, such as, "Are these my own values and beliefs, my interpretation of those of the profession, or is it those of the participants?" Use of a constructivist grounded theory methodology facilitated the transparency of the research decisions and grounded them in the experiences of the participants while also acknowledging that knowledge rests on social constructions arising from the research process (Charmaz, 2006, 2014).

I recognize that my values and norms may have affected my interpretation of the data. To mitigate this possibility, I had my dissertation supervisor and members of the committee review my interpretations and analysis of the data throughout the process. I also kept a record of my analysis using memo writing and a research journal so that my decisions were as transparent as possible to readers of this study.

Outline of Dissertation

This qualitative study followed a constructivist grounded theory approach to (a) develop a substantive theory describing the process of the social norm formation of nurses working in groups, and (b) identify factors influencing the process of group social norm

formation of nurses working together in groups in the health care setting. A review of the literature on relational practice, SIT, the social cognitive process of social norm development, and communication provided an understanding of the theories and concepts that formed the basis of the semistructured interview questions. I believe that the social identities and social norms of groups of nurses affect the outcomes of nursing practice and patient care and may contribute to nurses' decision to stay in the profession, but no theory exists to identify the factors such as communication between and among nurses that lead to the development of group social norms and the professional identity of nursing. This research has the potential to support nurses in (a) the development of a strong and effective social identity; (b) recognition of the impact of social norms in daily practice; (c) development of social norms related to group communication; (d) factors that facilitate or limit social norm development; (e) provision of a theoretical framework explaining social norm development in nursing groups to inform interventions within organizations and nursing education that can contribute to nurse retention; and (f) support for nursing groups in developing social norms and supportive group behaviors that allow them to overcome professional challenges and create a supportive, comfortable, and safe workplace.

Included in Chapter 2 are details about the conceptual and theoretical groundwork that I used to examine the process by which nurses develop their social identity and the group social norms. A review of the concept of relational practice, SIT, and the specific concepts of self-categorization, prototypicality, and belongingness, as well as the social cognitive process of social norms, and communication provided a deeper understanding of the development and impact of social norms on group interactions. These concepts and theories from the literature guided the development of the semistructured interview questions.

Chapter 3 provides an explanation of the research methodology and the rationale for using the constructivist grounded theory methodology developed by Charmaz (2006, 2014). My own philosophical beliefs also are presented in the chapter to facilitate an understanding of how I situated myself in this constructivist grounded theory study. I also provide details about symbolic interactionism as a framework for applying the constructivist grounded theory methodology. The underlying principle of symbolic interactionism identifies the ability of individuals to make meaning of the social processes that they are a part of, and even though that context, history, and social structures limit behavioural choices, they do not predict them (Oliver, 2012). Finally, I describe the methods used to collect and analyze the data, along with the strategies used to support the quality, rigour, and trustworthiness of the methodology and findings.

Chapter 4 presents the findings of the research. The theory developed from the study (i.e., being, becoming, and belonging) is described and presented. The three transitions of the theory and the concepts that support each one are described in detail. The four elements of context (i.e., personal attributes, work environment, relationships, and communication), along with their associated concepts, are described, and their influence on facilitating or limiting the ability of the nurses to move through the transitions will be supported. The chapter provides an in-depth examination of each of the transitions of the theory and context, supported by the experiences and voices of the 19 nurses who participated in the study, my interpretation, analysis, and construction of the theory through the iterative methodology of constructivist grounded theory.

Chapter 5 is a review of the theory and contextual elements, followed by the integration of the theory to the initial RQ and subquestions. The chapter examines three key areas where the theory can contribute to the community of nursing through education, practice, and

organizations. Areas for future research, knowledge mobilization, and limitations conclude the chapter.

CHAPTER 2: LITERATURE REVIEW

Theoretical Foundations, Concepts, and Prior Literature

Entering the profession of nursing is very much a social process. It is about changes in the ways that individuals identify themselves based on their interpretations of what nursing is, reasons they chose to enter this profession, and the ways that they will develop their sense of belonging to the profession. As nurses, we bring our own values and beliefs, beginning with each of us choosing to enter the profession of nursing. We may see ourselves as having some of the same characteristics as the nurses to whom we have been exposed, such as directly, in the media, in personal experiences with nurses, or through the stories of others. Once we decide to enter the profession through education and then as RNs, we become a part of that world, and our experiences are shaped by the social context of nursing.

There is very little research on the development of social norms in nurses' practices so the literature examined for this study is foundational to the examination of the process of social norm formation. We need to understand how the profession of nursing is situated in society, its education, and expectations of the legislation bodies to understand the values and beliefs carried by those who identify as nurses. SIT provides us with a theory to develop questions examining group belongingness. The cognitive process of social norms allows us to understand how group members identity the norms of the group and how these norms influence behaviour. Since we are social beings, communication facilitates or hinders the ability of nurses to learn these norms.

To begin this chapter, I discuss relational practice. Nurses are taught to engage in relational practice, which begins the socialization process of professional practice. I define the concepts of SIT, specifically self-categorization, prototypicality, and belongingness. Then I define and discuss social norms in relation to the development of individual social identity and

group belongingness. Finally, communication, an essential skill for the nursing profession, is defined and linked to the concepts of self-categorization, prototypicality, belongingness, and the development of group norms as the underlying knowledge for this constructivist grounded theory study.

Relational Practice

Researchers have described relational practice in relational and social psychology and organizational behaviour (Brickson & Brewer, 2012; Fletcher, 1998; Hogg et al., 2017). Fletcher's (1998) qualitative study of female engineers highlighted the underlying tenet of relational practice as the authentic engagement between and among individuals to engage in a profession, allowing individuals to grow from their shared experience. Relational practice is based on the responsibility of each person to foster growth in the other. This growth requires empathy, empowerment, and an understanding of the vulnerability of the other (Hartrick Doane & Varcoe, 2021). Values, beliefs, and norms impact the ability to take part in professional relational practice (Hartrick Doane & Varcoe, 2021).

Doane (2002) defined relational practice in nursing as "a humanely involved process of respectful, compassionate, and authentically interested inquiry into another and one's own experiences" (p. 201). Hartrick Doane and Varcoe (2021) viewed relational practice as encompassing nurses' way of being with and relating to patients and colleagues in the unique contexts of nursing practice. Relational practice has been described as involving nursing values, intentions, knowledge, commitment, decision making, and actions (Hartrick Doane & Varcoe, 2021; Watson, 1988). Relational practice competencies such as authenticity, active listening, self-awareness, empathy, rapport, trust, self-disclosure and confidentiality, mutuality and intentionality, complexity and ambiguity, and reflective practice have been linked to the

importance of relationships in caring nursing practice (Hartrick, 1997). These competencies reflect the values and beliefs of the professional practice of nursing, and when applied to the profession, they lead to a positive practice environment based on improved intraprofessional relationships and better patient outcomes (CNA, 2015).

Researchers such as Hartrick Doane and Varcoe (2021) have discussed relational practice in nursing as an essential way of knowing, being, and doing the work of nursing with patients. More recent attention has been directed toward the relational practice between nurses and implementation of the competencies described in working with others in practice (CNA, 2015). The CNA (2010) highlighted the contribution of relational practice to ethical practice and leadership to support others in the workplace. The report from the CNA (2010) presented scenarios demonstrating the application of the competencies of relational practice through communication with others. The ability of nurses to recognize the interplay of the intrapersonal, interpersonal, and contextual aspects of their practices supports their ability to communicate the values and beliefs that underlie the development of social norms (Hartrick Doane & Varcoe, 2021).

There has been recognition that the ways that nurses interpret others' intentions contribute to the outcomes of conflict and misunderstanding that result in others feeling disrespected and powerless (J. J. Moreland et al., 2015). Reflecting on ways to improve communication with others encourages the uptake of the components of relational practice that may impact the social norms of nursing practice and contribute to better conflict management. Research on the integration of the competencies of relational practice into nurses' intraprofessional practice through informal intracommunication practices has been scant.

Fletcher (1998) studied the relational practice of six female engineers and identified competencies similar to the ones that Hartrick Doane and Varcoe (2021) used to define relational practice in the nursing profession. The participants in Fletcher's study were asked if they believed that relational practice existed within their organization and, if so, what behaviours characterized it; what beliefs, values, and assumptions did these behaviours reflect; and how did these behaviours manifest in the organization? Fletcher identified four themes in her qualitative study based on the analysis of the participants' interview responses: (a) preserving (related to a task or supporting the completion of a task such as patient care in nursing practice), (b) mutually empowering (related to allowing or empowering others to achieve and contribute to a project), (c) achieving (actions to empower oneself to contribute), and (d) creating a team. Fletcher et al. (2000) identified empathy, mutuality, authenticity, and empowerment as behaviours supporting the growth of others and forming the foundation of what Fletcher as well as Fletcher et al. referred to as emotional intelligence, namely, the ability to put these behaviours into practice. These same behaviours have been supported by the CNA (2015) and the College of Nurses of Ontario (CNO, 2020, 2023) as contributing to ethical nursing practice. They are the behaviours fostered by the values and beliefs of the nursing profession.

The Lakehead University School of Nursing (2020), where I have been working for more than 16 years, has developed its philosophical foundation based on relational practice and its competencies. For example, the philosophy statement of the school of nursing stated that "nurses engage in relational practice with others in purposeful ways to develop mutual trust and respect to create conditions that foster holistic health" (p. 1). Teaching students the competencies of relational practice can help them to build relational skills such as reflective practice to improve knowledge, outcomes, and respect for others. Having these competencies will allow students to

learn from their own experiences as well as the experiences of others. By using relational practice competencies such as authenticity in the ways that they engage with others gives them the freedom to be genuine and real, and provide them with the values and beliefs to continue to grow in their professional nursing practices (Hartrick Doane & Varcoe, 2021).

Mastering content alone does not translate into having effective nursing practices (Hartrick Doane & Varcoe, 2008). For example, nurses who can perform procedures and assess their clients safely but cannot integrate relational practice into their interactions with others (i.e., patients, families of patients, nurses, and other professionals) may not be considered "good nurses" because they are unable to connect with those they care for. Being able to integrate knowledge, skills, and relational practice into their individual nursing practices is essential to being with patients authentically to develop the nurse-patient relationship and improve health outcomes. In summary, relational practice has guided nurses to understand patients' values, beliefs, and health care goals while recognizing the ways that their own values, beliefs, goals, and the context of practice affect the nurse-patient relationship. However, the nursing literature to date has focused on the use of relational practice in the nurse-patient relationship and has not directly addressed relational practice in nurse-to-nurse relationships (DeFrino, 2009; Hartrick Doane & Varcoe, 2021; Zou, 2016).

Nurse researchers have examined the concepts of relational practice such as trust, respect, authenticity, and engagement, as evidenced by the behaviours that nurses exhibit in their professional practices (Keyko, 2014; Young et al., 2019). Young et al. (2019) conducted a qualitative study using an appreciative inquiry method to interview a sample of preregistration nursing students and ask for examples of caring behaviour manifested by nurses with whom they worked in their clinical experiences. Young et al. found that the students identified the concepts

of relational practice (i.e., respect, trust, and authenticity) in their examples, such as nurses who maintained the confidentiality of patients and did not talk about them in public areas, nurses who spent extra time getting to know patients, and nurses who supported each other by staying late and coming in to work early. The students also saw uncaring behaviours in their clinical placements, such as talking over patients or dealing with poor nurse-patient relationships, that were strong motivators not to incorporate these behaviours into their own practices. Young et al. did not discuss the outcomes of group identity or the development of social norms in relation to the caring behaviours identified by the nursing students.

Nurses do not work in isolation; rather, they are dependent on the relationships between and among all of the individuals interacting within their specific units of work (e.g., patients, families, other nurses, other health care professionals, housekeeping, security) and throughout the hospital setting (DeFrino, 2009). Therefore, in the nursing profession, developing therapeutic relationships is essential to achieving better outcomes for patients. For instance, nursing practice is built on developing relationships with patients, families, members of nursing and health care teams, management staff, communities, and the context in which they work. Relationships are paramount to nurses' professional practices, and even though there has been copious research on the relationships between patients and health care teams (Aydon et al., 2014; Foronda et al., 2016), research on the relational practice between nurses and how they develop and maintain relationships in groups in their nursing practices has been lacking. Such relationships are important to nurses' professional identity and satisfaction, and they support the decision of nurses to stay in the profession (Kox et al., 2020; J. J. Moreland et al., 2015). Knowing that nurses' professional identity may be developed based on the values and beliefs of relational

practice served as the foundation to examine the roles of social norms, social identity, and communication in groups of nurses working in the health care setting.

Social Identity Theory

Social identity consists of cognitive, evaluative, and affective processes. Initially, social identity was said to develop through cognitive (self-categorization) evaluative (how the individual evaluates the group either positively or negatively) and affective (emotional connectedness to the group) processes (Reimer et al., 2020). As individuals, we are not merely bystanders in groups; rather, we bring our ideas of what we value and believe, in other words, we bring our own identities and respond to the interactions that we have with others in diverse social situations (Tajfel, 1982). These interactions may lead to us accept the social identity of the group.

Ashmore et al. (2004) conducted a literature review to identify the concepts that researchers and scholars have used to examine the social identity of individuals within groups and develop a framework to capture these concepts. Ashmore et al. found that the social identity of groups is more nuanced, describing seven theoretical concepts: self-categorization (includes prototypicality), evaluation, importance, attachment and interdependence, social embeddedness, behavioural involvement, and content and meaning. I examined the concepts of self-categorization (able to see ourselves as having similar characteristics and attributes of the group), prototypicality (able to identify the behavioural norms of the group), and belongingness in more detail. Understanding these concepts and the theoretical definitions allowed me to generate interview questions that let the participants share their day-day-experiences with these concepts and the meaning they ascribed to them.

Tajfel (1982) defined the concept of social identity as “the individual’s knowledge that he belongs to certain social groups together with some emotional and value significance to him of the group membership” (p. 18). Our social identities are formed as we come to see ourselves as possessing the attributes of those in the groups to which we feel we belong. These attributes could include being the same age as others in the group, having the same level of education, being of the same gender, and being in the same profession with the same values and beliefs. However, whatever the common attributes of the group are, we must see them as important to ourselves. A. D. Brown (2019) examined the use of SIT as a theory of intergroup behaviour and identity, highlighting the assumption that people sometimes see themselves as individuals and at other times as members of groups. Human beings need to belong to groups that contribute to their positive self-concept (A. D. Brown, 2019).

The claim that individuals seek group membership simply to improve their own self-concept has been challenged. Researchers have suggested that individuals also may seek group membership to reduce uncertainty about their social identities (Hogg, 2014); improve their ability to accomplish goals that cannot be reached individually; or improve their own knowledge and social status (A. D. Brown, 2019). Gaining knowledge regarding group behaviours and the ways that the development of group norms impacts the salience of group identity may help to explain why groups behave in the ways that they do and how the individuals within the groups contribute to these behaviours.

The importance of group relationships in nursing practice cannot be underestimated. As indicated in statistics reported in 2019 by the Canadian Institute of Health Information (CIHI), more than two thirds of nurses work on hospital units in groups with other nurses (as cited in CIHI, 2022). Willetts and Clarke (2014) proposed the use of SIT as a framework to clarify and

describe the social identity of the profession of nursing from the social context in which nurses are practising. Nurses need to be able to work within groups to accomplish the work of nursing and support each other in practice (Willetts & Garvey, 2020). Willetts and Garvey (2020) described the development of group and professional identity as being situated within the social context of nursing practice.

The ability of individuals to self-identify as part of a group, develop a sense of belongingness to a group, and then take on the attributes of the group are social processes identified within the frameworks of SIT and social categorization theory (SCT; R. Brown, 2020; Hornsey, 2008; Tajfel, 1982; Trepte & Loy, 2017). For individuals to begin to identify as belonging to a particular group, the process may be as simple as randomly putting strangers together, giving them a task, and requiring them to make decisions about members of their group when compared to members of another group. In these situations, individuals will make decisions that benefit their assigned group members over members of another group based entirely on the random group assignment (Tajfel, 1982).

Group members begin to make favourable decisions about other group members in comparison to members of another group, setting up an “us” versus “them” situation. This situation has been seen in nursing groups working in units in different hospitals: Even though they all identify as nurses, they see other groups as different from themselves (Oaker & Brown, 1986). Oaker and Brown (1986) interviewed a sample of nurses about their identification with their profession and their attitudes toward colleagues in specialized and general areas. They then compared the strength of the nurses’ group identification to the profession and the area in which they worked, as well as to intergroup attitudes. Oaker and Brown found that despite strong norms for cooperation between nurses, there was strong intergroup differentiation of “us” versus

"them," demonstrating that there is more to group identification beyond identifying as nurses and that much of nurses' interactional behaviours are shaped by workgroup membership and the context of the work.

Nurses in general and specialty areas gave Oaker and Brown (1986) different reasons for choosing to work in these areas. One reason cited by the nurses in the specialty areas was the opportunity to learn different personal or medical skills; nurses in the general units cited increased patient contact and work variety as their reasons for choosing to work in that area. Group friendships were not found to be the major component of work group identity. The nurses in the study perceived their group to be better than other groups of nurses from other units (Oaker & Brown, 1986). This was an interesting result because although nurses often do not have a choice regarding workmates, they can choose the specialty in which they want to work. Once nurses choose a specialty or a unit, they begin to identify as belonging to that group of nurses and attempt to fit into the group.

The ability of nurses to belong to specific groups is influenced by their ability to identify with the groups and adopt the characteristics or attributes of the groups. The concepts of self-categorization, prototypicality, and belongingness provide a framework for understanding nursing social identity (Willetts & Clarke, 2014). The concepts of self-categorization and prototypicality explicate how nurses identify as belonging to particular workgroups and make decisions to be part of those groups. These concepts have served as the foundation for understanding how nurses shape their social identities in their workgroups in comparison to other groups within the organization, as evidenced by Oaker and Brown's (1986) focus on studying nurses working on different units.

Self-Categorization

Reimer et al. (2020) defined self-categorization as a social cognitive process that gives individuals the ability to see themselves as belonging to particular groups. This process of self-categorization occurs as we see ourselves as having attributes similar to those of others. We begin to self-stereotype and see ourselves as being more like others, which is referred to as depersonalization, meaning that we now see ourselves not as having unique attributes but as having attributes shared with other group members (Turner & Reynolds, 2011). Once we identify as a group member with attributes similar to those of others of that group, we then begin to develop the group norms, values, and beliefs that influence the functioning of the group (Turner & Reynolds, 2011; van Kleef et al., 2019). Categorization results in seeing ourselves as members of some groups, referred to as in-groups, and not belonging to other groups, referred to as outgroups (Turner & Reynolds, 2011). We come to rely on those in our groups whom we see as like ourselves for information and group norms that influence the group members' thoughts, attitudes, and behaviours (Turner & Reynolds, 2011).

Self-categorization is dependent on the ways that individuals perceive a category or a group in a particular situation (Reimer et al., 2020). A category's accessibility depends on how salient that category is for the individual. For example, individuals may categorize themselves as student while attending classes, but they may not categorize themselves as students if working in part-time jobs. The category that an individual self-categorizes belonging to also is connected to the comparative and normative fit of the category in relation to the situation that the individual is in (Reimer et al., 2020).

Comparative fit of a category is related to how similar individuals identify with their group in comparison to other groups in a given context (Reicher et al., 2010). For example, if

nurses are in a room with a group of physicians, the nurses will identify more with the nurses' group than with the physicians' group, but if another group joins, such as a group of mathematicians, the nurses may see themselves as more like the physicians' group and possibly categorize themselves as health care professionals because they feel that they have more in common with the physicians than with the mathematicians. Normative fit is the degree to which individuals see others or groups as possessing attributes that fit their stereotype or expectations of the ways that they should behave or the values and beliefs that the group may have (Reimer et al., 2020). For example, I would expect that individuals who identify as nurses would maintain the confidentiality of their patients, but if the nurses release personal information about their patients, they are not meeting the normative fit of the group.

Self-categorization theory results in individuals either perceiving themselves as part of a group or perceiving others as belonging to their in-group or an outgroup. Self-categorization refers to the ways that we define ourselves (i.e., self-concept) and our membership in groups (i.e., social identity; Turner, 1982). To perceive ourselves as belonging to a specific group, we must see ourselves as having attributes similar to those of other members of the group, both by normative and comparative fit (Turner, 1982).

To identify as nurses, individuals must begin to self-categorize or perceive themselves as having the attributes that they believe other nurses also possess. Attributes associated with nursing practice often are those identified in relational practice: honesty, transparency, advocacy, caring, and respect (Hartrick Doane & Varcoe, 2021). The attributes that individuals see nurses possessing are communicated through various social environments (Trepte & Loy, 2017). These social environments could be media depictions of nurses, family members who are nurses, experiences interacting with nurses, opinions of others about what nurses are, and formal nursing

education (Simmonds et al., 2020), all of which shape the way that individuals identify others or themselves as being nurses.

Although individuals self-categorize as belonging to groups, they perceive the groups as having attributes similar to their own (Turner, 1982). They also bring to the groups those attributes that they identify as being part of their own self-identities. To understand the group, it is necessary to understand that the social identities of the individuals in the group define group behaviours and processes (Haslam, 2014; Turner, 1982). Even though individuals may identify as nurses, they also may carry other identities, including sister, brother, daughter, son, mother, father, friend, and teacher, with each of these groups manifesting overlapping and different attributes. Individuals in groups come to know the attributes of group members and their influence on group behaviour, possibly leading to (un)desired outcomes and influencing decisions to stay in or leave the groups (Ellemers et al., 2003).

Prototypicality

As the social identities of group members becomes more salient, individuals in a group develop the concept of what prototypical attributes of members of the group should be (Haslam, 2014; Hogg & Martin, 2003). Prototypicality refers to the attributes that individuals in groups perceive as defining typical group members. Although the group members often may be able to state the attributes of prototypical members, no member possesses all of the qualities or attributes that they feel prototypical members should have (Haslam, 2014). Prototypicality is not always a conscious or an explicit concept in groups; group members may describe the attributes of other members, or they may have implicit or unconscious knowledge and acceptance of group attributes that they are unaware of, unless they are asked to make them conscious by reflecting on group attributes (Goldman & Hogg, 2016; Hogg, 2005). The concept of prototypicality occurs

in groups once the members self-categorize as belonging to the groups; take on the social identity of the groups; and strive to have the same attributes, values, and beliefs of other members of the groups. We see this in nursing practice when individuals self-categorize as a nurse and then must become accepted members of groups of nurses on hospital units.

Belongingness

Belongingness results from the knowledge that individuals are similar to the other group members and that they know the attributes of prototypical members (Hogg, 2018; Hogg & Reid, 2006). The strength of individuals' sense of how prototypical they are of the group ideal (i.e., what they perceive an ideal member of the group would be) also affects the strength of their feelings of group belongingness (Goldman & Hogg, 2016). The stronger their sense of belongingness is, the more willing individuals become to go to extremes to support the group (Goldman & Hogg, 2016).

In contrast, individuals who do not feel that they are prototypical may feel that they do not belong to a group and will stay on the fringe of the group (Ellemers et al., 2003). This behaviour is evident in nursing practice, when some nurses seem to be excluded from the group and may not identify as having the same attributes as other group members. For example, nurses on a particular unit may value getting their work done quickly, but other nurses may feel that they need to take more time to ensure that they are not making mistakes, thus slowing down the amount of work accomplished. Others may feel that they are not contributing to the group outcomes and are slowing down the pace of care delivered to patients. Individuals in groups relate more positively to others whom they view as more prototypical of the groups, and they tend to exclude those who do not seem prototypical (Goldman & Hogg, 2016). As individuals

self-categorize and see themselves as fitting with the prototype of groups, they also accept or contribute to the development of the social norms of groups.

Nurses develop their sense of belongingness to work groups when they receive positive responses from group members about the behaviours that they display, with the result being that their colleagues respect them and recognize them as members of the team (Mohamed et al., 2013; Simmonds et al., 2020). Nurses who offer to help other nurses when their workloads are heavy or there are unexpected changes in patients' health status are seen as contributing to the group and supporting group members. Nursing students' sense of belongingness is mediated by the individual, interpersonal, contextual and organizational factors in their learning environments (Levett-Jones et al., 2007). The socialization of nurses and nursing students into their groups and the profession either support or hinder their development of a sense of belongingness (Levett-Jones et al., 2007; Teskereci & Boz, 2019). Nurses who can self-categorize as nurses and assume the attributes or prototype of the group develop a sense of belonging to the group.

Social Norms

Social norms are the implicit or explicit group rules specific to the acceptable behaviours, values, and beliefs of all group members (Aronson et al., 2019). For example, social norms need to be "social" (i.e., allow individuals to belong to groups); inform action-oriented decision making; affect people's health and well-being; and have positive and negative influences on group members (Legros & Cislaghi, 2020). Individuals must learn the values and norms of groups so that they can belong to and survive in them (Maltseva, 2018). These group norms or rules are learned by observing, communicating, and experiencing behaviours (Cialdini et al., 1991; Hogg & Reid, 2006; Shulman et al., 2017). The positive reactions of group members encourage individuals to behave according to group norms, but negative reactions to some

behaviours may result in individuals being ignored or disliked and may lead to individuals withdrawing from the group or profession. Group norms shape the social groups and contribute to the uniqueness of groups in developing a shared knowledge of prototypical and appropriate behaviours (Hogg & Reid, 2006). The following section provides details about descriptive and injunctive norms.

Injunctive and Descriptive Norms

Cialdini et al. (1991) discussed the role of normative rules in human behaviour. To understand the influence of norms on human behaviour, it is important to define the differences between how individuals see others behave around them (i.e., descriptive norms) and the rules that individuals know should direct their behaviour (i.e., injunctive norms; Cialdini et al., 1991; Lapinski & Rimal, 2005; Legros & Cislaghi, 2020; Shulman et al., 2017). Human behaviour is influenced by other individuals: families, friends, and groups. Individuals often are not consciously aware of how their behaviours are influenced by the people around them. We learn how we need to behave and act in ways that are socially acceptable so that we can belong to groups (Cialdini et al., 1991; Shulman et al., 2017). Norms rely on unconscious or implicit knowledge (i.e., we are not aware of) as well as conscious and explicit knowledge (i.e., we are aware of) that influence values, beliefs, and resulting behaviours. Individuals know that they need to follow the social norms of the groups that they want to belong to; otherwise, they may be ostracized (Cialdini et al., 1991).

Individuals who become nurses are required to work in groups and become members of health care teams. Although there is an overlap of expected behaviours or social norms between groups, individuals must be able to identify the social norms of their specific groups. Cialdini et al. (1991) asserted that the ability of social norms to influence the behaviour of individuals

depends not only on implicit and explicit group rules but also on the context. An example of injunctive norms for nursing are the values and beliefs learned through nursing education and clinical practice, such as respect for others, trustworthiness, maintenance of patient confidentiality, and reflective practice. These values and beliefs support nursing behaviours that demonstrate respect for patients, such as listening to their needs, concerns, and preferences; supporting them in accessing care; and responding to requests with interventions that support patient outcomes. When nurses' behaviours follow the rules of professional nursing practice and hospitals' expectations, nurses are identifying with injunctive norms, namely, their expected behaviours in practice.

On the other hand, descriptive norms are the behaviours that individuals in groups see other group members performing (Cialdini et al., 1991). For example, nurses know that the injunctive norms of the nursing profession and the organization are to avoid behaviours perceived as racist, such as stereotyping a particular group and treating all members as if they possess specific attributes. In such situations, nurses will tend to follow the descriptive norm of the group (i.e., unwritten rules specific to the group) to be seen as the same as their group, even if it is contrary to the injunctive norm. Individuals often will choose the behaviour that allows them to be accepted by the group; in this case, the descriptive norm gains them the approval of other group members (Cialdini et al., 1991; van Kleef et al., 2019).

In addition, context is very important to the activation of descriptive and injunctive norms. Research has demonstrated that individuals' behaviours are different when others are surveying the behaviours than when the individuals are on their own. For example, we may litter when no one is watching us, but we will not litter when we know we are being watched. The power of social norms to direct behaviours often lies in individuals being unaware that their

behaviours are being directed by the behaviours of others (Cialdini et al., 1991). Social norm development also is dependent on the length of time that group members have been together, the salience of the group's identity, and the possibility of social monitoring (Titlestad et al., 2019; van Kleef et al., 2019). Nurses' behaviours toward specific cohorts of patients as well as toward each other have been investigated by nurse researchers, but without the utilization of SIT and the social cognitive concept of social norms.

Social Norms and Nursing

Teskereci and Boz (2019) conducted a qualitative study to investigate the ways that first-year nursing students' clinical experiences supported the development of their professional socialization, behaviours, functions, and values using the framework of novice to expert developed by Benner (1984). In this framework, the progression of the development of professional identity from novice nurse to expert nurse is based on gaining experience, following the rules, learning the behaviours of nurses, and feeling like nurses. These outcomes reflect the definition of social norms in that they are the implicit or explicit group rules regarding acceptable behaviours, values, and beliefs of group members that can develop and change over time (Aronson et al., 2019; Titlestad et al., 2019). Norms are socially constructed rules that define what groups do or do not do, and they are the sanctions that maintain how group members behave together (Rimal & Lapinski, 2015). Investigating how nurses develop the social norms of their practices and whether they are consciously aware of the norms that direct their behaviours in practice as well as the factors influencing its development will build on understanding nurses' professional practices and help to develop a supportive program to retain nurses in the profession.

Tengelin and Dahlorg-Lyckhage (2016) examined nursing instructors' critical norms and concluded that understanding underlying accepted descriptive group norms will allow individuals to recognize norms that exclude or marginalize others. Tengelin and Dahlorg-Lyckhage supported the need for instructors to communicate information in ways that would influence the social norms of nursing students so that they would have a more critical perspective of nursing practice. The researchers stated that instructors were not always aware of how they were promoting different perspectives or biases toward the health practices of individuals. This result was significant because it highlighted the importance of making social norms conscious. The results also gave nurses insight into how group social norms and the ability to shape positive norms within the group may contribute to retention in the nursing profession. Nurses need to reflect consciously on the ways that they practice to fully understand how social norms direct how they behave and conduct their professional practices.

Reflection requires nurses to look explicitly at what they identify as norms in their nursing practices. It also requires nurses to acknowledge and communicate with others in work groups. Communication is important in forming and spreading the group norms among its members as well as members of other groups (Geber & Hefner, 2019). Although researchers (e.g., Geber & Hefner,2019; Hogg, 2018; Hogg & Reid, 2006) have identified communication 19as playing a role in the ways that individuals self-categorize as group members, identify with the attributes or prototypes of groups, and adopt the social norms of groups, communication has not been studied in the practice of nurses. The role of communication in the development of social norms remains unknown. Would communication underpin social norms, or would it be a factor influencing the process of social norm formation?

Communication

Researchers have identified communication as being important to the development of social norms (Hewitt et al., 2015; Hogg & Reid, 2006). Postmes (2014) explained that if group identity is salient, group members would expect to communicate in ways that make them understood by other group members. To understand how the social norms of nursing are communicated among nurses requires understanding communication and communication in nursing and in hospitals in particular. The following sections provide information about communication in general, communication in nursing, and informal and formal communication in organizations to facilitate an understanding of communication that may support or hinder social norm formation within nursing specifically as well as within organizations such as hospitals.

Definition of Communication

Communication is an essential skill that everyone needs. It is the way that people come to know each other to share a common understanding of self and society. According to the *Oxford Learners Dictionary*, communication is "the activity or process of expressing ideas and feelings of giving people information." The origin of the word communication is the Latin communicare, meaning to share, divide out; communicate, impart, inform; join, unite, participate in, literally "to make common," related to *communis*, "common, public, general" ("Communication," 2021). The definition and origin of the word indicate the power of communication in informing others of ideas and feelings that support the development of group identities through group norms.

The study of communication has focused on the ways people use verbal and nonverbal messages to produce meanings, such as the sharing of ideas and opinions within and between various contexts, cultures, channels, and media (Henderson & Barker, 2017; Keyton, 2017).

Although much of communication is meant to share information, it is not always an effective means of conveying messages. Barnlund (2008) postulated that communication is an evolution of meaning that there is a transactional (between individuals) process whereby the individuals receiving the communication interprets it to give it meaning that is relevant to themselves and based upon their experiences. From a transactional communication perspective, individuals involved in the communication process are not passive. They are receiving and sending messages; the communication is continuous (begins at birth or before and ends with death); and the meanings of the messages are constructed based on the individuals' knowledge, experience, and context (Barnlund, 2008; Manojlovich et al., 2015).

The transactional model of communication highlights the fact that communication is dynamic, such that individuals are constantly assigning meanings based upon past and present experiences. Another key concept of the transactional model is that communication is unrepeatable because other individuals will not find the same meanings in the messages that are being communicated. In sum, communication is very complex and is in constant improvement. There are many systems of communication, such as with oneself, the physical environment, with others face to face, organizational, and in other social contexts (Barnlund, 2008). Communication is required to create a common understanding between individuals; as such, people take an active role in explicitly and implicitly making sense of the social groups that they belong to (Ellis, 2006).

The importance of communication in nursing has been directed toward supporting individuals, families, and communities in meeting their health goals. The inability to communicate to come to a shared understanding may contribute to poor patient and intraprofessional outcomes regarding patient safety (Manojlovich, 2015) and teamwork (Hewitt

et al., 2015). In the following section, communication in nursing is examined in relation to nursing education and the definitions set out by the CNA (2015) and the CNO (2020, 2023).

Communication in Nursing

From a social cognition viewpoint, it is necessary to understand the language used in communication that facilitates the creation and exchange of meaning (Holtgraves & Kashima, 2008). The nursing profession uses a specific language to communicate patient information intraprofessionally (i.e., from nurse to nurse) and interprofessionally (i.e., with other health professionals). Nursing students, novice nurses, and experienced nurses learn this language by being immersed in the profession through education and practice (Hartrick Doane & Varcoe, 2021). Meaning is constructed by the individuals implicitly (i.e., from experience, not consciously remembered) and explicitly (i.e., consciously remembered, such as how to speak in relation to specific social contexts; Greenwald & Banaji, 1995). As individuals interact as members of social groups, they need to reflect on their understanding of the language and its effect on the meaning of communication as well as how others interpret their communication or the messages that they deliver.

The ability of nurses to communicate effectively in their professional practices is the result of their education and experiential learning (Benner et al., 2011). In the education of nursing students, much of the teaching around communication is directed toward the therapeutic nurse-client relationship and the ability of nurses to communicate patients' goals to the health care team and address the needs of patients concerning the context of illness and life situation (Gregory et al., 2020). Intraprofessional communication is taught during nursing students' education through their theory classes as well as their clinical and simulation lab experiences.

These experiences require that students have the ability to understand the language of nursing and act upon the information that they receive.

Guido-Sanz et al. (2019) conducted simulation experiences with advanced practice nurses (i.e., nurses with graduate education) to support student nurses in developing their communication skills. The student nurses felt more confident and understood their role in communicating patient information postsimulation (Guido-Sanz et al., 2019). The simulation facilitated collaboration between and among nurses in a safe environment that allowed the students to ask questions regarding how to communicate essential information (Guido-Sanz et al., 2019).

Professional nursing organizations such as the CNA and the CNO have outlined the need for collaboration in nursing practice. The CNA (2015) defined the practices of nurses as being autonomous and collaborative. Throughout the CNA's framework, neither collaboration nor communication is defined, even though the requirements for collaboration are discussed. These requirements are knowing and understanding the scope of practice of RNs, the scope of practice of interprofessional team members, and patients and families. The framework does not directly review intraprofessional communication (i.e., RN to RN), but it does refer to interprofessional practice and collaboration with other health care providers (CNA, 2015).

Education and experience contribute to the ability of nurses to communicate and collaborate with other nurses, patients, families, and members of the health care teams. The CNO (2020) mentioned communication and collaboration in its document on entry to practice. Throughout the CNO's (2019) document on mapping the code of conduct to the practice standards and guidelines, nurses are described as communicators: They must be able to establish a therapeutic relationship to identify patient concerns, share information, provide care that

improves health outcomes for patients, and act as collaborators who provide optimal care to patients. Nurses are expected to use communication skills throughout their professional practices. Communication has been discussed concerning outcomes such as collaboration, improved patient care, therapeutic nurse-patient relationships, and intra- and interprofessional collaboration (Foronda et al., 2016).

Simmonds et al. (2020) conducted a scoping review of teaching practices in nursing education that supported the formation of nursing students' professional identity. Their review identified five components of professional identity formation supported by nursing education: nursing knowledge and skills, professional nursing role, beliefs and values, belongingness, and personal attributes. Although Simmonds et al. noted the interconnectedness of professional identity to personal identity, relational identity, and professional practice, they did not link it to the communication within student nurses' practices. They identified the ability of student nurses to reflect on their practices to support their professional identities as nurses. This leaves us wanting to know how nurses form their professional identity.

Schools of nursing are beginning to put more emphasis on the skills required to develop relationships based on relational practice. Thus, nurses can continue to question what they and others bring to the relationships and how their values and beliefs impact themselves and others (Hartrick Doane & Varcoe, 2021). Nursing education, clinical experiences, organizational expectations, professional associations, and standards of practice all contribute to the knowledge of the ways that members of the nursing profession communicate with each other and the understanding of the language of nursing. As a nursing professor, I understand the importance of communication in the profession. I see intra- (i.e., between nurses) and intercommunication (i.e., with other professionals) as paramount to building therapeutic relationships, participating in

patient conferences, and giving and receiving reports. However, nurses and other health care providers must be able to understand and communicate with each other in ways that facilitate their therapeutic relationship with each other and support their desire to stay in the profession.

With two thirds of RNs comprising the workforce in Canadian hospitals, it was necessary to examine organizational communication structures and channels as a possible facilitator of the development of social norms in nursing groups. In the next section, organizational communication is defined, and the literature on communication is discussed.

Formal and Informal Communication in Organizations

Brewer and Westerman (2018) defined organizational communication as "the study of the process of creating meaning and understanding through coordination of the verbal and nonverbal communication within and between organizations" (p. 4). Organizational communication links individuals to simplify the creation of relationships necessary to meet the goals of employees and the employing organizations (Duncan & Moriarty, 1998). Peers and coworkers engage in communication relationships by providing important information resources to each another. Communication happens for a variety of reasons: (a) share information, (b) structure and control information, and (c) negotiate and coordinate activities (Keyton, 2017). For messages to be understood, there needs to be a common understanding of roles and knowledge.

Employees often rely on information from peers to a greater degree than information garnered from organizations (Xie et al., 2020). Coworkers also provide social support to one another because they share a unique understanding of the work tasks and the workplace environment (Streeter et al., 2015). Nurses are at the center of patient care, and difficulties in communication with other health professionals may occur because of a lack of understanding of the scope of others' practices, overlap in practices, concept definitions between health care

professionals, and the context of the interactions (Aydon et al., 2014; J. J. Moreland & Apker, 2016). Communication in organizations can contribute to misunderstanding the roles of others. Organizations have attempted to decrease the ambiguity of roles and expectations of workers through informal and formal communication channels (Brewer & Westerman, 2018).

Hewitt et al. (2015) completed a realist synthesis of 109 articles examining the influence of communications on the development of interprofessional team behavioural norms. A realist synthesis is a type of literature review used to evaluate complex social interactions that requires an examination of the literature for underlying theories, various outcomes, and contexts of concepts such as teamwork (Hewitt et al., 2015). The results of Hewitt et al.'s study identified four mechanisms involved in teamwork: open and equitable communication, shared information required to accomplish tasks, shared responsibility and influence among groups, and shared behavioural norms. Hewitt et al. found that new group members had difficulty recognizing the implicit norms of the groups but that communication of these norms by other members of the groups made them explicit and allowed the new members to feel that they had the support of the group members and were able to work together. This communication of social norms was presented informally between and among group members or formally by leadership.

Organizational communication is a complex and ever-present process that is necessary for the coordination of individuals' activities and organizational outcomes (Postmes, 2014). Communication inside organizations can manifest in diverse ways: It can be top down (management to employees), bottom up (employees to management), or horizontal (between all groups). It can be at the interpersonal, group, or corporate level. It can relay information, be persuasive, regulate activities and behaviours, direct tasks, maintain structure and human and relational interactions, and stimulate innovation. It can occur through formal and informal

channels. For this study, I defined formal and informal channels of communication in relation to nursing practice.

Researchers have discussed formal and informal communication channels or structures in organizational communication as supplying different types of information to the individuals in the organizations (J. D. Johnson et al., 1994; Keyton, 2017). Understanding how formal and informal communication is understood and affects intraprofessional communication in nursing is essential to the ability of nurses to practice effectively; each will be reviewed next.

Formal Communication Channels

Formal organizational communication has been defined as a structured process driven by organizational goals (Keyton, 2017). Researchers have identified formal communication within the organizational structure of job roles and responsibilities as a top-down, or vertical, movement of information (J. D. Johnson et al., 1994; Kandlousi et al., 2010). New technologies such as the implementation of electronic health records and computerized charting in health care often are formally instituted to address the flow of information. These forms of communication and information storage are an attempt to share pertinent information across disciplines to improve the continuity and consistency of shared information leading to safe patient care (Ernst et al., 2017; Wagner et al., 2015).

Formal communication in the hospital setting requires nurses to follow organizational policies, including how they chart; give reports; and interact with interdisciplinary teams, physicians, patients, and families (Foronda et al., 2016). Nursing has been constrained by policies in the hospital setting relating to how much they need to chart, how much time they can take to give information to oncoming nurses (shift handoff), and how they can communicate with other departments (Ernst et al., 2017). Ernst et al. (2017) interviewed a sample of nurses and

found that shift handoffs were complicated and that the nurses needed to understand the context of the units. In addition, the incoming nurses needed to first review the electronic medical records and have knowledge of the patients' previous medical issues, family concerns, and present assessments. The outgoing nurses were required to communicate the patients' conditions and concerns over the time that they cared for them. The hospital often restricted the amount of time allotted to shift handoffs, limiting the amount and quality of information that the nurses could share.

As research focusing on communication has shown, the loss of this face-to-face report handoff has meant not only a decrease in the information transferred to the incoming nurses but also a loss of mentorship (Bambacas & Patrickson, 2008; Streeter et al., 2015). Streeter et al. (2015) highlighted the need for face-to-face communication between nurses during handoff at the end of shift to enable the nurses to clarify information and identify interventions to support patient care. Formal communication channels can either support or block effective communication between and among nurses.

Informal Communication Channels

Informal communication is the sharing of information between and among employees for social and work-related purposes (Kandlousi et al., 2010). Informal communication, also referenced as horizontal communication, includes informal networks (Wagner et al., 2015). When employees feel that they are not receiving sufficient information from formal channels in the organizations, they turn to informal channels of communication with each other and from other sources such as the internet (J. J. Moreland & Apker, 2016). Papa et al. (2008) asserted that informal communication is an inherent part of organizational structure and is always occurring, not simply in times of ambiguity. Informal nurse-to-nurse communication is not planned; rather,

it often occurs in hallways, lunchrooms, and nursing stations, and it has been shown to have an impact on patient outcomes and nurses' satisfaction with communication (Wagner et al., 2015). Informal communication in the hospital setting is not easy to see or track because it occurs throughout nursing shifts and is not planned or documented.

Informal communication, which can play an important role in the development of social identity and group cohesiveness, has been examined by researchers studying gossip and grapevine activity in organizations (Altuntas et al., 2014; Crampton et al., 1998; Mills, 2010). In the nursing profession, it is essential that nurses not only understand the language of the profession but also develop sociopragmatic skills, such as what and how to say things and exhibit nonverbal behaviours, to engage appropriately in conversations with coworkers (Woodhams, 2014). Daily informal conversations between and among nurses that allow them to share information about their workgroups, the profession, and expectations of nurses in practice contribute to the development of nurses' social identities (Willetts & Clarke, 2014). Communication contributes to individuals identifying as members of groups as they build their knowledge of the language and use of jargon through which all group members communicate with each other (Holmes & Woodhams, 2013). Hogg (2018) also confirmed the existence of "norm-talk" that occurs between and among group members to build their identification with the groups.

The social identity perspective allowed me to examine informal communication from the perspective of individual and group influences (Postmes, 2014). Postmes (2014) hypothesized that if groups have a shared sense of future direction driven by shared norms reflecting group-specific values, rules, and beliefs, the group members are expected to share a common language. Salient identification with a group identity brings with it a sense of "we-ness," meaning that

group members implicitly and explicitly understand what is normative and antinormative in their groups (Postmes, 2014). Groups actively engage in collective sense making to reduce uncertainties and define the group norms (Hogg, 2018; Hogg & Reid, 2006; Postmes, 2014). Informal communication between and among group members facilitates the exchange of information about the social identity of the groups; who they are; what it means to be members of the groups; and the groups' norms, beliefs, and values (Hogg & Gilles, 2012).

This link between social norms and the practice environment was evident in R. L. Moreland et al.'s (2012) assertion that the socialization of individuals in organizations occurs primarily through informal communication with peers and supervisors in the workplace. They also stated that individuals new to the workplace monitor the behaviours and outcomes of other workers, gain feedback from others about their performances, and collaborate with peers. According to SIT, individuals need to feel that they belong to groups by understanding the values, beliefs, and expected behaviours of the groups so that they become accepted members (Haslam, 2014; Hogg & Terry, 2012; Tajfel, 1982; Turner, 1982). Knowing the social norms of groups of nurses will contribute to understanding how the individuals make sense of each other in the workplace, how they identify with others, and how they assume group norms (Rimal & Lapinski, 2015). New group members, therefore, need to learn the social norms of the groups that they have joined.

There has been a paucity of research into the ways that nurses informally communicate with each other during their day-to-day practices and how this informal style of communication impacts the development of social norms. Wagner et al. (2015) studied informal communication between managers and nursing staff. They found that informal communication between and among nurses, such as "grapevine" communication with the same level of employees for the

purposes of sharing information about emergencies and organizational policies, was not well developed, leading to the nurses feeling dissatisfied with the how they received information. Communication satisfaction and the ability to relate to others have been identified in the research literature as supporting a collaborative workplace environment, resulting in improved patient outcomes, nurses' intentions to stay in the profession, and the organizational ability to recruit new nurses (Duddle & Boughton, 2007; Wagner et al., 2015). Informal feedback from managers to nurses was seen by the nurses as improving their overall job satisfaction and the work environment (Wagner et al., 2015).

There has been a gap in the literature regarding what informal communication between and among nurses is, how it is accessed by nurses at work, and how it affects the group social norms and the outcomes of their practices. Communication plays an essential role in group members developing a sense of the group norms, along with their own and others' prototypicality in the groups and their own social identities as group members (Hogg, 2018; Hogg & Reid, 2006). The connections among social identity, social norms, and communication provided direction in understanding the role of informal communication in the formation of social norms in nurses' day-to-day practices.

Connecting SIT, Social Cognition Theory, and Informal Communication to the Process of Group Social Norm Formation

SIT and the concept of social norms can support research providing a more comprehensive understanding of the factors in nurses' practices that affect group values and beliefs, group behaviours, and the development of professional identity. Factors such as communication (Hogg, 2018; Holmes & Woodhams 2013; Rimal & Lapinski, 2015) may play a significant role in the development of the social norms of groups resulting in outcomes such as

positive work environments and patient outcomes. This knowledge served as the foundation allowing me to develop a substantive theory to explain the process of social norm formation and the factors contributing to or constraining social norm development in nursing groups working in the hospital setting. Communication and the meanings developed by nurses are essential for them to be able to self-categorize as belonging to a particular group such as one's team of nurses at work and then integrate the norms, values, and beliefs of that group into daily interactions with other nurses. Postmes (2014) explained that communication is the link between social identity and social reality. Scott (2007) contended that communication plays a significant role in the strength of social identities in different contexts.

Context is significant to the ways that individuals make salient the norms that they enact (Cialdini et al., 1991). Examining nurses' perceptions of the social norms of their professional practices provided insight into the ways that context may affect the activation of social norms. Once nurses develop social norms such as trust, respect, and reflective practice that are aligned with their values and beliefs, their work environment becomes more conducive to high job satisfaction and their willingness to stay in the profession. Several researchers who have examined social identity and communication have indicated that all is not well in the practice of nursing and that incivility, conflict, and stereotyping have had an adverse effect on the practice of nurses and the outcome of patients, and often are related to organizational structures and expectations (Lazzaro-Salazar, 2017; J. J. Moreland & Apker, 2016; J. J. Moreland et al., 2015) that may contribute to job dissatisfaction and withdrawal from the profession.

SIT and the literature on social norms have provided a better understanding of the ways that people identify with and align their behaviours to match those of other group members. Communication between and among group members contributes to the development of implicit

and explicit social norms that guide the behaviours of all group members (Hogg, 2018). The development of group social norms is influenced by the individuals in the groups, the strength of the members' social identities, and how prototypical the individuals see themselves in relation to the other group members (Hogg, 2018; Hogg & Reid, 2006).

Using the constructivist grounded theory approach allowed me to draw upon my own professional knowledge, academic knowledge, and professional experiences to begin my research process. The caveat in using a constructivist grounded theory approach is that researchers must acknowledge that they are part of the research process and are involved in the construction and interpretation of the data (Charmaz, 2014, 2020). Understanding the process of social norm formation of nurses working in groups will add to current knowledge that may support nurses by positively influencing the decision to remain in the profession.

Chapter Summary

This chapter situated nursing practice within the competencies of relational practice, which exposed the values and beliefs of the nursing profession and supported the ethical standards outlined by the professional bodies of nursing practice. Many nurses work in hospital and community settings where they are expected to follow the standards of practice of the profession. Through education and practice, nurses develop their own professional identities, but little is known about the development of group social norms among nurses and their impact on individuals identifying as nurses. Individuals' self-categorization and ability to identify what it is to be a prototypical group member leads to the formation of social norms specific to the group. The impact of social norms on the ability of individuals to belong to groups has been identified in the literature (e.g. Cialdini et al., 1991; Maltseva, 2018), but no theory has been developed to explain how social norms are formed in nurses' groups in the workplace. Group social norms or

rules are implicit as well as explicit, making them complex for group members to learn, despite being essential to the ability of nurses to identify as such. Identifying the development of group social norms will broaden the current understanding of how to better support nurses in manifesting behaviours that are supportive and contribute to nurses' sense of belongingness and connection to their groups and profession.

The concepts of SIT (i.e., self-categorization, prototypicality, and belongingness) helped to explain how individuals begin to identify with groups by seeing themselves as having the attributes of the groups or developing the attributes common to group members so that they fit into the groups. Group social norms are the rules that affect group members' behaviours (Cialdini, 2007). Missing from the literature is information specific to the process of group social norm formation and the factors such as communication that impact how social norms are learned and affect the behaviours of nurses working in groups.

I used a constructivist grounded theory methodology to develop a substantive theory to explain the process of social norm formation in groups of nurses. One RQ guided this study: What theory explains the process of social norm formation and the factors facilitating or limiting social norm development in nursing groups working in health care settings? Nursing groups referred to nurses working in groups on units in the health care setting. The following subquestions support the central RQ:

1. What are the components, or the systems of the rules and observations, that comprise the social norms of a group of nurses?
2. How do the social norms of a group of nurses develop?
    a. What factors contribute to or constrain the development of social norms?

b. What is the role of informal and formal communication in the development of group social norms?

3. What are the impacts of the group's social norms at various levels?
    a. How do the group's social norms shape nurses' social identity?
    b. How do the group's social norms impact the work environment?
    c. How do social norms affect how nurses perceive the profession as a whole and their decision to remain in the profession?

CHAPTER 3: RESEARCH METHODOLOGY

Chapter Outline

This chapter provides an overview of the research methodology and rationale for the selection of a constructivist grounded theory methodology to address the RQ: What theory explains the process of social norm formation and the factors facilitating or limiting social norm development in nursing groups working in health care settings? Also included in this chapter is a discussion of the use of symbolic interactionism as the framework used to investigate the development of social phenomena such as social norms within the practices of nurses. I then explain the reasons for choosing the theoretical frameworks and concepts used in the study based on my analysis of the research literature, my own experiences in nursing practice and research, and my philosophical beliefs. Information about the study design; recruitment and selection of the participants; the influence of social, cultural, and historical factors on the context in which the participants worked and lived; use of theoretical sampling; data collection (semistructured interviews); data analysis (coding, memos, theoretical sampling, categories, theoretical concepts); and integration of memos in developing a substantive theory complete the chapter.

Selection of Constructivist Grounded Theory

I chose to use constructivist grounded theory as the methodology for this study because it allows researchers to obtain information about their study participants' experiences and understand the contextual influence on those experiences (Charmaz, 2020). Researchers must remain reflexive and document decisions made during the research process so that they are transparent to the reader (Charmaz, 2014). Understanding the theoretical and substantive literature regarding relational practice in nursing, SIT, social norms, and organizational

communication, as well as acknowledging how this knowledge may have influenced the research methodology, demonstrated the reflexivity that I developed while completing this study.

Grounded theory assumes a qualitative epistemology situated in pragmatism and supported by the framework of symbolic interactionism (Charmaz, 2014, 2020; Charmaz & Thornberg, 2021). Developing a theory that explains the progress of the development of social norms in nursing practice required asking a sample of nurses how they formed and identified the norms of practice in their day-to-day work. In the practice of nursing, the factors that facilitate or limit the development of norms and nurses' social identities remain unknown. Using the lenses of relational practice, SIT, social norms, and communication theory will contribute to understanding the behaviours of nurses working in groups and identify how social norms either support nurses to remain in the profession or influence their decision to leave nursing.

To date, there have been no published articles on the process of social norm formation or the factors influencing the social norm formation of nurses working in groups in the hospital and other health care settings. The lack of literature surrounding social norm formation in nursing groups, as well as the barriers to and facilitators of social norm formation, has led to a gap in current understanding of what shapes nursing practice and what influences nurses to remain in the profession. This gap supported my choice of constructivist grounded theory to identify the process of social norm formation of nurses working in groups in the health care setting.

My own experience in practice has made me question how groups of nurses develop norms of practice and what the impact of these norms are on the behaviours of nursing groups in hospitals and other health care settings contributing to my choice of constructivist grounded theory. As such, I brought my experiences and knowledge as a nurse and researcher to complete this study. Within the constructivist paradigm, researchers must acknowledge their previous

knowledge, values, and beliefs, all of which impact their interactions with their participants as well as the analysis of the collected data (Charmaz, 2020; Lincoln et al., 2011).

I chose to use constructivist grounded theory as a framework to examine the process of social norm formation of nurses working in groups. Charmaz (2014) identified the process of constructing grounded theory by stating that "we are a part of the world we study, the data we collect, and the analysis we produce" (p. 17). Constructivist grounded theorists are immersed in the data and are constantly collecting, interpreting, and analyzing the data while recognizing their own biases, which are impacted by where they are situated in particular times, places, and situations contributing to the construction of the theory (Charmaz, 2014). As a researcher, the premises of symbolic interactionism that our meanings are constantly being impacted by our experiences, constructed from these experiences, and affected by the context in which they occur, resonated with my experiences and how they have affected my beliefs and values.

Glaser and Strauss (1967) developed the grounded theory methodology, which required the use of constant comparative methods to develop a theory grounded in the data. Charmaz (2014) described constructivist grounded theory as using constant comparative analysis while recognizing that researchers and the participants construct a reality based on what they both bring to the experience and what they do within it. Constructivist grounded theory has given researchers the flexibility of choosing a methodology that is reflective of their worldviews and the question to be researched (Lauridsen & Higginbottom, 2014).

In Glaser's (2007a) grounded theory, he explicated that the data obtained from the participants depends on the experiences and the contexts of the individuals. Researchers then analyze and compare all of the data (Glaser, 2007a). In classic grounded theory, as in constructivist grounded theory, the constant comparison between the data and the analysis

supports the development of theoretical coding, substantive coding, and the application of theoretical sampling to reveal the abstract development of theory. Glaser felt that abstraction allows researchers to focus on the data rather than on their construction of or interactions with the data so that they can maintain objectivity.

The procedures used by Glaser (2007b) to develop grounded theory were to maintain researcher objectivity and subsequent development of a substantive theory (specific to the participants and modifiable) or a formal theory (developed from the core categories of multiple substantive theories using the conceptualizing constant comparison method). Maintaining researcher objectivity is where Charmaz and Glaser disagreed. Charmaz and Thornberg (2021) included the researcher as an active part of the research process in the construction of grounded theory, whereas Glaser felt that the researcher should not be constructing a theory but developing a theory that was grounded in the data collected from the participants. I felt that as the researcher, I was not an objective bystander; rather, I had an active role in conducting the research, interpreting the data, and constructing the final theory (Charmaz & Thornberg, 2021).

As the researcher of this study, I brought experience from my own nursing practice of more than 45 years, my education, and my life experiences that led me to want to examine how nurses develop the social norms of the groups in which they work. Charmaz (2014) discussed use of the term “constructivist” (p. 14), noting that using this approach requires researchers to be embedded in the social lives of their study participants, gather data, and then analyze the data. As a researcher using a constructivist grounded theory methodology, I recognized that I constructed the theory from the data based on my past and present experiences, my interactions with the participants, and the meanings gleaned from these interactions (Charmaz, 2014).

Constructivist grounded theory is concerned with how people develop meaning in their life and how they act based upon the context in which they are located (Charmaz, 1990, 2014, 2017; Charmaz & Thornberg, 2021). To understand the development of social norms within nursing practice, the nurses were asked about their experiences in clinical practice and were encouraged to share how they came to know the norms of practice and how these norms influenced their interactions. The very act of interviewing or asking questions of their study participants plants researchers firmly within the interactions, and this new experience of researcher and participant affect what is revealed and the ways that it is analyzed (Charmaz, 1990, 2014, 2017; Charmaz & Thornberg 2021). This methodology requires researchers to be reflexive, identify why questions are asked, and know how decisions concerning the data are categorized. It is an inductive process that acknowledges multiple social realities (Charmaz, 2017).

My Philosophical Assumptions and Interpretive Framework

As a White, cisgender female nurse, I brought my own nursing practice experiences, the knowledge that I obtained from completing a master of science in nursing degree, and my progression toward a doctoral degree in psychology to this study. As a researcher, I had to acknowledge my philosophical beliefs and experiences so that I could be reflexive and explain how my experiences could have impacted the research (Charmaz, 2014, 2017; Charmaz & Thornberg, 2021; Creswell & Poth, 2018). Over the past 45 years as a nurse, my experiences have influenced how I have viewed the profession of nursing. I have seen changes in practice and the evolution of the nursing profession that have affected the ways in which I have interpreted my own experiences. I have practiced on a burn unit and an intensive care unit. I have been a nurse educator in critical care, a clinical and lab instructor, and a faculty member in a

school of nursing. I chose to use the framework of constructivist grounded theory to develop a substantive theory to explain the process of social norm formation and the factors facilitating or limiting the social norm development of nurses working in groups in the health care setting.

My experiences have contributed to my philosophical beliefs and assumptions, which I feel have been constructed by realities based on interactions with others and the meanings attributed to them (Charmaz, 2014). Assumptions can change over time and are directly influenced by the experiences, interactions, and the meanings created by these interactions. The meanings that we incorporate into our identities shape our beliefs and actions and are influenced by the context in which they occur (Blumer, 1969). As a researcher, I believe that we must reflect and acknowledge these changes and their impact on our worldviews.

Once researchers can reveal their preconceived ideas and the ways that these ideas may impact their interactions and analysis of the research, they are said to have "methodological self-consciousness" (Charmaz & Thornberg, 2021, p. 316). I believe that our experiences and the context in which they occur shape our understanding of how we fit into the world. Being reflective of their decisions, values, and beliefs before, during, and after the research process allows researchers to challenge their initial understanding of the data and facilitate defining and creating critical questions (Charmaz & Thornberg, 2021; Creswell & Poth, 2018). This flexibility in the research methodology allows researchers to ask probing questions to further understand the experiences of the study participants. My previous experience contributed to my having a deeper understanding of nursing practice that allowed me to reflect on my taken-for-granted beliefs that could have implicitly influenced the question development, collection of the data, analysis, and theory development (Charmaz, 2014).

Symbolic Interactionism: The Philosophical Underpinning of Grounded Theory

Symbolic interactionism is both a theoretical and a philosophical perspective situated in the belief that individuals' actions lead to the construction of self, situation, and society that was initially described by George Herbert Mead and later named and made accessible by his student Herbert Blumer (1969; Charmaz, 2014; Oliver, 2012). Symbolic interactionism is a perspective based on the principles of social psychology that individuals behave toward things based on the significance of those things for them (Blumer 1969; Oliver, 2012). In this theoretical perspective, there is an assumption that language and symbols play a crucial role in the formation and sharing of meanings, actions, and interactions with others. Critical to this perspective is the understanding that individuals' interpretations and actions are reciprocal with others, meaning that people act in response to how they view their situations (Charmaz, 2014). The meanings of context and interactions change for researchers and participants, thus suggesting a temporality to meanings based on interpretations of present and past interactions (Charmaz, 2014).

The guide of semistructured questions (see Appendix A) that I developed in collaboration with my dissertation committee members to conduct the interviews moved the participants temporally from the time that they self-categorized as having the attributes of nurses to their present experiences when they practiced nursing in groups and how they saw themselves in practice in the future. Their past and present experiences created the meanings that the experiences had for them in their daily practices. Therefore, the dynamic nature of symbolic interactionism aligned well with this study examining the process of social norm formation by nurses and the factors affecting and limiting its development in nursing groups. Charmaz (2014) acknowledged the important decision made by Strauss to incorporate symbolic interactionism into his version of grounded theory, thus bringing a different lens through which to collect,

analyze, view, and identify new theoretical questions to clarify the analysis of the collected data. The ability of researchers to be open to the experiences of their study participants, explore their experiences and their meanings, and inspect and analyze these experiences makes symbolic interactionism and constructivist grounded theory well suited (Blumer, 1969; Charmaz, 2014). Combining constructivist grounded theory and symbolic interactionism provided insight and direction in exploring the concept of social norm development because social norms are rooted in all human social interactions and the ways that individuals interpret and respond to situations and groups (Blumer, 1969; Charmaz, 2014; Hogg & Reid, 2006).

Research examining the development of social norms within nursing groups has been scant. Using symbolic interactionism gave me a framework to formulate adequate interview questions to ask the nurses about the process of social norm formation in their work groups. Social norms, which form the rules directing how group members work together, can change, demonstrating the temporality of group social norms. Making visible the process of social norm formation may help to better support and retain nurses in the profession.

Blumer (1969) described three premises of symbolic interactionism:

> 1) Human beings act toward things on the basis of the meanings that things have for them, 2) The meaning of such things is derived from, or arises out of, the social interactions that one has with one's fellows, 3) These meanings are handled in, and modified through an interpretive process used by the person in dealing with the things he encounters. (p. 2)

The premises of symbolic interactionism link well with those of social identity and social norms. Individuals' identification with groups and learning the norms of the groups are based on their understanding of how they self-categorize (i.e., identify with the characteristics of the group) as part of the group and how they learn through interactions and observations and experience what the rules or group social norms are (Aronson et al., 2019; Hogg, 2018; Turner,

1982). Together, SIT, social norms, and symbolic interactionism have offered perspectives on the ways that individuals take an active role in constructing their own realities based on their interactions with others. Symbolic interactionism relies on language, communication, and interactions with others for individuals to develop their meaning of society, reality, and themselves (Charmaz, 2014). The interview questions for this study incorporated SIT, the social cognitive process of social norm development, communication, and symbolic interactionism to focus on the process of social norm formation of nurses working in groups and the impact of these norms on nurses themselves, their work, and their retention in the profession.

Ethical Considerations

Initially, solicitation of the sample for this study was directed toward nurses working in two hospitals in northwestern Ontario. I sought and received ethics approval from Lakehead University's Research Ethics Board (REB; see Appendix B) initially because the university and the two hospitals had a reciprocity agreement depending on the data requirements for the research. I sent potential participants (i.e., eligible nurses) an email recruitment letter through their hospital email accounts to describe the study, solicit their participation, and provide my contact information. I sent a follow-up email to all eligible nurses 2 weeks later to encourage their participation. This first recruitment attempt saw no volunteer participants come forward. An amendment (see Appendix C) was approved by Lakehead University's REB for the additional use of social media platforms to recruit nurse participants working in the health care setting in northwestern Ontario.

To maintain the privacy of the participants and not reveal their identities, I recorded and assigned codes to the interviews prior to their being transcribed verbatim by a professional transcriptionist. In addition, I was the only one who had access to the codes. The research data

were presented in a way that did not identify any of the participants, thus maintaining the privacy and anonymity of all 19 nurses. The participants were informed of the process to maintain their confidentiality and that they would be able to withdraw from the study at any time without penalty. They also were advised that they could withdraw their interview responses up until 2 weeks postinterview. The interview recordings are being kept on an encrypted and secure computer hard drive. I will store the data in a locked cabinet for 5 years, as per REB requirements, after which time they will be destroyed.

Study Setting and Recruitment of Participants

Nurses working in groups in the health care setting in northwestern Ontario were invited to participate in the study. These settings were initially chosen because the purpose of the study was to develop a substantive theory explaining the process of social norm formation by nurses working in groups in health care and the factors that facilitated or inhibited social norm formation. The following criteria also determined eligibility to join the study: presently working in health care for at least 3 months, 18 years of age or older, able to speak and read English well, willing to take part in a reflective process and narrative regarding their development of the group social norms of practice, and willing and able to sign the consent. The recruitment letter sent to all the nurses in the two hospitals that agreed to participate in the study resulted in no nurses volunteering to take part in the study. One of the hospitals serves a population in northwestern Ontario of more than 250,000 residents. The hospital has 375 acute care beds, offers a wide range of specialist services, and is designated an academic health sciences center. The second hospital has 37 inpatient beds: 15 acute care beds, 15 long-term care beds, and seven chronic care beds.

The recruitment started once Lakehead University's REB approved the study, I contacted the chief nursing executives at both hospitals to explain the study and request permission to send an email information letter and a recruitment poster to all RNs and registered practical nurses (RPNs) working at the hospitals. I also presented the study to the board of directors at the one of the hospitals and received their approval to commence the study at the hospital. No RNs or RPNs responded to the initial email request, so I submitted an amendment to the REB to recruit RNs and RPNs through social media platforms such as WhatsApp and Facebook and received approval to change my recruitment strategy.

In this new recruitment strategy, I created a poster and sent it to a WhatsApp group for nurses. Potential participants showing interest in taking part in the study contacted me; I sent them the information letter and consent via their email. Individual Zoom interviews were scheduled at times convenient to the participants once they had read the information letter and signed the consent. Each participant and I reviewed the consent, and I answered any questions that the participant had. The participant verbally agreed to the consent and sent a signed copy of the consent, which is stored in a locked file cabinet, to my email at Lakehead University. The snowball sampling resulted in 19 participants working in the health care setting joining in the study.

Population and Study Sample

The sample comprised 17 RNs and two RPNs who were working in groups in the health care setting in northwestern Ontario. The 19 participants (Note: The pilot study participant was one of the 19 participants in the main study) had experience ranging from 2 years to 49 years of working in groups. Their ages ranged from 25 to 69 years. Of the 19 participants, 18 self-identified as female, and one self-identified as male. The areas of practice were diverse:

medical/surgical (*n* = 2), neurology (*n* = 1), dialysis (*n* = 1), intensive care (*n* = 3), gerontology (*n* = 1), ambulatory care (*n* = 4), oncology (*n* = 2), medicine (*n* = 3), corrections (*n* = 1) and addictions (*n* = 1). Because I was attempting to develop a substantive theory of the process of social norm formation within nursing groups, the study was open to all RNs and RPNs working in health care in groups.

As a nursing researcher in a smaller community and a teacher in the school of nursing, I understood that I may have recognized some of the study participants. Ten of the participants knew me in my capacity as a teacher. This relationship may have impacted the experiences that they chose to share with me. I did not work with any of the participants in a "power over" role.

Potential participants emailed me directly after reading the recruitment poster to volunteer to take part in the study. I reviewed the information and consent with them prior to inviting them to join the study. I also explained the procedures to maintain their privacy and confidentiality, as outlined in the consent. They indicated that they understood that they could withdraw from the study at any time without any repercussions. None of the participants chose to withdraw from the study.

Purposive, Snowball, and Theoretical Sampling

I used purposive, snowball, and theoretical sampling. Purposive sampling was used to recruit nurses who met the eligibility criteria, snowball sampling allowed the participants to ask colleagues if they would be willing to participate in the study, and theoretical sampling was used to guide the simultaneous process of data collection and analysis. Purposefully selecting nurses who had experience working in groups helped to inform an understanding of the process of social norm formation (Creswell & Poth, 2018). Snowball sampling gave me access to other potential participants through nurses who had already been interviewed for the study and who

forwarded the recruitment poster to other nurses. Researchers use theoretical sampling to achieve saturation of each category and concept emerging in the theory. Applying theoretical sampling requires researchers to constantly collect and reflect on the data to find categories that are contributing to the development of an emerging theory (Charmaz, 2014; Creswell & Poth, 2018).

As researchers discover the categories through constant reflection and analysis of the data, they can develop an overall understanding of the developing theories. To confirm that the emerging categories support the developing theories, researchers go back to the participants with further specific questions regarding these categories (Charmaz, 2014). Purposive and theoretical sampling techniques are essential in giving researchers ways of developing explicit theoretical categories arrived at through the iterative process of analysis and reflection on the experiences of the participants that guide data collection (Butler et al., 2018; Charmaz, 2014).

Theoretical sampling is unique to grounded theory (Charmaz, 2014; Glaser & Strauss, 1967). This technique allowed me to be open to developing categories within the data from the participants as I constantly collected, examined, reflected on, and analyzed the data to see if new categories arose (Charmaz, 2014; Glaser & Strauss, 1967). I did not see any new categories emerging from the data as they were collected from the 19 participants. Theoretical sampling was critical to the conceptual and theoretical development of my analysis of the data (Charmaz, 2014). As such, theoretical sampling continued until no new data were found that could have added new properties to the categories of the theory.

Theoretical saturation of each category and concept guided the number of participants in the sample for this study. Within the literature, the number of participants in grounded theory studies has ranged from as few as eight to hundreds, with data collection using observation, documents, and in-depth interviews touching on topics from homelessness to chronic disease

(Charmaz, 2014; Glaser & Strauss, 1967). Theoretical saturation is the point when no significant new insights from data can be more clearly described or can identify new categories, or contextualize the categories that have emerged from data (Charmaz, 2014). Theoretical saturation was reached at 19 participants (Charmaz, 2014; Glaser & Strauss, 1967; Morse, 2007).

Data Collection, Management, and Analysis

Focusing on simultaneous data collection and analysis is a hallmark of grounded theory research. This focus allows researchers to be grounded continuously in the data, identify early ideas emerging from the data to support the evolving theory, and inform further data collection (Charmaz & Thornberg, 2021; Glaser & Strauss, 1967). Data collection, management, and analysis within a constructivist grounded theory approach rely on the methodological self-consciousness of researchers to be reflexive of themselves and the research processes, as well as the experiences of the participants and the researcher to reveal taken for granted beliefs of the researcher (Charmaz, 2014, 2017; Charmaz & Thornberg, 2021). The aim of methodological self-consciousness is to allow researchers to acknowledge that their own positions, privileges, and priorities affect how they conduct their studies as well as the relationships developed with the research participants (Charmaz, 2014, 2017). For example, in my study, my experience as a nurse could have biased my analysis of the data. By continuously reflecting on and questioning why I identified codes and categories, going back to the participants' data for confirmation, and asking probing questions in the next interviews, I preserved and stayed true to the participants' experiences in the emerging theory.

The use of memo writing throughout the research process from question generation to the development of a grounded theory is connected to the reflexivity and insights of the researcher into the theory construction. The reflexivity of the researcher contributes to the iterative nature of

a constructive grounded theory methodology and leads to the collection of rich data reflective of the experiences of the participants. Being reflexive allows for questioning of the codes and categories as they emerge from the data, but are they our own preconceptions arising from our own experiences of knowledge, class, gender, age, and culture, or are they those of the participants? This questioning was made visible in the process of memo writing throughout data collection and analysis in my study.

Because the purpose of this study was to develop a substantive theory of the process of social norm formation of nurses working in groups, my ability to be reflexive and identify my own biases and knowledge of nursing was paramount to preparing the interview questions for the study and in the analysis and identification of emerging categories and concepts. Listening to the participants' responses helped me to learn about the experiences and meanings of the participants and not make assumptions about what they meant. Collecting rich, detailed, and focused data (Charmaz, 2014) gave me a more comprehensive understanding of the nurses' experiences in developing the social norms of their practices.

Data Collection

Data were collected from demographic and open-ended questions in the semistructured interviews. The purpose of interviews in constructivist grounded theory studies is not only to learn about the empirical world of the participants but also to advance the construction of a theory (Charmaz, 2014). The constructivist grounded theory methodology is an emergent methodology applying constant and simultaneous data collection and analyses, which may result in researchers reinterviewing participants to clarify their experiences or ask probing questions to facilitate defining and developing emerging categories (Charmaz, 2014).

Interviews were conducted with the 19 nurses between January and March 2022 during the COVID-19 pandemic through Zoom, an online audio/video platform. The interviews followed a semistructured interview guide that was developed based on the literature on social identity, social norms, and relational practice, all of which also incorporated my own experiences as a nurse working in groups. The development of the interview guide was informed by Charmaz's (2014) constructivist grounded theory approach.

The first interview guide that I developed was reviewed by my committee before being used to collect data from the participants. The second guide contained the same questions as the first but incorporated more prompts and probes and reflected the temporality of the development of social norms. I piloted this guide and received feedback from one participant, and based on the feedback, this guide was used in the data collection.

As I began to see categories emerge from the analysis of the data, I started to question whether there were gaps in the analysis. I went back to the participants to ask them about emerging categories, such as their ability to become a part of the group. I added more probes and prompts to my interview guide to allow the participants to take more time to reflect on their experiences and add to the meanings that the experiences held for them. In the example of becoming part of a group, I asked them to give me examples of when they felt that they were becoming part of the group. Their answers contributed to the theoretical saturation of the emerging categories/concepts.

It is important that researchers balance asking questions and exploring their study participants' responses. Asking open-ended questions such as, "Can you give me an explanation of the social norms of your group, can you give me an example?" and probing questions such as, "Can you tell me more about that?" allowed the participants to reflect on and control what they

were willing to talk about. Interviewing allows researchers to be reflexive in the process of asking probing questions to explore the interviewees' responses to facilitate the collection of richer data related to the interviewees' substantial experiences (Charmaz, 2014). Studying the data enables researchers to identify nuances in the participants' language and meanings (Charmaz, 2014).

The interviews completed in the constructivist grounded theory methodology acknowledge that the verbal data transcribed from the interview responses are only a part of the process. Participants' silence, nonverbal behaviours, and interviewer-participant relationships contribute to the emergence of categories and concepts captured through the use of a researcher journal, with transcribed data and journal information both contributing to the data collection and analysis (Charmaz, 2014). Interviews give researchers and participants the opportunity to explore and clarify understandings arising from the RQs and interactions, giving voice to validating the participants' experiences (Charmaz, 2014; Charmaz & Thornberg, 2021). Researchers need to reflect on the way in which interviews are conducted and the ways that their questions, nonverbal behaviour, and responses may affect the information that participants are willing to share. This highlights the significance of the iterative process within constructivist grounded theory studies. The researchers actively collect and analyze the data, enabling them to identify ways in which interviews impact the data collection. In this way, researchers are free to add or delete questions as well as add probing questions or prompts to identify emergent categories needing more clarification from the participants (Charmaz, 2014).

In this study, I asked probing questions as I continued the interviews to add to the data collected to clarify the emergent categories. During the interviews, I also asked the participants to provide more examples of behaviours that they felt demonstrated their group social norms and

how these behaviours made them feel in practice. The interview guide held the initial questions that I asked to explore the process of social norm formation by a sample of nurses working in groups in the health care setting. The interview guide was piloted by one of the 19 participants, who gave feedback supporting use of the guide. All the nurses felt that having the opportunity to revisit how their values, beliefs, and attitudes affected their practice gave them time to reflect and provide more information during their individual interviews.

The ongoing iterative process of data collection and analysis using a constructivist grounded theory methodology gave me the opportunity to add or delete questions after identifying concepts emerging from the data that required further investigation (Charmaz, 2014). A total of 19 nurses participated in individual interviews, but as the interviews progressed, I realized that the nurses needed a clearer explanation of the definition of social norms at the beginning of each interview, so this information was added in subsequent interviews. I did not add or delete questions in the interview guide, but I did add more probes and prompts that allowed the nurses to expand on their experiences so that I could check the development of categories and the links between and among the categories (see Appendix D).

The development of an interview guide gave me the foundation to collect data that reflected the phenomenon under study so that I could develop a substantive theory. The constant collection and analysis of the data gave me the flexibility of returning to the participants to gather more focused data to answer analytic questions and conceptual gaps (Charmaz, 2014). Open-ended and nonjudgemental questions encouraged the participant to share their experiences (Charmaz, 2014). Actively listening to the participants and acknowledging their experiences contributed to having a more in-depth understanding of the participants' language and the meanings of their experiences.

Mutual connections may occur between researchers and study participants that result in deeper explorations, evolving understandings, validation of identities, and acknowledgement of the participants' experiences (Charmaz, 2014). Probes and prompts were included in the interview guide to give the participants time to reflect on particular experiences or feelings: "Would you be able to tell me more about that?" "What was that like for you?" "Would you be able to give me an example of that?" These probes may have facilitated the disclosure of more information to support or contradict emerging categories and concepts (Charmaz, 2014).

The use of semistructured interviews to explore the process of social norm formation of nurses in their practices allowed the nurses to engage actively the interviews and reflect on their experiences. As the researcher of this study, I was actively engaged in the interview process and continuously used my reflective journal and written memos before and after each interview. Understanding the theories impacting the process of group social norm formation helped to structure the questions, thus allowing the concepts of SIT to be examined in the participants' experiences. Interviews were conducted through Zoom, an online platform, at times convenient to the participants. Each interview lasted approximately 1.5 hours. The interviews were recorded and transcribed verbatim by Rev.com, a professional transcribing service.

Reflective Journal

I kept a journal while conducting the study to document information not readily available through the recordings of the interviews (e.g., context [where the participants were located during the Zoom interviews], nonverbal behaviours of the participants and myself, and emotional tone of each interview) that added to the analysis of the data. This journal helped me to reflect on and document how I felt before and after the interviews, how the interviewees responded to my questions and presence, nonverbal communication that occurred during the interviews, and my

reflection and identification of bias. The journal facilitated the preliminary coding and iterative study design, increased the rigour and trustworthiness of the study, and provided the context needed to inform the analysis of the data (Charmaz, 2006). The following is an example of an entry in my research journal.

Reflective Journal

The interview with Dave took place through Zoom an online platform at a time agreed upon by Dave and myself. Dave appeared relaxed and was sitting at a table in his home. He stated that he was home alone. This was my third interview, so I felt more comfortable asking the interview questions and was able to ask Dave to give me more examples and explain some of his answers in more detail. Dave has been working on the unit for 5 years and stated that he felt comfortable in his role as a nurse and with the group. I found that he was able to give me examples of what he felt were his values and beliefs and that for the most part they were what he saw other nurses on his unit enacting. He stated that when float nurses worked on the floor that they were not always comfortable and that he was able to let them know the expectations of the nurses on the unit. He did say that being a male nurse was different and that he did not always take part in the casual conversations with the female nurses, but that he felt he belonged on the unit. This is interesting as gender may be an influencing factor in the development of social norms and behaviours on the unit. Dave also stated that he had developed good relationships with his group and felt he belonged on that unit. Dave also explained that he tried to be positive and support other nurses and tried not to be involved in gossip about other nurses. He said when the unit was short staffed it was sometimes difficult to do everything, he needed to do for his patients but that other nurses offered support without being asked. They would check on his other patients and make sure they were cared for. Reflecting on Dave's answers to the interview questions, I began to see a relationship between the changing context of the unit, such as the need for float nurses the business of the unit, the comfort of the nurses, there sense of belonging and working together. Dave was the only male nurse that took part in the interviews, in future studies it would be important to see how gender may play a role in the process of social norm formation in groups. Dave's interview also prompted me to reflect on gender and the affect it may have on social norms.

Data Management

The interview responses were transcribed verbatim by a professional transcriptionist. I entered the data into NVivo v.1.7, computer-aided software, to assist with data management and analysis. Using NVivo allowed me to organize the data so that I could analyze each initial code and progress to focused coding. Using NVivo allowed me to keep track of the data when I was collapsing and analyzing the focused codes and eventually elevating the codes to concepts and then combining the concepts to support an emerging category. I was able to keep track of my codes and participant interviews by going back and forth between the interviews to check for repeated codes and new codes as the research progressed. I also used memo writing, described in the next sections, and the research journal to track the development of codes and categories, and reflect on the interview process, data collection, and data analysis.

The raw data and my journal are stored on a secure computer with an encrypted password. The data files were coded with identification numbers that only I knew. Data obtained through my researcher's journal, coding, memos, participant interviews, and demographic formation were included in the data analysis to facilitate the development of a substantive theory. This information was accessed only by myself and my supervisor. The data will be stored securely for 5 years on a secure, password-encrypted computer that will be kept in a locked cabinet in my office at Lakehead University. I will then erase the electronic data from the computer and destroy all other data and documents relevant to the study.

Data Analysis

Corbin (2009) stated, "The analytic process is first and foremost a thinking process" (p. 41). Researchers using a grounded theory methodology must be open and reflexive with the information shared by the participants during the interviews (Corbin, 2009). Data analysis began

with the collection of data from the first interview and continued in an iterative process throughout the interviews. The methodology of grounded theory using the constant comparative approach (Glaser & Strauss, 1967) allowed me to progressively focus on the interview data. Constantly comparing the emerging codes and categories, along with recognizing similarities and differences in the data, facilitated development of the theory. The process of theory development began with substantive coding, which consisted of open (i.e., line-by-line, word-by-word, or idea-by-idea) coding and focused coding (Charmaz, 2014; Charmaz & Thornberg, 2021; Glaser & Strauss, 1967). Using open coding allowed me to interpret the process of social norm formation through the language and meanings of the participants (Charmaz, 2014).

The grounded theory methodology follows a procedure for collecting and analyzing the data, but the researcher must also be open to and flexible regarding the interactions and insights posed by the data (Corbin, 2009). Grounded theory seeks to learn about how concepts or phenomena are experienced by the participants and demonstrate how the researchers have analyzed the data thoroughly and systematically to ground the theory in the data (Charmaz, 2020). This type of analysis allowed me to uncover the process of social norm formation of nurses working in groups in the hospital setting that may have affected their decisions to remain in the profession. The iterative process of data collection and analysis in grounded theory allows researchers to return to the participants in subsequent interviews, if required, to clarify concepts revealed in the data (Charmaz, 2014).

I returned to the participants to narrow my focus on emerging categories and the concepts within the categories to develop and refine them. This process also allowed me to complete the properties of the categories and demonstrate the links between and among the categories. For example, one participant felt able to influence the group only after feeling as part of the group,

not when becoming a part of the group. I went back to the participants to clarify this concept. They explained how they felt that they could influence the social norms of the work groups and that this ability to influence the norms was linked to their confidence. This made me think about how the individual nurses' attributes also impacted the concepts and fluidity between and among the categories. Moving forward with the interviews, I added the probe of asking them to explain their experience further, which lead them to provide more details about why they felt that they could or could not influence the groups' social norms.

The hallmark of grounded theory developed by Glaser and Strauss (1967) is the simultaneous process of data collection and analysis to help to focus on the developing concepts. The simultaneous collection and analysis of data allows researchers to recognize connections and develop more questions to clarify the meanings of the participants' data, as explained in the aforementioned text, thus moving the analysis beyond purely describing the data to developing new concepts that explicate what is happening in the form of a substantive theory (Charmaz & Thornberg, 2021; Corbin, 2017).

Data Coding

Coding of the data is essential in grounded theory and keeps researchers interacting with the data from their participants and remaining immersed in the analytical process (Charmaz, 2014; Glaser & Strauss, 1967). Coding allows researchers to begin to define what is happening in the data and direct the further collection of data. Data coding begins the process of analysis by building an analytical framework with which to view the data (Charmaz, 2014). Glaser and Strauss (1967) stressed the significance of using a constant comparative method in the analysis of the data. This method requires researchers to continuously analyze and compare the data as

they are collected to identify categories, properties, and hypotheses relevant to the concepts under investigation.

The constant comparative method of data analysis is used in constructivist grounded theory. The coding consists of at least two phases and is referred to as initial and focused coding (Charmaz, 2014). Phase 1 entails initial coding consisting of a detailed word-by-word or line-by-line review of the data to identify the participants' experiences and views (Charmaz, 2014; Charmaz & Thornberg, 2021). This initial understanding may require researchers to rethink their questions and go back to the participants for clarification. In my research, I was able to ask for more clarification of potential concepts and categories because I continued data collection and analysis simultaneously. It did not require me to ask more questions but to probe the participants for further explanations of their responses.

Phase 2 of coding involves selecting or focusing on the most common or meaningful initial codes to organize, synthesize, and manage large amounts of data (Charmaz, 2014). The researcher must continuously move back and forth between the data and the coding to ensure that the early connections and codes are supported by the participants' data (Charmaz, 2014; Charmaz & Thornberg, 2021).

Strauss and Corbin (1990) applied a third approach, axial coding, which connects categories to subcategories to bring the data back together. Charmaz (2014) did not formally apply this third method of axial coding because she felt that the links between and among categories are both the construction of the participants and the interaction of the researcher with the data. I applied the initial and focused coding to the data, as well as my reflections on the connections that emerged between and among the categories, that resulted in the development of the theory. To understand the process of social norm formation of nurses working in groups in

the hospital setting and develop a substantive theory of social norm development, I followed the iterative process of the grounded theory methodology using data coding and memo writing. These processes are defined and described next according to the constructivist grounded theory approach outlined by Charmaz (2014).

Initial Line-by-Line Coding

The first phase of coding requires researchers to look at the language and actions of the participants that ground them in the empirical world. The use of phrases and ideas common to the participants' responses to the interview questions helped to reveal the actions of the nurses that supported the process of group social norm formation. The codes that emerge from the analysis of the data reflect the language, meanings, and perspectives not only of the participants but also of the researchers as they describe what they have found significant in the data (Charmaz, 2014; Charmaz & Thornberg, 2021). My experience as a nurse meant that I was familiar with the language and experiences of my own practice that allowed me to be comfortable with the way that the nurses described their experiences were and be open to new perspectives in the data through the developing codes and categories. Gaining an early understanding of the data through the development of codes gives researchers insight into possible implicit and explicit meanings (Charmaz, 2014; Charmaz & Thornberg, 2021).

Charmaz (2014) suggested that researchers examine the data for actions (e.g., learning, enacting, influencing, developing) rather than applying preexisting categories from earlier knowledge, theories, or experience. By looking for actions in the coding, researchers are trying to give meaning to the participants' experiences, because actions and their meanings are informed by interactions with others. When conducting this study, I continually reflected on how my past experiences influenced the way that I saw and interpreted the data. I continually

reflected on my RQ and subquestions to make decisions about the collection and analysis of the data as I conducted the interviews and when reading the interview transcriptions multiple times. I kept in mind how I was analyzing the data and whose perspectives I was considering (i.e., those of the participants, society, or myself). Researchers need to interact with the data, discover meanings, and reexamine these meanings to identify gaps in the data and develop significant categories as theoretical concepts.

Throughout the interviews and subsequent analysis of the data, I moved back and forth between the interviews and the initial coding to stay grounded in the data. This meant that as I reviewed the nurses' interview responses, I remained cognizant of the impact of my own experiences and knowledge on my relationship with the data. I initially started to review the data line by line but found that the responses of the participants needed context. For example, when the participants indicated that they felt overwhelmed, they also provided context of the situations that ensured the collection of rich and in-depth data. I began to look at the responses cohesively and started to code them as I saw that they resonated with the concepts developing from the analysis of the data. This sometimes resulted in the data being entered into more than one concept. For example, the participants responded to the question, "When do you feel comfortable working with the group you are in?" by giving examples such as being welcomed to the unit and supported in learning about the unit. These data also would fit with the values and beliefs of being a good nurse: The participants considered the provision of support as something extended to other nurses, patients, and members of the interprofessional teams.

Sadie explained:

> Like I said, my beliefs, my values and my practice as a nurse just increased due to the other nurses as well. Them doing the same thing that I wanted to do, like I said, made me comfortable in actually doing it, so obviously I want to help them out.

Sadie's explanation of her comfort also could have fit into the concept of building relationships: She wanted to help them because they had helped her. This reciprocity in helping each other was a concept that ran through all the transitions/categories of the theory of being, becoming, and belonging.

Following the coding strategies described and used by Glaser and Strauss (1967) and Charmaz (2014), using memos and theoretical sampling provided me with a methodology that supported the discovery, analysis, understanding, and construction of theoretical meanings affecting the development of nurses' group social norms.

Selective (Focused and Conceptual) Coding

Selective, or focused, coding of the data is the second phase of the data coding process (Charmaz, 2014). Once researchers have identified strong analytic directions, the focused coding facilitates the connection of larger data segments that may have overlapping meanings. This type of coding helps researchers to make decisions about the data that support developing categories. Often, this process is not linear and requires movement between and within data to make explicit any information that was initially implicit. Charmaz (2006, 2014) referred to it as that "aha" moment when the data reveal new topics and connections that become apparent by focusing the coding. In my data, that moment often occurred while I was reviewing the data and initial codes and was struck by the fact that when the nurses felt that their values and beliefs aligned with those of other members of their work groups, they felt they belonged. This also occurred in being and belonging because values and beliefs were the connection of individual nurses to their work groups and the profession. In this active process, where new ideas emerge, researchers act upon the data rather than passively read the data (Charmaz, 2006, 2014).

Through focused coding, researchers can condense the data by moving within and across interviews to compare the actions, experiences, and explanations of the participants (Charmaz, 2014). Coding is an emergent process, which means that the codes identified in the first phase from the analysis of the responses of one participant may reveal or support the responses of other participants. This was the case in the initial coding of the values and beliefs of the nurses in my study. All of them were able to give examples of their values and beliefs, but it was the strength of their combined experiences that supported the condensing of the codes during the focused coding. This lead me toward discovering the theory to explain the process of social norm development among nurses working in groups. The comparison of data to data to develop focused codes helped me to refine emerging patterns and meanings, thus contributing to the data analysis. I also agreed with Charmaz (2014) and Glaser (1978) that focused coding often is more conceptual than the initial line-by-line coding advancing the theoretical direction of the research.

As Charmaz (2014) explained, identifying codes is possible only when researchers engage with the data to explore theoretical possibilities. Looking at the data with an attempt to invoke a language of action allows researchers to code for what is happening in the data, not just focus on the individuals such as using action verbs when examining the data, I initially identified 286 codes. As I returned to each code, I found that some overlapped, so I collapsed these into one code; for example, “feeling like a nurse” and “I know some things that people don’t know” were collapsed into “feeling like a nurse.” As I continued to examine the data from these and other codes, they eventually became the concept of “feeling like a nurse” by developing confidence, gaining expertise, and being recognized as a nurse by others. Looking at how the experiences of the nurses resulted in action was reflective of symbolic interactionism because the

interactions and meanings that individuals develop with others result in actions. The concept of feeling like a nurse eventually supported the transition/category of being.

Memo Writing and Conceptual Categories

Memo writing allows researchers to use analytical reflection to develop and explore the concepts and categories that arise in the data analysis (Butler et al., 2018; Charmaz, 2014). It is the transitional step when researchers move between coding and writing their initial analyses and drafts of the emerging theories. Initial codes developed in the data are based on the properties or characteristics of the data and the interpretations expressed by researchers. Memo writing maintains the interactions and reflectivity of researchers with the data because it is in questioning and following up on connections that keep researchers active and open minded, and help them to gain insight from the data toward discovering new theories.

Memo writing allowed me to question the data, reflect on what the participants shared in their interview responses, and gave me insight into what they saw as their group social norms and how the norms impacted their ability to continue to practice or leave the profession. Following is an example of my memo reflecting on what the nurses perceived as examples of the social norms of nursing and how they influenced their practices, ability, and desire to remain in the group or in the profession.

> **Memo**
>
> As I reflected on what the nurses talked to me about in their experiences of social norms in their practices, I found that they often gave behavioural examples of the norms, such as sharing knowledge, being aware of how other nurses were managing and providing patient care. They talked about how their ability to demonstrate these norms were also influenced by the context of the environment, for example the workload. Dana, Gina, Dave and Adele talk about the emotional impact workload had for them. They felt they could not maintain the level of care for their patients. If this was something they faced everyday of their practices, they felt they could not remain in the group or even in the profession as Victoria expressed. It was interesting as the

> groups' ability to support each other even when the workload was great changed the way the nurse's viewed workload. If they knew they would all work together to provide care to patients, they felt better able to cope with the day. (May 6, 2022)

Constant Comparative Analysis

Constant comparative analysis is one of two central characteristics of grounded theory. The first is the use of a systematic methodology that follows the process of reading the interview text line by line, identifying codes, placing organizations of concepts into categories, and understanding the properties of the categories. The second is the use of constant comparative analysis (Hallberg, 2006). Glaser and Strauss (1967) described constant comparative analysis as a method for generating theories from the analysis of the data. This method allows researchers to continually move between the data and analysis to develop more abstract concepts and think through inductive processes (Charmaz, 2014; Tie et al., 2019). When first applying the constant comparative methods, I compared data to data (continually read the interview transcription of each participant and between interviews to identify new codes) as I was coding, I reviewed the interviews as they were completed, constantly returning to them to see if the nurses talked about similar or different ideas and comparing the data between and within the participants' interviews.

By being immersed constantly in the data, I was able to understand the process of social norm formation of nurses working in groups. I was aware of my own assumptions about the practice of nursing and was constantly questioning if my own beliefs were impacting the data collection and analysis. To avoid making assumptions about the data collection and analysis, I reflected on my decisions regarding the data, constantly compared the codes and resulting concepts and categories with the data they were constructed from, wrote memos, and documented my decisions in my journal.

The use of constant comparative analysis allows researchers to see differences and similarities arising from the data collection and analysis by consistently returning to the data and analysis in an iterative process (Tie et al., 2019). As I moved between and among the data, the codes, the emerging concepts, and categories, I questioned how the nurses developed their group social norms of practice and why they identified specific norms. They also shared how the norms impacted the ways in which they practiced. For example, most of the nurses talked about the difficulty learning the norms of the work groups that they had joined. One said that "there was no handbook" of the norms of the work groups. This sentiment was reflected in another nurse's statement that "each shift, I would just see how people do things." The nurses needed to watch, ask questions, and take part in the work groups to learn the group social norms, which often changed in the groups that the nurses worked with. I also reflected on how the nurses had difficulty learning the social norms of their work groups and how their thought about the norms changed as they engaged with other members of the groups.

Theoretical Sufficiency or Saturation

Theoretical sufficiency or saturation is the point where there are no new properties of the core categories: The relationships between and among the categories have been defined, checked, and explained (Charmaz, 2014). According to Glaser and Strauss (1967), theoretical saturation is reached when the data no longer reveal any new properties, categories, or relationships. Dey (2007) suggested using the term *sufficiency* rather than *saturation* to describe the process of determining that there are no new properties, categories, or relationships in the data and analysis. Researchers may make the decision of theoretical sufficiency from their perspectives of the analysis and the construction of the theory, but they would not be able to predict with certainty that further data may provide a new perspective (Dey, 2007). For this

study, I felt that theoretical sufficiency occurred once I had interviewed the 19 nurse participants. I did not see any new information to support new categories or concepts and that the identified categories and the connections between and within them supported the core category of the process of social norm formation.

Gathering rich data in grounded theory studies begins with the RQs. One RQ guided my study: What theory describes the process of social norm formation and the factors facilitating or limiting social norm development in groups of nurses working in health care? Researchers need to consider who holds the experiences and knowledge to provide rich data upon which to broaden and deepen their knowledge and understanding of the participants' worldviews (Charmaz, 2014). When researchers purposefully select their study samples, they do so to inform their RQs (Creswell & Poth, 2018). I used purposive sampling to invite potential participants who were nurses working in groups in the health care setting to share their experiences developing the social norms of the groups. Snowball sampling also was used in this study to allow the participants to recommend the study others whom they felt could contribute rich data to answer the RQ (Creswell & Poth, 2018).

Theoretical Sorting

Theoretical sorting involves the use of the analytic memos developed during data analysis to strengthen the clarity of the categories (Charmaz, 2014). Sorting allows researchers to create and refine the theoretical integration of the categories to form the theory (Charmaz, 2014). Throughout the research process, I moved back and forth between the data and the categories/transitions and their supporting concepts. Sometimes, I would feel that the concepts would support the categories of being and becoming, but once I reviewed the participants' data, I found the concept to support one or the other category or possibly support each in a different

way. I reflected on the data and how they supported the core category, categories/transitions, and how the concepts within each contributed to the nurses' process of developing the social norms of the group.

To visualize theoretical sorting, I drew five iterations of the emerging theory to illustrate the core category and the three resulting categories/transitions (see Figures 1 & 2). Figure 1, the first iteration, was developed during early data collection as I saw the transitions emerging from the data and how they were supported in the data. I noticed how the context in which the nurses worked, along with communication and relationships surrounding the transitions, caused a flux in how the nurses moved through each transition. The third iteration brought the theory closer to the final diagram. In this third iteration, the concepts supporting each transition became clearer as the data collection and analysis continued through each interview. In addition, as per grounded theory methodology, I sought feedback by presenting my initial and additional diagrams to experts, and with their feedback, I made further iterations of the theory. In discussion with these experts, I found that although I was on the right track, I needed to go back to the data to confirm the emerging concepts within the transitions. The final concepts identified in the data supported the process social norm formation in each of the transitions. The use of the constant comparative analysis and consultation with experts in qualitative research and constructivist grounded theory resulted in the final theory and diagram (see Figure 3 in Chapter 4) depicting the process of social norm formation.

The concepts in the categories and transitions connected with each other to either facilitate or limit the ability of the nurses to identify as nurses, become part of their work groups, and belong to the groups and the profession. As I reflected on the memos that I had written, questions arose the data and my analysis of them. I also discussed these with my supervisor (Dr.

Stroink), a committee member (Dr. Costa) and colleagues, which lead me to reexamine my initial thoughts about the theory. This reflection lead to changes, with many of these changes supporting the emerging theory. For example, when I first read and began to analyze the data, I was not sure if the concept of influencing the group social norms was a part of becoming or belonging. Many of the nurses did say that they tried to influence the norms of their work groups as they were learning the norms, but other nurses were not comfortable influencing the group norms until they felt that they belonged to the groups.

Figure 1

First Iteration of the Process of Social Norm Formation in Nurses Working in Groups

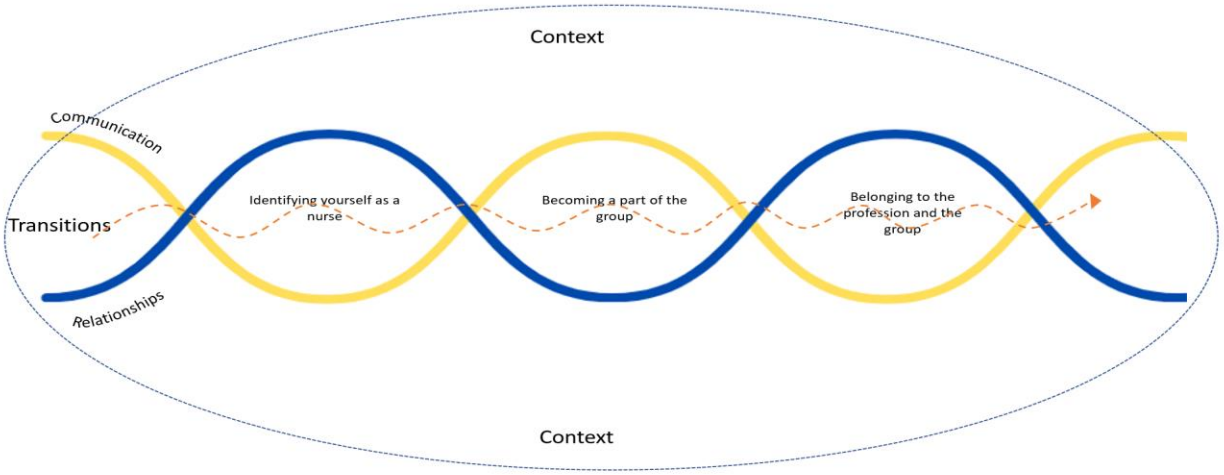
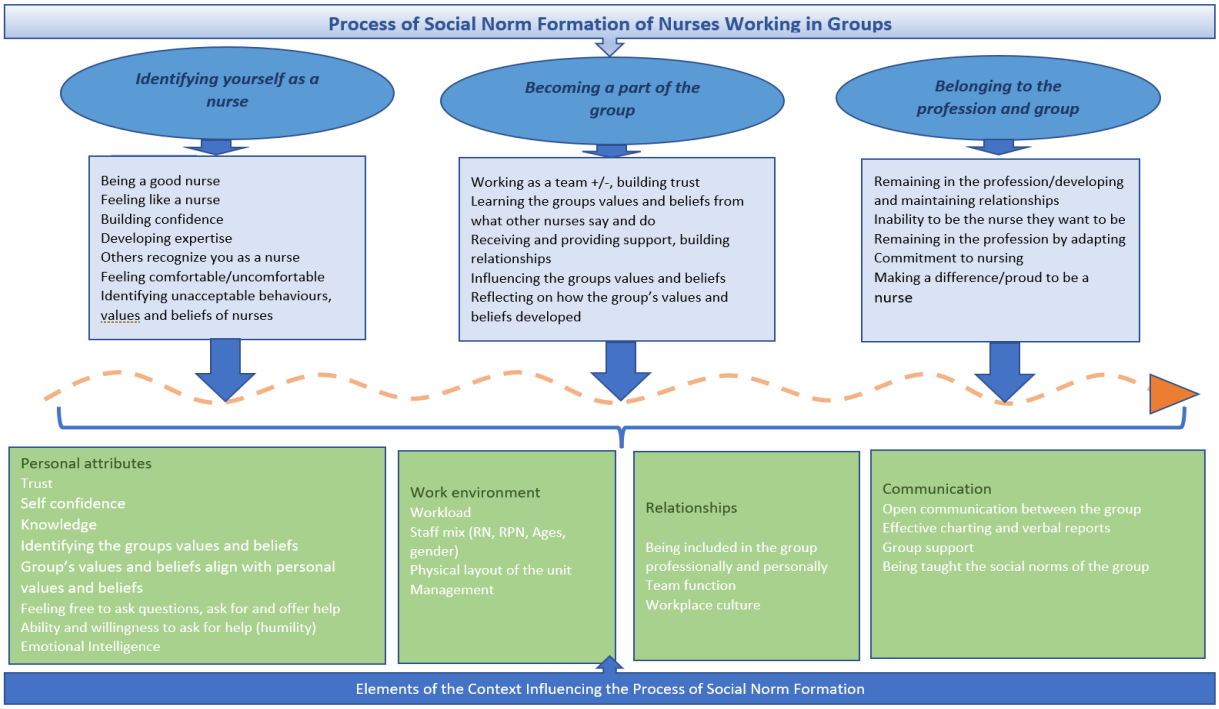


Figure 2

Third Iteration of the Process of Social Norm Formation in Nurses Working in Groups



Conceptualization

Conceptualization is the process of abstraction that seeks to provide explanations of patterns of behaviour in social settings (Holton, 2008). The constant comparative methodology of grounded theory allows researchers to generate explanations of the relationships between and within the concepts (Holton, 2008). Initially, researchers analyze the data for codes, attach labels to segments of the data, and make preliminary analytical notes or memos to identify categories emerging from the data (Charmaz, 2014). As the iterative comparison of the data continues, the categories become more theoretical and ground the emerging theory (Charmaz, 2014). The social process of learning group social norms supported the nurses in being, becoming, and belonging, the three transitions of the theory. The nurses explained that they had to learn the social norms of the groups of nurses with whom they were working by asking other group members, observing

the behaviours of others, or being praised or ostracized for their actions. Therefore, my theory served as an interpretation of the process of social norm formation that was grounded in the data.

Through semistructured interviews, the 19 nurse participants provided thick and rich descriptions of their experiences in the process of social norm formation of nurses working in groups. The iterative and simultaneous approach to data collection and analysis allowed me to identify codes and compare them throughout the collection and continuous analysis of the data. Continuously moving between data collection and analysis eventually led me to identifying categories represented by codes that occurred more often, ultimately becoming the concepts supporting each transition in the theory. Codes that occurred less frequently in the data were examined to determine if they could be collapsed into other categories or as the data were being collected if they became more common. It was important to remain open to the potential for new categories and concepts to emerge from the data analysis that could have presented a novel perspective that had not been identified in the data obtained from participants who had been interviewed earlier. Eventually, focused codes were raised to conceptual categories because they informed the temporal, social, and situational conditions of the theory (Charmaz, 2014). This constant comparative analysis resulted in the advancement of the theoretical concepts essential to developing the theory of being, becoming and belonging.

Integrating Data and Developing a Substantive Theory

According to Charmaz and Thornberg (2021), constructivist grounded theory means more than just focusing on the participants' experiences. It also is about revealing and making transparent the methodology of grounded theory to make transparent to the reader the analytic processes used in developing the theory. In Strauss and Corbin's (1990) view of grounded theory, the philosophical foundations were built upon pragmatism i.e., (the value of theories lies

in their practical applicability) and symbolic interactionism (i.e., human actions and meanings shape the self, experiences, and society), and they emphasized structure and process (Charmaz, 2014; Corbin, 2009; Strauss & Corbin, 1990). Charmaz's (2014) assumptions about the process of constructivist grounded theory rested in her belief that the finished grounded theory is a construction of reality based on the data collected and analyzed, along with researchers' interactions with the participants and their worldviews.

The research process used to develop the theory of being, becoming, and belonging, was not linear. The iterative process of data collection and analysis allowed me to identify and focus on significant concepts identified from the participants' experiences. The detailed process of developing constructivist grounded theory, coupled with guidance from my research committee and colleagues, was helpful in preparing me and providing direction toward the theory that emerged. In summary, this process involved purposive, snowball, and theoretical sampling; semistructured interviews; coding; memo writing; concept development; and active engagement with the data. In addition, the clarification and collection of new data from the study participants facilitated the construction of a substantive and formal theory (Glaser & Strauss, 1967).

The purpose of this study was to generate a substantive theory to explain the process of social norm formation and the factors facilitating or limiting the social norm development of nurses working in groups in the health care setting. The development of the theory also required using my theoretical sensitivity supported by the literature review, my experience as a nurse working in groups, and the data collection and analysis. Included in the next two sections is a discussion of the role of my theoretical sensitivity and reflexivity as the researcher to enhance the quality of grounded theory.

Theoretical Sensitivity and Reflexivity

Theoretical sensitivity is developed when researchers can view the participants' experiences from multiple perspectives: extant literature, researchers' personal and professional knowledge, society, and participants to make comparisons, follow up on emerging codes and categories, and build on questions generated from the data (Charmaz, 2009). For this study, I went back to the participants to ask them about emerging categories, such as their ability to identify as a nurse. I added more probes and prompts to my interview guide to give the participants the opportunity to take more time to reflect on their experiences and add to the meanings that the experiences held for them. I asked them to further explain their experiences and prompted them to think of other experiences that reflected similar meanings for them.

Theorizing means looking at the lives of the participants through the data and RQs, and pausing to reflect on the emerging meanings (Charmaz, 2014). The acts involved in theorizing foster the potential to see possibilities, establish connections, and ask questions (Charmaz, 2014). The use of action verbs to develop codes and memos asks researchers to look at the actions and processes that lead to the development of a code, concept, and category because the meanings of these actions answer the "why" questions in developing theory (Charmaz, 2014).

When developing my initial codes, I looked at the data describing the actions of the nurses that generated the process of social norm formation. For example, in regard to being (action) a good nurse, the actions that identified a nurse as a good nurse involved being supportive, kind, compassionate, and empathetic. Each of the concepts in each transition of the theory held an action that the nurses felt needed to be completed to feel that they knew the social norms of themselves as a nurse, as a part of a group, and as belonging to the group and the profession.

According to Charmaz (2014), reflexivity refers to the ability of researchers to question and reflect on how they have made decisions about the research process, the data collection, relationship with the participants, analysis of the data, and development of a substantive theory (Charmaz, 2014). Decisions regarding the research methods and questions arising during the process were made visible through my use of memos and journaling in documenting the process of data collection and analysis. My reflexivity during the study will allow readers of the research to see how I attended to my own preconceived assumptions that could have influenced the study and its findings.

Creswell and Poth (2018) stressed the need for researchers to reflect on how their interpretations of the data may implicitly include their own views specific to culture, gender, social position, and politics. Being reflexive of my decisions during the research process and analyzing my writing helped me to make explicit my ideas, allowing me to acknowledge the impact that I may have had on the theory development. I wrote memos and kept a journal to reflect on my data collection, data analysis, and experiences while conducting the study to reveal how these experiences with the participants and data may have shaped the findings, as suggested by Creswell and Poth. In addition, having ongoing discussions with my research committee about the methodological processes of grounded theory facilitated the identification and influence of my previous assumptions and theoretical knowledge on the data collection and analysis as well as the development of the theory.

Quality in Constructivist Grounded Theory

The principles proposed by Lincoln and Guba (1986) to evaluate the trustworthiness of qualitative research are credibility, transferability, dependability, and confirmability. These principles are foundational for researchers to demonstrate the validity of their findings (S.

Johnson & Rasulova, 2017; LoBiondo-Wood et al., 2009). The criteria used to evaluate the quality of qualitative methodologies depend on which methodology (phenomenology, ethnography, grounded theory, or constructivist grounded theory) is followed and the philosophy of the researchers who developed the different methodologies (S. Johnson & Rasulova, 2017).

Quality in grounded theory has been a topic of much discussion, and there has been debate regarding the criteria application and the quality of the research findings; however, there has been agreement that the research process must be transparent and that researchers must demonstrate reflexivity and follow the most appropriate methodologies (Birks & Mills, 2011; Charmaz & Thornberg, 2021; Glaser, 2007b; Glaser & Strauss, 1967). Charmaz and Thornberg (2021) added that even though researchers may be versed in the theories and literature regarding the topics being studied, they must be open to how the data may or may not support these theories and assume that every methodology is underpinned by an epistemology or a philosophy regarding knowledge. Despite the debate, researchers must apply measures to ensure the trustworthiness and quality of the research data and theory development.

Glaser and Strauss (1967) took a more positivistic view and focused on the criteria of credibility and applicability. Credibility relies on the ability of researchers to provide rich descriptions of the data, demonstrate how decisions were made throughout the analysis, and have an adequate number of participants to increase the generalizability of the theory. My own experience with qualitative phenomenological research and support from experts in this field gave me experience in interviewing participants and analyzing their narratives.

Applicability is met by researchers when demonstrating the “fitness” of the data in supporting formation of a substantive theory, which must be clear and understandable to the reader. The theory also must be general enough so that those wishing to apply the theory and

others can see the application of the theory in the social realities of their studies (Birks & Mills, 2011; Charmaz & Thornberg, 2021; Glaser & Strauss, 1967). For this study, the criteria described by Charmaz and Thornberg (2021) as credibility, originality, resonance, and usefulness were applied to evaluate the quality of the process of the development of the theory using the constructivist grounded theory approach.

Credibility

Constructivist grounded theory is underpinned by pragmatism, symbolic interactionism, and constructivism; as such, it recognizes the multiple realities or truths experienced by individuals that are developed through their actions with others, the meanings they shape, and the language they use (Charmaz, 2014). This methodology requires researchers to collect data that are representative of the concept through the experiences of various groups and individuals. It also requires researchers to acknowledge the behaviours and thoughts that are constructed through their interactions with the participants, the data, and previous knowledge (Charmaz, 2014; Charmaz & Thornberg, 2021). Sandelowski (1986) emphasized the significance of the description of the experiences of the participants so that others experiencing the same phenomenon may be able to relate them to their realities.

Credibility of this study was situated in how the experiences of the nurses in the process of social norm formation were collected accurately using semistructured interviews and the researcher's journal. Ensuring the credibility of the study required following the methodology of grounded theory and constant comparative analysis. I wrote memos and kept a journal to reflect on the analytical process and ask questions to develop the codes and categories. The memos detailed the decisions that I made in returning to the participants and developing probing questions to clarify concepts emerging from the data. Memos also added to the transparency of

how I made decisions while conducting the study to develop a substantive theory. My dissertation committee members were active participants in the research process, adding their expertise to the analysis and synthesis of the data to validate the categories and concepts of the substantive theory. Experts in qualitative research also were consulted to discuss the development of the theory and question my decisions as the researcher requiring me to be reflective of and support the decisions made during the process of constructing the theory.

Charmaz and Thornberg (2021) stressed the importance of researchers' views and actions. The use of memos and a journal also explicated why and how decisions were made during data collection and analysis. The memos made visible my assumptions in making decisions about the coding and development of the categories and theory, as explained in the findings. Writing questions that I had about the process of constructivist grounded theory and the concepts and theory that I Identified during the analysis allow me to be reflective of my decisions and understand how my own epistemology may have impacted the decisions that I made. Charmaz (2014) referred to this as the methodological self-consciousness of the researcher, which is important in discovering how hidden beliefs affect the research process and findings. Regular meetings with my research supervisor and a committee member with expertise in the constructivist grounded theory methodology and concepts were conducted to determine if there was agreement among us about the identified codes and categories.

Memo

After the first interview, I reflected on how the participant responded to the interview questions. I found that the concept of social norms was not something the nurses explicitly though about or were able to identify without some reflection on their practices. When asked what behaviours they felt identified the social norms of the group they gave many examples, such as supporting one another, putting patients first, and sharing knowledge. This lead me to wonder if in day-to-day practices nurses consider how their values and beliefs lead to the social norms of the groups and thus the behaviours of the group. I have come to reflect more on how my behaviours let others know what my values and beliefs are and whether I was influence behaviours. This allowed me to probe the participants' responses to what they thought about the norms of the group and the influence they may have on the group. (June 15, 2022)

Originality

Originality is met when the data offer new insights and novel conceptualizations and establish the significance of the analysis (Charmaz & Thornberg, 2021). When the data resonate with the participants and readers of the research by providing insight into the experiences of the participants, researchers demonstrate an ability to connect with the data through the processes of grounded theory. I documented the process of data analysis by describing the methodology of collecting, coding, using memos, and developing categories to analyze the data. Reflecting on the process and that support that I received from the experts on my dissertation committee strengthened the contribution to the social and theoretical significance of the work, challenging, adding to, or refining present understandings (Charmaz, 2014). Peer review of the developing codes and categories with the corresponding memos by the committee added to the development and conceptualization of the data (Morse, 2007).

The theory developed in this study offers new insight into the practice of nurses and how, through the process of social norm formation, they make decisions about the salience of their identity as a nurse as well as their decisions to become a part of a group and feel they belong in

the profession. Nurses also make decisions about staying in or leaving the profession that are influenced by their interactions with nurses in their work groups and the meanings of the interactions. The theory also identifies the contextual elements that facilitate and limit nurses' development of group social norms. I followed up with the nurses in the study to confirm that the theory represented their experiences. One of the nurses explained that even though she identified as a nurse, she did not feel that she could become a part of the group that she first joined because the other nurses in the group did not have the same values and beliefs as she did. She left the group and joined a different group where she felt that she belonged. She said that the concepts within the transitions truly reflected her experiences.

Resonance

Charmaz and Thornberg (2021) explained that resonance demonstrates the ability of researchers to portray the richness of their participants' experiences and provide insight to others outside of the study. This study conceptualizes and conveys the process of social norm formation of nurses working in groups and how this process affected the nurses in their day-to-day practices. The categories and concepts developed from the analysis of the data represented the experiences of the nurses as they moved through the process of self-categorizing as a nurse to feeling that they belonged in their groups and the profession of nursing. The analysis revealed their taken-for-granted knowledge of learning, following, experiencing, and reflecting on the social norms of their work groups while navigating the social milieu of the work environment. This theory highlighted the impact of the process of social norm formation on the nurses' identity as a nurse and their ability to practice within groups.

Resonance is linked to the ability of researchers to construct theories that represent the participants' experiences and the underlying social processes that can provide insight to those

reading the research (Charmaz & Thornberg, 2021). The reflections that I wrote in my research journal captured ideas and meanings gleaned from my interactions with the nurses as well as the data and input from other experts in qualitative methodologies. Memo writing allowed me to capture how I interpreted the data and see changes in my thinking over the research process guiding me in the construction of the theory.

Sharing the development of the theory with nurses who also had expertise in qualitative research gave me the opportunity to discuss the theory, the connections between the categories and the concepts, and the connections between and within the categories to gain their perspectives. These nurses provided feedback based on the theory and felt that it did resonate with them. That they could see themselves experiencing the process of social norm formation and its impact on their own practices, one of the nurses spoke about feeling she did not belong to the first group of nurses with whom she worked, so she changed her area of practice. In her role as a nurse in the new area, she believed that she belonged because she felt that the nurses in this group held the same values and beliefs as she did. These experts in qualitative research were able to identify feeling that they either belonged or did not belong to the profession through the concepts in the category/transition of belonging to the group and the profession.

I also shared the final theory diagram with the 19 participants through email. Fourteen of the 19 participants responded to my email by either giving me verbal feedback or written responses by email. They all felt that the theory reflected their experiences of social norms in their practices in their groups. They demonstrated a connectedness to the theory by providing their own thoughts related to their practice and how their experiences connected to the theory.

As Victoria commented, “Your points and theory really hit the nail on the head. It’s clear you got a lot of honest feedback during your research.”

Another participant, Cindy, replied:

> I can say your theory holds true, at least for me. Social norms and workplace culture among nurses play a huge part in remaining in the profession. I left a job I loved back in November partly due to the poor group dynamic between me and the one other nurse I worked with at that facility, I almost gave up the profession entirely because of it and because of the massive burnout I experienced.
>
> But now I'm in a new role in a new facility and I have regained my love for the profession and have a supportive group of nurses surrounding me, which in turn is allowing me to be the nurse I want to be again, and allowing me to be a support to the others around me. (In fact, while I'm typing this email, one of my nurse coworkers just messaged me to come cofacilitate some sexual health programming for an elementary class because she values my views, experience, and input in harm reduction when it comes to sexual health and substance use topics).
>
> Fantastic work! Social norms will make or break a nurse in any field. You're doing some powerful work and research. If you ever need more input or if you're doing any other research, I'm more than happy to be part of it.

Usefulness

The study and the development of the theory will be useful in contributing to nurses' understanding of the ways that their experiences in learning group social norms impact their identity as a nurse and their decision to remain in or leave the profession. Organizations may be able to develop policies and devise practical solutions that can help to retain nurses by supporting their feelings of belonging to their work groups and the profession. This may stimulate new areas of research and reveal underlying practices and processes that also may help to retain nurses in the profession. Understanding the process of social norm formation of nurses working in groups within the hospital and community settings may give nurses insight into their groups' implicit and explicit rules. Supporting nurses to reflect on the social norms of their work groups and change them in positive ways may ultimately improve the decision to remain in the nursing profession. Knowing that social norms are fluid and develop based on the individuals in the group may help nurses to reflect on how their behaviours are shaping group norms.

Developing a substantive theory of the process of social norm formation of nurses in practice may contribute to the ability of organizations to create positive work environments that support the development of social norms that promote collegial relationships and decrease nursing turnover rates. Supporting nurses to build collegial relationships has the potential to save organizations the costs associated with new hires and support those nurses already working to remain with the organizations. Nursing education may be able to use the knowledge from this study to support nursing students' knowledge of the ways that group social norms are developed.

Dissemination of Key Findings

I feel that the dissemination of study results is an expectation of those who conduct research, who have a responsibility to the public and their study participants to disseminate the findings. Research must be conducted ethically and follow the appropriate research methodology to meet the criteria of quality, trustworthiness, and credibility to be shared with academic and public venues. Once research findings have been peer reviewed, research teams have an ethical responsibility to present the findings. Wilson et al. (2010) stated that there is a significant gap in the movement of research into practice.

I conducted this study to develop a substantive theory to explain the process of social norm formation and the factors facilitating or limiting its development within nursing groups. Rules are the social norms of groups, so they drive the behaviours of the group members (Cialdini et al., 1991). Understanding the process of social norm formation of nurses working in groups may help to develop strategies to support nurses in remaining in the profession and improve group outcomes and group belongingness. This understanding would be helpful to organizations in developing staff retention programs. Nurses also may benefit from this knowledge because social norms often are implicit or unconscious, so making them conscious

may reveal norms that are supportive and detrimental to group members. Only by making things explicit and being open to discussion and feedback can we hope to encourage change.

Strategies to Disseminate Research Findings

There are several ways of disseminating research findings. Over the past 2 decades, methods for disseminating research have moved to digital platforms such as "Research Gate," blogs, wikis as a form of "open notebook science," TED talks, and YouTube to name a few (Ross-Hellauer et al., 2020; Tripathy et al., 2017). Some researchers have kept the public and other scholars involved in the research process using open notebooks (Ross-Hellauer et al., 2020). I intend to use traditional methods to disseminate my findings: publications in peer-reviewed academic journals, conference presentations, open access publications, and workshops. I also will investigate web-based dissemination resources such as ResearchGate and blogs. Then I will develop dissemination materials based on the audience by adapting the language and type of communication strategy, such as using the hospital-wide internet (e.g., short video presentations); bulletin boards that are accessible to visitors and staff; and local libraries.

Wilson et al. (2010) performed a scoping review to examine the frameworks used by researchers to disseminate their findings. They stressed the importance of a nonlinear approach, which involves two-way communication between researchers and target audiences throughout the research process. I also intend to disseminate my findings with organizations in and beyond the community that I belong to. I have made connections with the health care organizations in the community and will keep these connections open to facilitate communication of the theory developed in this study. Sharing knowledge of how nurses develop group social norms may support the development of strategies to retain nurses in the health care setting because norms directly impact nurses' feeling of belonging to the profession. I also want to present to students

enrolled in the university's school of nursing.

Chapter Summary and Conclusion

This chapter presented details about the methodology used in this constructivist grounded theory study and the process used to develop my substantive theory. The research methodology of constructivist grounded theory was informed by Charmaz (2014) and was guided by one RQ and three research subquestions. My research committee also played an important role in guiding me during this process. The rigour and quality of the findings were ensured by following the methodology of grounded theory, as explicated by Glaser and Strauss (1967), combined with the framework of constructivist grounded theory outlined by Charmaz (2014) and maintained by the steps described in Chapter 4.

CHAPTER 4: FINDINGS: PRESENTING THE THEORY AND THE CONTEXT

The heavy load makes the heart heavy in advance.
Today I have the one who rang the bell twenty times last night.
I start the day crying.
Do I tell anyone? Look around. Who is on the floor, in the hall?
Who has my back? Can I imagine that protection? Leaning back
The way patients do into my arms when I lift them?
Shake it off.
Excerpt from "I Start the Day," by Ronna Bloom

Chapter Outline

The opening poem for this chapter provided a window into the experiences of the 19 nurses interviewed for this study. The poem set the scene for the findings, and it hinted at the significance of personal attributes, context, relationships, and communication that constantly cause a flux in the ability of nurses to follow the social norms of groups and transition from identifying as a nurse (being) to becoming part of groups and belonging to their groups and the profession. The poem also spoke to the need for nurses to have support during times when they have heavier workloads because of the lack of nurses to help them, made them feel that they were working alone. A health care crisis is happening in Canada, so it was important to hear the voices of nurses who go on their shifts to find out they will be working alone with sometimes double the normal patient load. Such a scenario has become very common, and I have heard it from colleagues and nursing students, who question their desire to become a nurse after completing their clinical placements because they are afraid of the workloads that they may encounter. The shortage of nurses has had a significant impact on nurses' mental health, leading to the worsening of emotional distress since the COVID-19 pandemic.

Dialogue is an essential skill in hearing the concerns of others, voicing our own concerns, and building trusting and respectful relationships (Costa, 2022). Dialogue allows us to enter each other's world, and if we really listen to each other, we can bring the concerns identified by the nurses in this study to those who can support nurses by addressing their ability to remain in the profession and provide safe patient care (Costa, 2022). The voices of nurses are not being heard, so as nurses, we need to engage in dialogue with other nurses, the patients and families we work with, the organizations and communities in which we work, as well as the government, to support us in providing holistic and collaborative care. All of these issues motivated me to develop the theory that explains the process of social norm formation. I would like to bring forward the voices of nurses to highlight the need for nurses to play an active role in developing the social norms or rules of the group and the profession that will support them during their professional journey.

To develop the theory, I used the three fundamental premises of symbolic interactionism: "(a) Individuals act toward things based on the meanings that those things have for them, (b) meanings arise from interactions with others, and (c) individuals interprets the meanings of these interactions or things they encounter" (Blumer, 1969, p. 2). These premises were seen in the experiences of the nurses as they reflected on the ways that they developed the social norms or rules of the profession and their work groups. These premises also applied to me as the researcher because my interactions with the participants and their stories affected the interpretation of the findings and required me to follow the methodology of constructivist grounded theory using constant comparative analysis to support the development of the theory (Bryant & Charmaz, 2007; Charmaz, 2014; Glaser, 2007b; Glaser & Strauss, 1967).

The experiences of the nurses in this study also were supported by the literature on the process of social norm formation as being very much a social process and one in which the individual, group, and context impact the process by both facilitating and limiting it (Cislaghi & Heise, 2018; Haslam, 2014; Hogg & Terry, 2012; Rimal & Lapinski, 2015; Tajfel, 1982; Turner, 1982). Maltseva (2018) asserted that "norms provide the rules describing what behaviour should be like, and values provide criteria by which behaviour is judged as good or bad" (p. 1). The contextual elements identified by the participating nurses provided knowledge of the formation of social norms in individuals and groups, and how they impacted the nurses' transitions of being nurses, becoming part of the groups, and belonging to the profession. Understanding how these elements impacted the transitions helped to support the context of the nurses' workplaces and build space for interactions to allow them to feel a part of their work groups and the nursing profession, and ultimately remain in the profession.

Chapter 4 has four parts. Part 1 is an overview of the theory of being, becoming, and belonging: The process of social norm formation of nurses working in groups. Part 2 provides details about the three transitions making up the theory. Part 3 presents the four elements of context (i.e., personal attributes, workplace, relationships, and communication) that influence the process of social norm formation. Part 4 presents the interactions of the three transitions of the theory and the four elements of context that influenced the nurses' social norm formation and their ability to move through all three transitions of the theory.

Part 1: An Overview of the Theory of Being, Becoming, and Belonging

The core category of the process of social norm formation of nurses working in groups consists of three categories depicting the transitions that the nurses experienced as they gained knowledge of the social norms of nursing, their work groups, and the profession. The transitions

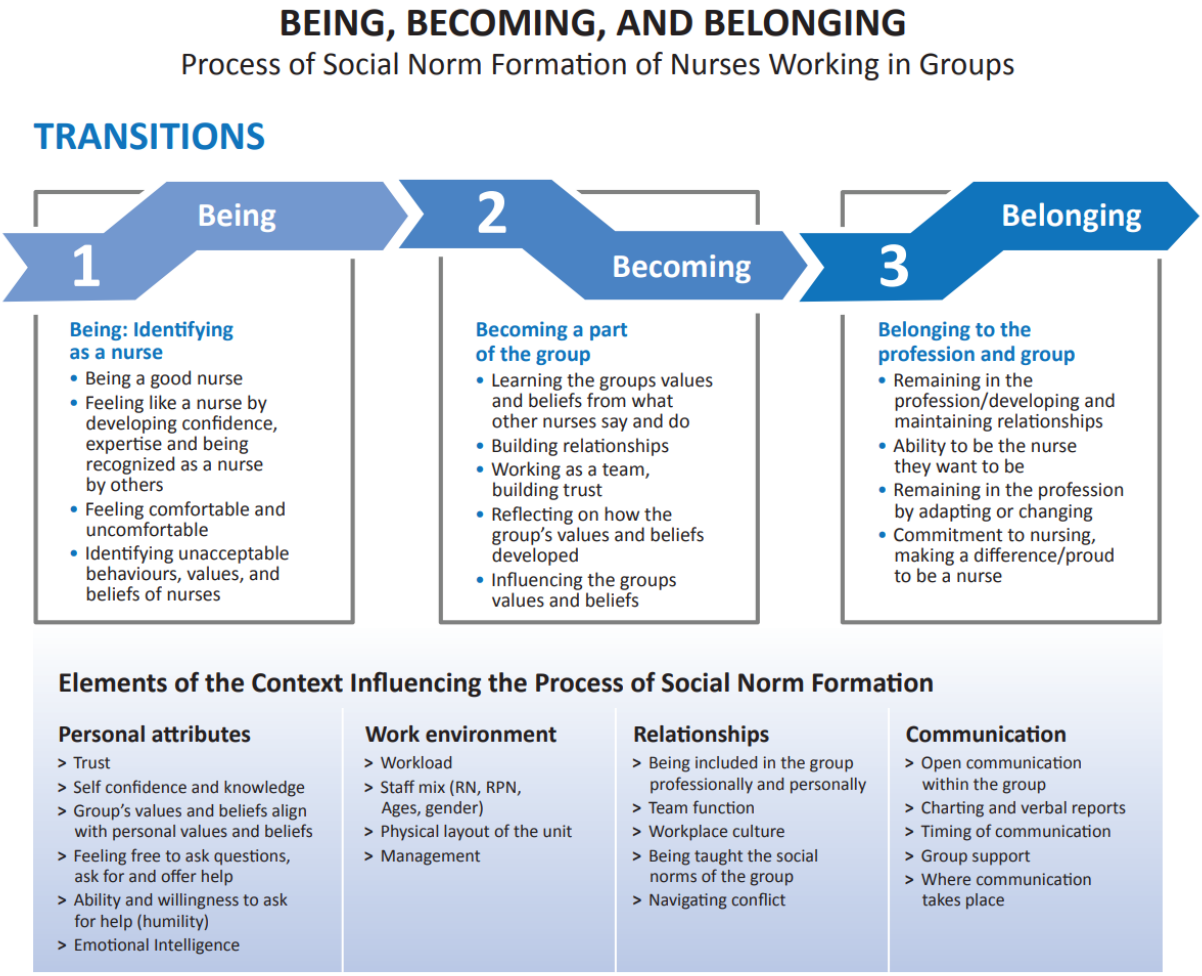
were supported by 13 concepts. The theory was constructed based on the experiences of the 19 nurse participants, my interactions with the participants, and the iterative process of data collection and analysis (Charmaz & Thornberg, 2021; Creswell & Poth, 2018).

The transitions occurred over time and reflected the temporality of the changes that the nurses experienced in learning the social norms that they held of their groups and the profession. The participants stated there were times when they felt like nurses, were a part of the work groups, and belonged to the profession; however, there were other times when they questioned themselves, feeling they were not a nurse, were not becoming a part of the group, or did not belong to the profession. This flux in the transitions was influenced by the contextual elements of personal attributes, the work environment, relationships, and communication present in their individual nursing practices that impacted the formation of social norms and influenced their ability to move to the next transition and ultimately remain in their groups and the profession.

The three transitions and categories supported by the concepts described the temporal and interactional process of social norm formation. The transitions were grounded in the experiences of the nurses, were connected to each other, and supported the core category of the process of social norm formation of nurses working in groups. Figure 3 shows the theory with its core category, transitions, concepts, and elements of context influencing the process of social norm formation.

Figure 3

Being, Becoming and Belonging: Process of Social Norm Formation of Nurses Working in Groups



Memo

Figure 3 is the fifth iteration of the theory; throughout the research study, I continually returned to the data to see if the transitions in the theory were supported by the concepts revealed in the experiences of the nurses. Although the final diagram looks to have definite transitions, they are closely tied to each other and affect the ability of the nurses in the study to move through each. In the first diagrams, I found that I had encircled the transitions with the contextual elements. This did not clearly depict the significance of the contextual elements on each of the transitions, so I chose to identify each of the elements and through the diagram show how they as well as the transitions impacted the movement of the nurses' process of social norm development.

Progression through the three transitions was in a forward direction, as indicated by the arrow in Figure 3. This forward movement meant that the nurses could not move backwards in the transitions because they had been influenced by the values, beliefs, and behaviours of other nurses in the groups around them and had formed their own ideas of the social norms of the profession of nursing and their work groups. Although nurses will always be influenced by previous experiences with their work groups, they also explained that when they changed groups, they once again found themselves learning how to become part of their new work groups. The nurses could not ignore the knowledge that they learned while moving through the transitions. Even when they left a group or the profession, their previous interactions influenced future interactions because of the iterative processes involving the ways that individuals make meaning from social interactions and the contexts in which they occur. Each of the three transitions, along with the concepts supporting them, is discussed in Part 2.

Part 2: Being, Becoming, and Belonging: Transitions

Part 2 presents an in-depth description of the three transitions in the theory developed through the participants' experiences as well as my analysis and interpretation and the inclusion

of some of the relevant literature. This study followed an inductive method guided by constructivist grounded theory methodology, so the theory was generated from the experiences of the participants, not from any previous literature. The theory was developed to understand the meanings and actions of the participants while recognizing that the interactions between the participants and the researcher added to the construction of the theory (Charmaz & Thornberg, 2021). The study did not set out to test a hypothesis generated from the literature; rather, the literature was incorporated into Chapter 4 and Chapter 5 to contribute to the theoretical understanding of the theory developed in this study.

The nurses needed to be able to identify their own social norms as well as the social norms of the profession and the other nurses in their work groups. Identifying social norms was essential for them to move through the three transitions. The contextual elements contributed to facilitating and limiting the nurses' movement within and between the transitions. The nurses described times when their own values and beliefs aligned with those of the group and when they did not, with both scenarios having outcomes for their practices and patient care. Social norms are embedded in social interactions, and the meanings developed by the nurse participants in their practices depended on the context (Hogg & Terry, 2012) and meanings. Charmaz (2014) stated that "knowing and learning is embedded in social life" (p. 14).

In Chapter 1, I identified a gap in nursing research focusing on the combination of informal communication, social identity, and social norms. The experiences of the nurses in this study will add to the current understanding of the ways that nurses develop group social norms to support each other so that they can thrive in their day-to-day practices, feel part of their work groups, and develop a sense of belongingness and social identity as nurses. Identifying the process of social norm formation of nurses working in groups will contribute to the body of

research on the ways that nurses identify as group members. This knowledge builds the capacity of nurses to understand how their social norms and those of the group influence the way that they feel about their place in the group and are able to practice. The process of social norm formation was ongoing for these nurses, and they often experienced either comfort or discomfort when the social norms or rules of their work groups changed or conflicted with their own values and beliefs, which are aligned with the literature on the process of social norm formation (Aronson et al., 2019; Titlestad, 2019).

Each transition and category represented a process in the nurses' formation of social norms. Although interconnected with each other, the transitions could stand alone with its set of concepts (Dey, 2007). Table 1 outlines the core category, categories/transitions, their concepts, and remarkable quotes. The transitions and their concepts are discussed in detail later in Part 2.

Table 1

Outline of Core Category, Categories/Transitions, Concepts, and Supporting Quotes

Core category	Categories/Transitions	Concepts	Supporting quotes
Being, Becoming, and Belonging: The Process of Social Norm Formation of Nurses Working in Groups in Health Care settings	Being: Identifying as a nurse	Being a good nurse Feeling like a nurse by developing confidence, expertise and being recognized as a nurse by others Feeling comfortable/uncomfortable Identifying unacceptable behaviours values and beliefs of nurses	… just a genuine respect for humanity…P10 …empathy and compassion Sadie Doing it (nursing)…Hannah It (nursing) feels like it's woven into my identity…Adele …like I've got this, and I've got this, I can help Bev think that there's a sweet spot that we all hit a couple years into nursing where we're not scared at work anymore. We feel confident in our practice. So we have the luxury of really being present and caring for our patients. Kim … you just represented the art and the science of nursing today. Kim I'm quick to pick up potential problems Patricia I'm comfortable within the group and just speaking what I need. Nancy …you feel kind of on the outs side, Dana …felt at times humiliated and belittled Emily The person who was orientating me sat at the desk and didn't do anything because they wanted to see how I could manage the load. Josie
	Becoming a part of the group	Learning the groups values and beliefs from what other nurses say and do Building relationships: receiving and providing support, Working as a team, building trust with others Reflecting on how the groups values and beliefs developed Influencing the groups values and beliefs	… people don't share their knowledge… Patricia I know that we can work well as a group Gina …but you can watch the other people functioning within a clinic and then you can compare how well the clinic runs by the behaviors of who's there Nancy a lot of observing and sort of taking in what the norms are or what the group is doing, so that you then know how to behave within it. Josie you realize that they're (other nurses) willing to help you and they want you to be doing the best care. Dana …older nurses and management maybe…And it's like, I don't know, it's just how we do it. Nancy …if they need help, they know they can ask me. Adele …I'm going to take that knowledge, build on it, and then teach somebody else when they need help. Jodi
	Belonging to the group and the profession	Remaining in the profession by developing, maintaining, and fostering relationships Ability to be the nurse they want to be Remaining in the profession by adapting or changing Commitment to nursing, making a difference/proud to be a nurse	Finding your people with the same values as you make …Nancy …dedicated nurses who totally have your back. Dave Nursing is easier when you have a good group, and you can love your job again. Josie And now you feel the heaviness of the system because you're able to look a little broader and you realize everything that's wrong. And I just feel like that's where everybody is right now Kim I had to get off X after a couple years. Julia Um, and then adaptability, and, I think, curiosity. Dave having those moments where you really feel like you've made a difference Cindy I'm proud to identify as a nurse because I do it well. Josie

Transition 1: Being: Identifying as a Nurse

This first transition was represented by identifying as a nurse. The transition was supported by four concepts: being a good nurse; feeling like a nurse by developing confidence, expertise, and being recognized by others as a nurse; feeling comfortable/uncomfortable; and identifying unacceptable behaviours, values, and beliefs of other nurses within the group (see Figure 4).

Figure 4

Transition 1: Being: Identifying as a Nurse

Identifying as a nurse was essential for these nurses to move to the next transition. The four concepts supporting this transition were described by the nurses in their interview responses.

Being a Good Nurse

One of the first concepts to emerge from the experiences of the nurses was to identify the values, beliefs, and behaviours that resonated with them of what a "good nurse" was. Several of the nurses talked about being a good nurse.

Josie said, “But if you want to be a good nurse, you have to care about the patient and the patient’s outcome.”

Eden shared that “I just think being passionate about your work, passionate about the people you care for, being diligent with your work, you have to be dedicated to be a good nurse.”

Kim stated, “To be a good nurse, I just feel like you need to have a level of intelligence, an appreciation for human life, be a good people person, be kind.”

I wrote the following memo while reflecting on the first few interviews with the nurses. I found that they were able to explain their values and beliefs when they attached them to behaviours.

> **Memo**
> As I conducted the interviews, I found that it was sometimes hard for the nurses to tell me their values and beliefs, but they were better able to define them when asked to describe behaviours that they felt belonged to a good nurse. It may be that the values and beliefs constructing the social norms are implicit to these nurses and it is only by reflecting on the behaviours that they become explicit. As they described behaviours such as listening to others, completing their work, supporting their patients and peers they began to see that their values were compassion, empathy, trust, kindness and commitment, authentic, accountable and patience. (April 22, 2022)

The nurses felt that they brought their own values and beliefs to their practices, and that these aligned with those they felt fit the attributes of what a good nurse was.

Kim explained that for her it was showing

> a genuine respect for humanity, and what makes people who they are, and being able to show presence when they’re at their most vulnerable. But for me, what it means to be a nurse is to be able to be with someone at their most vulnerable. To do whatever it is needed to make it a little bit easier.

This connection with patients and the provision of support to individuals in their care resonated with all the nurses and was a core value for them. Eden noted that “behaviors that are

going to benefit the patient, that are concentrating on the patient and it's making them feel great and the families" was an essential belief explained by several other nurses that their practice should benefit the outcomes for patients and their families.

The nurses shared that they demonstrated ways in which they operationalized their beliefs and values when caring for patients. The nurses thought about the behaviours that they felt nurses should display in practice instead of stating the values and beliefs that they felt were a part of their practice. An example from their practice involved calling families during the COVID-19 pandemic to update them about their family members and giving them the opportunity to speak directly to the family. As Nancy explained, "Pick the 86-year-old who has no way to communicate with his family and just reach out to somebody and tell them," allowed the nurses to see their values enacted. These behaviours were directly connected to the values and beliefs that Sadie, Nancy, Gina, Cornelius, Judy, Cindy, Jody, Hannah, and Bev explained that in their experiences, their values were definitely empathy and compassion and were supported by the care that they provided.

Adele expanded on what compassion meant to her practice, and she felt that being a nurse involved being compassionate. She further stated that if she needed a nurse, she would want them to be compassionate and understand what it is like to be a patient:

> So I think it's like I want to continue on this path nursing, because I think at some point we're all going to... If we're fortunate, we won't, but I think there's a better chance that we're all going to need a nurse at some point in our life. And to me, it's really important that nurses are compassionate.

The notion that the values and beliefs were reflected in the behaviours of the nurses was seen in many of their experiences as they interacted with other nurses in their groups. The nurses also acknowledged the importance of relating to the work groups of nurses in a way that reflected the values and beliefs that they held.

Gina mentioned needing to exhibit caring, compassion, and advocacy with the group:

> Yeah, that it's not only about being caring, compassionate, and being an advocate and kind for your patients, it's also, aside from that, you have to do all those things for your group. It's not just about the patients but also about the group.

Throughout the concept of being a good nurse, the nurses were able to identify their own values and beliefs and recognize behaviours that demonstrated the values and beliefs of the group or the social norms of the group. The ability of the nurses to learn the values of the group was supported by their ability to communicate with each other and observe the behaviours of others. Nursing is a relational practice that was interpreted by the nurses in their daily interactions with each other. The nurses' own behaviours produced meanings for other nurses during interactions with each other on the units. If the values and beliefs supported those of other nurses, they felt that they worked well together; if not, they may have felt that there was conflict. All the nurses identified being a good nurse with having empathy, compassion, and kindness; being accountable to the patient, other nurses, and the profession; and sharing their knowledge with others. These social norms contributed to the nurses self-identifying as nurses.

Julia commented:

> I think just by having common goals and sharing the ones that I believe to be a nurse, the knowledge, the kindness, the patients, remembering that they're at the most vulnerable and you're here to assist them. I think when I surround myself with those same people, I really do feel like I belong and I'm a nurse.

Sarah explained the need to understand the values and beliefs of what nursing is in order to have a good foundation to begin practicing as a nurse. She said, "And so if you have a good solid foundation of beliefs and values and all of that, then I think you're going to do much better than if you don't have that."

Cornelius explained that nursing encompassed not only the ideals of compassion and respect but also the knowledge that nurses bring to their practices was vital to the care of

patients. She explained, “Well, compassion, respect, competency and... What’s the word I want to use? It’s triage, right? And being able to think quick on things happening at work. That’s the word I wanted to use, critical thinking.”

The following memo was written after the initial coding of the interviews. It struck me that when the nurses were talking about the values and beliefs of nursing, they included values that reflected the ways that nurses should act as well as the knowledge and patient care that they were responsible for.

> **Memo**
> Values and beliefs of the nurses in this study ranged from compassion, kindness, caring, empathy, to knowledge, and putting the patient first. It struck me how nursing is composed of the soft skills or art of nursing that sets a foundation for relationships and the ability of the nurses to provide care to patients. The nurses demonstrated insight into their practices and identity as nurses by reflecting on the values and beliefs they held. (April 23, 2022)

The importance of both the art and science of nursing was explicated by all 19 nurses as the foundation of self-identifying as a good nurse. The nurses talked about their ability to provide care that was empathetic, kind, caring, respectful, authentic, and compassionate. This “art” side of nursing is how nurses make connections and develop relationships with patients that build trust. The nurses also described knowledge as the “science” of nursing essential to safe patient practice, their knowledge, and expertise. The knowledge of nursing involves the constant questioning of practice and how it impacts the relational aspects of interactions with others (Hartrick Doane & Varcoe, 2021). This combination of art and science was at the core of these nurses’ values and beliefs and was needed for them to consider themselves good nurses and to keep patients at the forefront of their nursing practices.

Feeling Like a Nurse by Developing Confidence and Expertise and Being Recognized by Others as a Nurse

The 19 nurses shared many experiences in practice that contributed to their feeling like nurses. They gave examples of building knowledge, expertise, and confidence; connecting with patients; being acknowledged by others as a nurse; and also doubting themselves as nurses. Many of the nurses identified education and being licensed as nurses as the beginning for them to start feeling like a nurse.

Josie explained:

> So in terms of getting through school and getting to the end, doing it well and understanding it, then it was like, "Yeah, I'm a nurse," because I understand this and I do this job well. I guess reflecting it that way, I would say, I guess essentially the same thing now. I'm proud to identify as a nurse because I do it well.

Sarah stated:

> Okay. Well, besides my title that we get after graduating, the Bachelor of Science in nursing and then passing my NCLEX (Licensing exam for registered nurses) and all that stuff, and getting the title RN, I would say the fact that I'm doing almost the action of nursing people as well.

The knowledge that they gained in nursing school, along with their ability to pass the licensing exams, contributed to their knowledge, expertise, and confidence and moved them toward identifying as nurses. Along with education and licensing, for many of the nurses, the experience that indicated to them that they were nurses was the recognition from peers, families, friends, and the interprofessional health care teams. This signified the importance of interactions with others and the meanings that these nurses associated with those interactions that contributed to their feeling like nurses.

Nursing is a relating profession that requires nurses to identify their interpersonal beliefs and values of relating to others, how they relate to others (the interpersonal), and how the context

in which they work impacts their ability to relate ((Hartrick Doane & Varcoe, 2021). In the context of this category, the nurses talked about times when they felt like nurses, did not feel like nurses, and would continue to feel like nurses postretirement.

Nancy and Eden explained that they would always feel like nurses, whether in retirement or not working a shift.

Nancy noted:

> Well, that's a hard question for me to answer, but I truly believe... You know how some people believe, like even after I'm retired, I'll still be a nurse. I associate with that now. I think a lot of us as nurses, that's who we are until the day we die. I think that we introduce ourselves often as that. And so, I don't know. I think that I'm smart enough and I think I'm empathetic enough to be this and do this. And I still love it. I love it enough to be that person. Otherwise, I would've retired.

Eden shared:

> I just think being passionate about your work, passionate about the people you care for, being diligent with your work, you have to be dedicated to be a good nurse. You have to dedicate your life to that profession because it was day and night. Even after work, people identified you as a nurse.

Several of the nurses mentioned that once others knew that they were nurses, they would ask questions regarding their health because they felt that the nurses would know. Sarah found that her identity as a nurse did not stop once she left work; instead, others who knew she was a nurse related to her in that way, regardless of whether it was outside of the work environment:

> So it doesn't just stop nursing once you leave work, it kind of continues with you. And once people know that you're a nurse, they'll ask you hundreds of questions and yeah. So personally, and then at work as well.

We all have many identities: friend, sister, brother, mother, and father. Identifying as a nurse can be more salient than other identities, depending on the context of where we are, who we are interacting with, and the meanings that we develop from these interactions. Individuals who identify as nurses do so by comparing themselves to others to see if they also have the same

values and beliefs of those around them, thus allowing them to develop a shared reality (Hogg & Rinella, 2018).

Josie explained that she felt like a nurse because of her education and because she knew what nursing is and she did her job well. She was proud to be a nurse:

> I guess all along... Right now it's because I am, I do it and I do it well. If I go back to when I was in school, I think it was just the drive behind it. Starting to learn it, it was very interesting to me. I became very passionate about it, I wanted to apply myself more, I wanted to achieve those things and I wanted to be successful at it. So in terms of getting through school and getting to the end, doing it well and understanding it, then it was like, "Yeah, I'm a nurse," because I understand this and I do this job well. I guess reflecting it that way, I would say, I guess essentially the same thing now. I'm proud to identify as a nurse because I do it well.

Josie's ability to feel that she did her job well was connected to the relationships and communication that she had with others. She recognized that her knowledge allowed her to do the job of nursing and support coworkers. She explained, "Because I'm there for my coworkers. I'm there to make improvements, and I think that that's the biggest part to the job, is that applying your knowledge and everything to help the patient, that is a nurse."

Kim also reflected on what made her feel like she was a nurse. It was the validation from those she worked with in her group. She commented. "Validation from my peers is probably the one thing that I feel most part of the profession." This sentiment was echoed in Emily's comment that *"*over time, my skills have improved. People have come to me when they need help."

Gina explained that she did not feel like a nurse until she had developed confidence in her nursing abilities:

> Probably not until developing confidence and enough knowledge that you are confident in your practice and being able to critically think and being able to think... I don't know how to explain it from your assessments being able to then determine a care plan or being able to put your knowledge in place in practice.

Gaining confidence in their practice took time and experience to develop. Sadie explained that even though nurses must be able to see how their knowledge has grown, others also needed to acknowledge it. Sadie believed that her ability to help others also made her feel more like a nurse:

> Even … I feel like even though I've been nursing for almost 2 years ... Like I said before, it's not still that long. But they still treat me as much of a nurse as they are. They'll ask me for help too. It's not only me asking them for help. It's them asking me for help, because as a nurse you don't do every single skill in the book every single day. So sometimes you'll come upon something that you're like, oh, crap, I haven't done this in two years. I know how to do it, but I just need a little extra hand. So they'll do that for me too. They'll come to me and be like, "Hey, have you done this recently? I haven't." So it also enhances my confidence as a nurse. I'm like, "Okay, yeah." When you said before ... I think you asked the question of, what makes you feel like a nurse? That also makes me feel like more of a nurse too. I'm helping them, you know? They're not just the one helping me.

When they started their practices, several of the nurses talked about being task orientated. They knew there were expectations of what they needed to do for patients and how to accomplish them. It was through experiences and interactions with others that they began to feel confident and could then begin to focus on their patients.

Kim explained that in her role as a nurse, the experience of caring for patients gave meaning to her and was at the core of her practice:

> Probably the role that I've played in people's lives at their most vulnerable. When you start, you're so task oriented and you just get through. As I've gone on and you realize the very important role you play in someone's life, whether they get better, they travel onto somewhere else. I think that's been the biggest part that I feel makes me a nurse, as opposed to other professionals. I don't know if that makes sense, but that's what makes me feel the nurse is being there. The person they see the most often on the healthcare team at their most vulnerable.

Julia explained that it took time for her to build her confidence in her identity as a nurse:

> Yeah. I would just think of like when I went down to this unit, because I wasn't confident, there would be a lot of nurses on night shifts being able to take their break, or relax at the desk, or do lots of chit-chat, but I felt like I didn't fit in because I had so much stuff to do still, or like, I was so anxious for the morning. I'm like, to do my PD

> (peritoneal dialysis), to do my trach care and everything with my vents that like, I felt awkward. I felt, on the night shift, I was just kind of keeping to myself, and then I thought people thought I was this little keener, I don't know. But it's more like, because I didn't know what I was doing. I was just constantly checking things or rechecking, whereas I found that lot of other people were more relaxed because they'd been there and were confident. At first I thought that I was coming off standoffish because I was so in my head and on my worksheet.

Julia's experience was echoed by several of the other nurses that they, too, had to become confident as nurses to start to interact more with the other nurses in their work groups. They felt that they could not relax enough to build relationships with other group members because they were too busy learning to do the job of nursing: providing good care to patients.

The nurses experienced times when they doubted themselves as nurses. As Dana explained, that doubt was sometimes connected to the response of others to their skills and ability as nurses, as well as her own feelings regarding her confidence in her abilities.

Dana explained the difficulty of having confidence when just starting out and that others' opinions and treatment had the ability to increase or decrease confidence:

> And when you're learning and someone's telling you, you're slow at giving out medications, it's like, okay, well this is kind of scary. So I kind of wanna make sure that I'm doing it appropriately. I'm following all of my medication administrations. But when you're getting bullied by someone, it, it beats down your confidence.

Dana also felt that she needed to have time to perform skills so that she would not make mistakes, but the expectation of others was to get things done quickly. Completing skills quickly only happened as nurses gained more experiences and built their knowledge and confidence.

Dave described an experience that decreased his confidence:

> Mm, and then one moment stands out when a- a coworkers' who was probably thinking that they were being very helpful, just completely took the reins, uh, and I said like, "Hey, you know, what do you think about this?" and they just fully reassessed my patient, and, uh, made the same recommendations that I had with much greater authority, uh, and I- I wish that they had just said their recommendations, and we could have been like, "Oh, okay, we're on the same page, thank you."

Dave felt that he had not come across as confident in his assessment as he would have liked, so the other nurse stepped in to take over. Although the other nurse's assessment was the same as his, he felt that the nurse had not trusted his initial assessment. The behaviours of others greatly impacted how the nurses evaluated themselves and how they may have questioned their values and beliefs with those of the group. Dana felt that the other nurse did not understand her need to proceed slowly to prevent errors and that she was still learning, whereas Dave felt that he did not come across confident enough, which resulted in another nurse reassessing his patient. The nurses' ability to feel like nurses was connected to their own knowledge and confidence, as well as the behaviours of other nurses toward them.

Adele explained that once she had knowledge and exhibit that knowledge by providing care that improves patients' outcomes, other nurses recognized this and come to her for advice. She explained:

> I think yes, like in terms of, if there's like really unwell end of life patients, quite a few staff on the floor, because they know I have experience in that, will come to ask me for guidance, or if they have a really critically unwell patient and they're looking for like a nurse with more experience, they'll ask me for help. And so I think the fact that I like offer help a lot has given people who like, if they need help, they know they can ask me.

Recognizing that they had knowledge others have not gained and were able to share experiences contributed to the nurses self-identifying as nurses. Social identity is connected to the capacity of individuals to enact the values and beliefs of the profession through their knowledge and ability to build relationships with others. Nurses need to be confident in their own abilities, but they also have to have the recognition of others that they are indeed nurses. The interactions of group members and the meanings formed by individual nurses and the group are significant to the function of nurses to support good patient care and outcomes.

Adele described her experience, noting that her confidence and interactions with others made her feel respected by the other nurses and feel that she fit in with her work group. She gained this confidence by recognizing her own knowledge and abilities and having others recognize her contributions to the group and patient care:

> It also comes with a little bit of a burden in the sense of I'm very busy at work all the time because I'm that helper, and always getting people to orientate or stuff like that. But yeah, that's really helped me fit in because it's almost helped me not worry about what people think because I know that I'm confident in my own practice. Like when I go to work it doesn't matter who I'm working with because, yeah, I'm respected, and I guess I know who to ask for help, if that makes sense. And so, yeah, just my confidence. And I only got confident because of the years that I worked, and I guess like going from somewhere where I really didn't want to be to now somewhere where I think it's my fit, but you know. So, yeah.

Feeling like a nurse by developing confidence, expertise, and recognition by others takes time, as described by the nurses in this study. It is complex and is related to their ability to reflect on their own values, beliefs, and behaviours and how these fit with the social norms of the group and profession.

Feeling Comfortable and Uncomfortable

The nurses were asked about their experiences feeling either comfortable or uncomfortable on the units on which they worked. When the nurses reflected on their experiences in their work groups, their feelings of comfort and discomfort were tied to their interactions with other nurses and the feelings or meanings generated in them.

Feeling uncomfortable manifested in the nurses' practices when they felt that they did not know what was expected of them or did not have the knowledge to do their work. Feeling uncomfortable may happen during a new situation, joining a new group, and dealing with different patient complications or unexpected behaviours of others toward them. The experiences of the participating nurses indicated that it was possible to feel uncomfortable in situations where

they had previously been comfortable, and that experience and knowledge did not exclude them from having feelings of discomfort working in their group. Even the experienced nurses were able to describe recent experiences of discomfort in their practices. These findings were not surprising because the nurses' interpretation of the actions of and interactions with others produced meaning for them and how they fit in the work groups (Blumer, 1969). Feeling uncomfortable often lead to the nurses reflecting on the situations in which they felt uncomfortable and the subsequent development of new knowledge about their own and the groups' values and beliefs.

Feeling Comfortable. Feeling comfortable was associated with the ability of the nurses to follow the social norms of the groups that they felt were essential to their identify as a nurse.

Sarah described how her approach to the other nurses she worked with affected her feeling comfortable:

> So yes, definitely more comfortable, definitely feel like part of the team. It doesn't take long. I'm lucky on our floor that you pretty much, if you have a good attitude and if you're positive and have your smarts and a good head on your shoulders, it's easy to get along with most people. Sometimes it's not as easy with certain nurses, but a lot of the times I found we're all kind of a family, you spend 12 hours a day with these people, which is probably more than you spend with your own family. So you pretty much become your own work family.

Sarah acknowledged that her own behaviours and ability to demonstrate positivity and knowledge contributed to others wanting to work with her and her feeling comfortable in the group. She said that the other members of her work group were like a "work family," and this feeling of family was her interpretation of her interactions with the group and may have been the result of the other nurses having the same values and beliefs as her own. Sadie explained that along with helping patients, she also supported other nurses. By helping other nurses, she was learning from them and contributing to the comfort that she was developing in her own practice.

Sarah explained that learning from experience that the nurses on the floor liked to work together added to her comfort on the unit and her identity as a nurse:

> Yeah. I mean, I think the type of person I am, as much as I want to help the patients, I also do want to help the nurses. I want to make sure that all of our experiences that day is a positive one. So I think it just enhanced me, if that makes sense. Like I said, my beliefs, my values and my practice as a nurse just increased due to the other nurses as well. Them doing the same thing that I wanted to do, like I said, made me comfortable in actually doing it, so obviously I want to help them out. Me knowing that, that's kind of how we work on the floor. I was like, perfect.

Nancy commented on becoming comfortable working as a nurse in her group. The group members had developed cheat cards to help them to be prepared for the different clinics they ran and what each of the physicians and patients needed for procedure to run effectively. Nancy explained that they shared the norms of their own practices by communicating them verbally and in writing:

> Yes. I know the clinics. I know how the clinics need to proceed. I have a good understanding of what needs to occur. And we also put little things into place to make us more comfortable in my department. We have, for example, cheat cards in our department. Because we work with so many physicians and such a variety of physicians and we do such a variety of procedures that we have cards, a lot of which I've made that have a lot of key information that we need to run clinics efficiently. And we all use them.

Gina and Dana talked about being able to work with others and to have a plan for the day so that they had an idea of what was expected of them and what others were doing. Gina felt more comfortable because she knew that there was a plan in place:

> The most comfortable? I think when we have a plan when we're working together, when I feel less comfortable when we're working separately. When we're working together and we have a plan and everyone has their task, things run smoothly I feel more comfortable. If everybody's just for themselves and doing their own thing, it makes me feel less comfortable because I don't know what's going on or what's getting done and what's not getting done.

Dana explained that she built her comfort on the unit by finding colleagues whom she could ask questions, knowing that they would support her with knowledge or physical assistance

to provide patient care. Although the norms of the unit are to support the team, there are always those who do not. This cautions nurses to question assumptions that the collective norms of the group are the same as the nurses' individual perceived norms.

Dana sought out those whom she knew were prepared to support her and not judge her decisions. She mentioned a time when a move to another unit, which required her to learn how the nurses on the unit worked together and gain new knowledge, required to care for the patients on the new unit:

> I noticed that I was like finding people that I was more comfortable with, and I was able to ask questions too. I would find more resources on the computer. I would ask my patients more what they need. And I found different ways around, um, complications that I found throughout the day. Like if a patient was struggling to get up and use a walker or something, I'd be able to find someone else to walk with me to make sure that the patient stayed safe. And I didn't feel as judged if I was making different decisions than what other people did. Um, it was easier after time. Then I also switched floors and I started working as a float nurse. So that was a very different experience because it was really stressful at first when I was, um, working in new environments, they're all the floors are basically the same, but there's little things that are different, there's staff that are different, there's certain surgeries are different. So when I first started seeing knee surgeries and no knee, knees on X, I didn't really know what I was supposed to do. And it was kind of harder to find someone to ask my questions to, but you had to just realize that you're all in that together in a team. And I just had to just ask someone, whoever was nearest to me and they were very well, um, they, they were helpful.

Hannah talked about feeling comfortable after gaining the knowledge needed to care for the patients on her unit and what her role was as a nurse. When she felt that she did not have to rely on others' knowledge, she was able to focus on building her relationships with the nurses in the group and began to feel more comfortable:

> Just putting in the time. Just kind of getting comfortable with knowing what I'm doing and knowing that my role in my job. Then, once you kind of know what you're doing and like I said, working in ambulatory care is very different than working on the floors. So once I felt comfortable with, I knew what to do and I didn't have to rely on other people to tell me stuff. Then, you kind of know who you like to work with, and you can enjoy your relationship with your coworkers more because you're not uptight about, oh my God, did I forget this? Or how do I do that? Or where such and such? You know what

> you're doing in your job, so then you can concentrate, or not concentrate, but you're more receptive to your relationship with your coworkers.

Adele echoed Hannah's feelings about working as a team and knowing those you work with. She stated, "I feel comfortable working on X is because I know that the teamwork is there."

Adele also commented that because of these relationships with her team, she knew that "I can ask anybody who I work with for help and they're going to help me." This idea of knowing that others would be there to support you and who had knowledge and experience enhanced the comfort that the nurses perceive.

Cornelius explained:

> When I go into work and I see Jed-eyes (experienced nurses) on the floor, I'm very... I know they have my back, I know if I get a call on that team on someone, that they're going to be there.

There was a point where some of the nurses felt that they may have been too comfortable with their groups. Adele found that they may have overshared information in inappropriate places, such as in the hallways, patients' rooms, and public places as they became more comfortable. Adele said, "Like it gets to be a little too informal and there's maybe too much like oversharing in inappropriate places." Oversharing lead to some of the nurses feeling uncomfortable with how communication was taking place because it may have impacted other social norms of practice, such as breaking patient confidentiality, not focusing on their work, and possibly sharing unwanted information.

Feeling Uncomfortable. Kim was an experienced nurse and usually felt comfortable with the group of nurses she worked with. Kim described the following experience when asked if she ever felt uncomfortable working with the group. She explained how discomfort forced her to reflect on what happened and how it could be prevented in the future:

> It would actually be fairly recent, and I don't know that it was anyone's fault, but it was the first time my patient crashed being back in this ICU, and I didn't know the physician, it was a new physician. I didn't know the team dynamics and how they worked. And aside from communication breakdowns, which happened, the code didn't go well because what I was used to doing and running was different to how they were. And I was not okay for weeks after, until I ran into the physician and, being like, I need to talk to you about what happened. And then had to talk to a couple of the people that were present about what happened. And I was like, this is the most uncomfortable I've ever felt nursing ever and it was just, I think a culture clash a little bit and then poor communication with me and the physician… And at the end we were both like, okay, so next time we'll do this. And then next time, I'll do this, and we'll make sure that doesn't happen again.

Kim's feeling of comfort with the group was significantly negatively impacted by her experience. She was surprised how uncomfortable she was and wanted to discuss this with the physician and the group she worked with. She said that she did not know the team dynamics as well as she had assumed, and this made communication during the experience difficult. The result of her reflection on her discomfort allowed for her to communicate this with others and identify better communication as one of the solutions for herself and the group. The norms for communication of the group were not what she had expected, and this resulted in her feeling uncomfortable.

Joining another group even as an experienced nurse caused discomfort for some of the nurses in this study. Nancy described feeling comfortable and acting as a unit leader on her previous floor, indicating that she had knowledge of the social norms of the previous unit, the unit, and the patients who were normally cared for. She had gotten to know the other group over time and felt comfortable in her role there. When she moved to a new department, she had the lowest seniority on the unit and felt that she needed to learn to fit in with this group. As she explained, she did not like this feeling of discomfort of not knowing all the answers:

> I came to that job with 20-plus years [of] experience. I had a difficult time... I moved to a department with a lot of seniority. So I went from being second highest in seniority on a X floor to choosing a job that... I chose the job because it was good for my family.

> Honestly, I had teenage boys, I was a single mom. That's why I chose the job. And I went to a place where the nurses there had a lot of seniority, and I struggled with feeling like I was new again because I'm not really comfortable with that feeling. I was the unit leader just about every single day that I worked on a X floor to all of a sudden being the newbie who didn't know the answers and didn't know where everything was and that's hard for me to do.

Dave also talked about not feeling comfortable at times. He discussed feeling like he did not belong and referred to himself as the odd one out. He explained that he did not really know the nurses on the team and felt uncomfortable just jumping into the conversation:

> Uh, sometimes, I mean, sometimes it's just, uh, you know, you're- you're sitting in the corner charting, and like everybody else is hudder--huddled on the other side of the unit like having a--a fun conversation, and you're like, "Hmm, I really, I'm really the- the odd one out here," you know…That's a big part of it, yeah. Um, yeah, not- not knowing the people, you know, not- not wanting to just jump into a conversation that you're not included in, you know? Um, yeah, sometimes not knowing the subject matter too, whether it's like, you know, they're talking about, you know, Doug or Dianne, and you're like, "I don't know, whose that?" [laughs]

Dave became comfortable as he explained that as he got to know the group and the interprofessional team, "yeah, no, I think, there's, um, there's a lot of comfort in knowing that even if the shift is difficult, you've got a good team at your side." Dave's experiences with the group and gaining knowledge of what the values, beliefs, and expectations on the unit were that lead to his feeling more comfortable.

Bev explained that she was uncomfortable when she did not feel a part of the group. She said, "Like in the middle of the night, when you have time and you're chatting, the conversation was never focused on me."

Sarah mentioned the need to feel included in the group to be able to have a good day and enjoy working:

> So yeah, absolutely. It's hugely important that you feel like you have a good balance in your workplace, because if you feel like you're on the outside of it, it would be really, really hard to justify having a good day at work because yeah... It's like high school or different areas in life where you just want to be liked and appreciated. That's human

> nature to want to feel like you belong and you're well liked. So yeah, it would definitely be difficult for sure. And I feel for nurses who feel like that because yeah, that would make nursing a thousand times harder than it already is.

The context of the units where the nurses worked contributed to the discomfort that the nurses discussed when sharing their experiences.

Cornelius described how staff shortages and young RNs contributed to the feeling of discomfort that she had working with the group:

> I don't know if I've been super, super uncomfortable. Staff shortage is huge. Staff shortage is really, really huge. And when we have critical patients and we have young staff that don't have a lot of experience taking care of critical people, right? Like, if there's a lot of young RNs on and the manager has put a young RN and she's done that all the time, one year experience, and they're my leader in the playground, they're leading the group, and a critical patient and…

Cornelius felt uncomfortable because she did not see the leader having the knowledge or expertise needed to oversee the unit. She anticipated from her experiences that the leader would not be able to support her if there were changes in patients' conditions. The norms of the group were to have an experienced nurse in charge, but this changed because of the loss of experienced nurses and a decrease in staffing, which caused Cornelius to feel uncomfortable in her role as a nurse in this group.

The nurses sometimes felt conflict between the ability to follow the injunctive norms of the organization and the descriptive norms of their work groups. Adele explained that she was uncomfortable when she tried to enforce a norm such as decreasing noise on the unit at night so that patients could sleep. This was an injunctive norm set by the management of the unit. Some of the nurses in her group did not seem to follow this norm and were noisy at night.

Adele reflected on this in the following experience as she saw the need for patients to be able to sleep:

> Like I heard a thing before and they had like sound police on a floor, where they like on a unit with like really sick patients, they made sure that the nurses like kept their voices down, you know? So there was like a sound police, and I thought, "Oh, like that's pretty..." But I'm never going to be like, "Hey, you guys are being too loud," right? So that's like I think I know. Like, there's lots of times where I feel like, "Hey, you know what? Like, there's still sick people. And like your voice in the hallway carries exponentially to the rooms." And there's lots of times where I think, "You know what? This is like a bit too loud," but I'm uncomfortable saying something in that scenario.

The other nurses were behaving in a way that did not reflect the norms that Adele felt were important to her as a nurse, that is, putting patients' needs first. Not being quiet at night impacted the sleep of patients and could have impacted their health outcomes. Adele felt uncomfortable not being able to follow the norm that she valued.

Gina mentioned feeling uncomfortable when some of the group members displayed behaviours that she did not agree with, such as gossiping and excluding others. She was unsure how to voice her feelings about this and so chose not to question them. Although she said that she did not participate, her nonparticipation was noticed by the group and may have impacted their interactions with Gina, and hers with them. This was an interesting example of how one's inaction may trigger other behaviours that we are not aware.

Gina remarked:

> I've always felt that I wanted to be a part of this group, although sometimes I feel uncomfortable and don't participate in the negative parts, parts that I just don't participate in the parts of the group that I'm uncomfortable with. Gossiping or excluding, those behaviors, although I don't address them. I don't participate.

SIT, relational practice, and symbolic interactionism share similar perspectives. Through SIT, the meanings that we develop from interactions and communications determine our identification of norms and our social identity (Rimal & Lapinski, 2015). Through relational practice, we recognize our intra- and interpersonal values and beliefs (Hartrick Doane & Varcoe, 2021). Through symbolic interactionism, interactions produce meaning for us and contribute to

our actions with others (Blumer, 19969). Although Gina did not participate in the negative behaviours, others may have seen her not taking part in the gossip as giving them reasons to reflect on their own actions.

> **Memo**
> Inaction is something I have thought about. Gina talks about not participating in the behaviours she identifies as negative, but feels for the most part she wants to be a part of the group. How does her inaction around the gossiping affect how the rest of the group interprets it. Might it allow others to continue with the behaviour. This may link to discomfort and comfort, moral distress, and cognitive dissonance a feeling of discomfort first, then the nurses reflect on these feelings to make sense of them.

Some of the nurses talked about feeling uncomfortable because they did not have the knowledge needed to complete certain skills effectively. Sometimes they felt that they were being like they were a burden because they needed to keep asking questions. Often it was the result of being new and not having the experience to draw on. This discomfort led to their feeling that they did not want to stay in the job.

Victoria explained:

> And I'm like, but I don't, I'm not specialized in this. So that's why I'm asking. Um, yeah, it was, yeah, that would be it. Then I, you know, as a nurse, you should know how it feels like to work in something that you're not comfortable doing. Um, so you should at least be able to help. But yeah, that's when I was treated like a burden and I was like, "I don't wanna do X (laughs) anymore." 'Cause it is broad. You get everything in, in it. And, and that was hard.

This feeling of discomfort was mentioned by other nurses as they were first learning their job and understanding the needs of patients on the unit as well as the values and beliefs of the nurses they were working with. They often felt that they did not have time to develop relationships with other nurses because they were too focused on meeting patients' needs and did not ask for help.

Julia stated:

> Yeah. Just like feeling not confident on shifts when I just felt like I didn't belong because I wasn't organized, or I wasn't able to break on time. So then when I'd walk into the break room, they're all like, "Where were you?" I'm like, "I don't know. I was busy with my patients." Because I didn't know, even at the time, I didn't know who to ask for help.

Memo

After coding the interviews and identifying the concepts of comfort and discomfort the nurses experienced in their practices, I reflected on how this contributed to the process of social norm formation. It appeared that they felt much more comfortable when they knew how to behave with the group, who they could go to for information and what the group expected them to do. Interestingly comfort in the role was not always associated with the length of time they had been a nurse but more to the context and nurses working with them. Comfort made them feel a part of the group and reinforced the behaviour they had explained. On the other hand, discomfort made them reflect on what went wrong and they often realized they had missed something or misunderstood what they needed to do, did not recognize the social norms. (April 26, 2022)

The participants' ability to feel comfortable or uncomfortable in their work as nurses and with the groups was influenced by their interpretations of the meanings of their experiences as well as the context in which these experiences occurred and their experience identifying as a nurse. Comfort and discomfort played a significant role in the nurses being able to identify as nurses and enact the role successfully. The nurses in this study learned the group norms as they began to feel comfortable in their nursing role. Discomfort allowed them to reflect on their knowledge and behaviours, as indicated throughout their experiences. The feelings of comfort and discomfort were associated with the values and beliefs that the nurses held if the behaviours of others contradicted the nurses' own beliefs and values or if the values and beliefs they felt the profession held caused them to feel discomfort. The aforementioned experiences of the nurses in the study indicated how the feelings evoked by interactions with others caused them to feel comfortable or uncomfortable.

Identifying Unacceptable Behaviours, Values, and Beliefs of Nurses

Throughout the transition of "identifying yourself as a nurse," the nurses experienced interactions with others that contributed to their knowledge of what being a good nurse was. The nurses' norms of nursing practice were supported by their own values and beliefs that they felt aligned with their behaviours and what they saw in the behaviour other nurses. The ability to identify acceptable and unacceptable social norms of the nurses they were interacting with stimulated them to reflect on their practice and possible causes of the behaviours of themselves and others.

Social norms can be implicit and explicit, meaning that the nurses were aware of some norms and could easily list them. Other norms were implicit, meaning that the nurses were not always aware of the norms that they were enacting. If the nurses themselves behaved in a way that others felt was unacceptable to nursing practice, they were ostracized by other nurses not wanting to work with them. This was one way in which implicit norms were made explicit to the nurses in the work groups. The participating nurses talked about different behaviours that caused others or the interprofessional team members to feel uncomfortable. Sometimes it had to do with the ways that the other nurses judged their practices or behaviours.

Kim commented:

> I was talking with a colleague when we went for a walk that I cannot believe how judgey the team is. Wild, wildly judgey, very hard on the other professionals. I don't know why. That's something that I'm fascinated with. Like interprofessional relations are really fascinating to me. So I would say judgey has been a very, very common one and I hate to say it, but honestly, everyone's so burnt and I know that it's not the same as when I first started. Just Burnt. All of them.

Kim felt that it was the result of the nurses feeling burnt out, but she was not sure why the nurses were so "judgey" or why they did not support the interprofessional team.

Not being a team player was described by Eden as being toxic to the team, which spoke to the importance of nurses working together to support each other and their patients. Eden stated, “If you don’t have a team player or if you have people that dislike each other, it will impact. It’ll impact how that person works in the unit. Not good. It’s toxic, toxic.”

Being “judgey” could impact the relationships among the nurses on the team as they developed their ability to work together. Consistently being critical of coworkers was viewed as unacceptable behaviour by several of the nurses in this study and lead to difficulties working together. The behaviours of being critical and showing dislike for others resulted in poor working environments where the group members may not have trusted each other.

Nancy explained that others’ behaviours and interpretations of the behaviours could impact the work environment and result in others starting to think it was too hard and they were asked to do too much. These sentiments were reflected in Nancy’s experience as she started to question whether she was working too much:

> I think sometimes yes, it does influence it because sometimes now there’s the ripple effect. So it’s a lot harder to bring everybody up than it is to drag everybody down. So if somebody starts a ripple effect and starts grumbling and dragging people down and telling people that this isn’t good and that this is too hard, then sometimes that ripples through and other people are like, maybe they’re right. Maybe we are working too hard. And it’s much harder to say, no, no, this is really good. Like I worked every second weekend. I worked every second Christmas and every second New Year and every... There’s lots of good about it.

One norm that several nurses mentioned was the inability to say no. As nurses, they often felt that they could not say no, which sometimes meant working more shifts, taking on higher patient load, and taking on the skills of other members of the interprofessional teams. Unacceptable behaviours appeared to be the result of the expectation to take on increased workloads and the nurses’ perceived expectation that they could not say “no.”

The behaviours of others often set the tone on a unit. Josie described her experience working with nurses who did not support each other:

> Whereas if you have a group where you're going to say, "I'm drowning," and nobody comes to help you, it's going to be a shitty day, it's going to be a shitty group, and you're going to distrust the other members of the group. "Well, I can't rely on these three people to come and help me when I have a bad day, how do I then drop everything to help them when they're having a bad day?" Because I found that a lot with XX (nursing unit). There was one person who always needed help, super negative, "Come do this, do this, I need this." Just negative perspectives on a lot of things. But when you turn around and you be like, "Oh, can you help me just boost this person?" "No, I don't have time for you." And you're like, "But I just helped you do all of these things. You can't just turn around and offer this little bit of support?" And then it just wears down at the group dynamic, because then you never want to help that person, or you're always listening to their negative communication, or whatever. They're pessimistic, they just bring that atmosphere, so then your group just kind of like... The group becomes negative and pessimistic because there's that personality there that's causing it, so.

Josie explained that knowing that some nurses would not help made the work much more difficult and set up feelings of unfairness. It is through the interactions with the group that nurses develop meaning, so and by others being pessimistic and not supporting each other, it affects not only the mood of the group but the feeling of unfairness that other nurses do not reciprocate support. It is not only supporting each other with the physical work that impacts the group and the patients; rather, it is the ability to share knowledge with each other.

Patricia remarked:

> You know what, I think it works down to teamwork. Eh, I guess if you're... What I've found, mostly that I've found really hard. I think people don't share their knowledge anymore because... I don't know why that is. If they want to be more superior or I don't know. You see, when you work as a team, you got to share. Whereas when you work individually, you shine more I guess if you know more. I don't know what the... There is a problem though, with the nurses coming out of school right now. And I'm not sure what it is.

Sharing knowledge is important to the practice of nursing. Nurses need to mentor each other to provide care that leads to good patient outcomes. As indicated in Patricia's statement, not having others share knowledge leads to distrusting others and trying to understand why other

nurses will not share their knowledge. The norm of the group is to share knowledge, and not sharing knowledge is considered unacceptable. Unacceptable social norms often were recognized by the nurses as making them feel uncomfortable or unable to provide care to their patients and creating a poor work environment of distrust and unhappiness.

Jody described the influence that other nurses' behaviours could have on the group and the feeling in the work environment when they were present. There was a tenseness that she felt contributed to an uncomfortable work environment as well as not knowing what was causing the issue:

> Yeah. So, when you have some person, I don't know, whatever their outwork situation is, but if they're having like a very negative closed-off mood, so they don't want to communicate with the other team members. Or when you try to communicate, you get that short, snippy comment that's really out in left field, like it doesn't belong, so it makes you feel tense. Like you can feel that cloudiness and you're like, "Oh, that's not a good feeling." And you could feel it. That doesn't make it very effective at all when you have that situation. And then sometimes, it's actually hard to approach. Like is there something going on because they're already so...

The context in which the nurses worked also contributed to unacceptable behaviours, as Dave observed on his unit and throughout the hospital:

> Uh, but mostly, uh, from the floor, and not necessarily the floor, but the whole hospital, um, the, uh, ongoing global staffing crises is, uh, really wearing on people, uh, you know, a lot of the times the COVID floor is- is short, and part of that is burnout, and part of that is lack of staff. Um, and so we'll end up getting pulled over there, and then we're working shorts and, um, yeah, that's kind of created a culture of just frustration and, uh, fatigue.

Not having enough nursing staff on the unit impacted the ability of the nurses to work as teams or take time to share their knowledge. Cindy described a colleague not wanting to share information, noting that "she doesn't like to tell anybody anything. It's her business, her business only. Um, she feels the smartest when she's the only one who knows what's going on."

The nurses were unable to control the number of staff available to work or who they worked with, which may have lead to the frustration and fatigue that Dave mentioned. The feelings of frustration may have lead to some unacceptable behaviours exhibited by some nurses, such as an unwillingness to help or share information, poor communication, and changes in patient outcomes that the nurses in this study discussed.

Several of the nurses described bullying as an unacceptable behavior. Emily explained that "I felt at times humiliated and belittled by some of the staff that worked there because their expectation was so high that I just, I felt like I could never live up to it." Hannah described the actions of the bullies she had dealt with, commenting, "I remember when the bullies were there, I mean, one of them was horrible, this screaming and this kind of finger pointing in the face kind of thing." These types of behaviours made it difficult for the work groups to function well together and created animosity and self-doubt among group members.

Gina said:

> Yeah, creating conflict and bullying. I think it's important to be a hard worker and that I think there should be leaders, but I don't agree with the negative, gossiping…I think it greatly impacts work environment, whether it's going to be a smooth positive day or a stressful day. I think we all impact each other greatly based on how the day's going to go.

Most of the nurses in the study talked about situations that changed the feeling of their work groups from one of support and teamwork to the situation that Gina shared. The behaviours of nurses in the work groups impacted the way in which the team functioned, which could change the day from positive to negative, as Gina explained.

Jody gave an example of a work group not supporting a nurse, making Jody feel uncomfortable and possibly leading to mistrust of the group:

> "So, this poor nurse was having a really hard time during part of her shift and then they would go, "Ah, she didn't learn anything. She's useless. And I would say, "You didn't even help. You didn't even help her."

Jody felt that the other nurses had not even tried to help this nurse during the day, even though they recognized that she was struggling. Nurses like Jody may feel that they cannot change the behaviours or social norms of the nurses who are bullying or treating each other unfairly.

Josie and Sarah explained that behaviours that took nurses away from patient care were unacceptable and impacted other nurses they worked with. Using a cell phone and not responding to patients or supporting other nurses were issues identified by both Josie and Sarah.

Sarah explained, "If some of the nurses see you hanging around on your cell phone at the desk and your feet up and not really giving a hand, then that doesn't go over well, really, on our floors."

Josie described her experience and used herself as an example:

> I'm going to sit on the desk and play on my phone, or socialize and chit chat, and do all these things that are not work related, when my patient is needing something, or I could be doing something for my patient, or my peer needs me for some reason.

When other nurses see that a nurse is not doing the job, they will choose not to support that nurse when needing help or will not include that nurse in group activities. These examples highlighted the significance of the impact of others' behaviours on the ability of the group members to work together. Nurses who do not follow the social norms of the group affect overall group functioning and cohesiveness. The socialization of the group strengthens the perceived norms of the group and the norms of its members, so it is important for nurses to recognize the impact of the social norms of the group on their behaviours and identification with the group because it directly impacts their ability to nurse. Sometimes newer nurses do not know how to address the behaviours of senior nurses. It may be that the norm in the group is not to confront senior nurses when their behaviours are not acceptable to the group.

Dana shared her experience:

> Like, when you, XX (nursing unit), sometimes there were senior staff that would come in super late, and they would come in and change the board last minute. And it's, you've already researched all your patients, this and that, and that nurse isn't gonna change their way. So then you get stuck redoing all of your work. So that puts you in a bad mood, but you can't let it affect you in that way, because it's just one nurse's attitude that's affecting everyone, but it's not worth ruining your entire shift over.

Although Dana did not identify changing assignments as bullying, it is a form of power over others exhibited by senior nurses, who feel that they can simply change patient assignments without considering the work that other nurses have already done based on their initial assignments. Dana did not feel that it was worth bringing the issue forward, even though it impacted the workplace environment in a negative way.

All 19 nurses valued the ability of the members of the work groups to function as teams and support patients. Social norms that could cause a change in the tone of the workplace environment from positive to negative impacted the way that the nurses worked.

Julia explained:

> Yeah, that's what I was going to say is, when you're with the ones who are negative and who don't really care to, they'd rather do this than go help a lady wash her hair that hasn't got her hair washed in a week, it's definitely, the morale is low and the vibe is negative, and I feel like the patient's sense that. Whereas the ones that I enjoy being around, because we kind of have the same goals of what we're doing for the day, and the kindness, and the extra mile with our patients, it's, oh, the day is light. Things can go so wrong and you're like, oh, it's okay. A few code blues, a few of this, but it's still like, I'm just doing my job, and it's good. Yeah. So, it makes such a difference.

The ability of nurses to identify the unacceptable behaviours, values, and beliefs of other nurses is essential for them to address these issues and bring them forward. However, several of the nurses felt that they could not bring these behaviours forward to management because of the seniority of the nurses behaving in ways that went against the social norms of the profession and the work groups. Other nurses felt that they could voice their concerns.

Sarah described the following situation when she discussed racism:

> I don't know, maybe it's biases. I know we're not supposed to be biased when it comes to nursing and not supposed to judge, but they're still people at the end of the day and they're going to have their own feelings and prejudices and all of this stuff towards people. And I find, and it's not, it's everywhere, but racism, for example. And that to me is not acceptable, whereas to some people whose beliefs are different, it might be. They might see that as okay. But I am not one of those people. So I'll openly say that as well. Or I don't really agree with that or whatever the circumstance might be. So racism is a huge no-go for me when it comes to that.

In this situation, Sarah felt comfortable addressing her concerns about racism. For her, this behaviour was unacceptable and one that she felt that she could address.

Summary of Transition 1: Identifying as a Nurse

The nurses' experiences during this this transition encompassed their ability to assess how they as individuals made salient their identity as a nurse. This transition was about the nurses knowing themselves before they could continue the process of social norm formation. It is a temporal transition that can change over time depending on nurses' day-to-day interactions with other nurses, friends, and families, along with the meanings they built regarding their identity as a nurse. This section summarizes this transition and its four concepts of being a good nurse; feeling like a nurse by developing confidence, expertise, and being recognized as a nurse by others; feeling comfortable and uncomfortable; and identifying the unacceptable behaviours, values, and beliefs of nurses.

The first concept in this transition was one that required the nurses to decide whether their values, beliefs, and behaviours reflected those of other nurses whom they encountered. They talked about what it meant to be good nurses. The attributes that the nurses in this study associated with being good nurses encompassed values, beliefs, and behaviours that they felt reflected their own values and beliefs: empathy, compassion, trustworthiness, knowledge, supporting each other, putting patients first, and demonstrating accountability and responsibility

to patients and each other. For these individuals, feeling like nurses and identifying as a nurse required them to interact with others to learn the norms of the nursing through communication with each other to give meaning to their perceived identity as a nurse.

Hogg and Reid (2006) stressed that communication is essential for individuals to share their ideas of what the norms are of specific social identities "[because] norms are shared patterns of thought, feelings, and behaviours" (p. 8). The development of social norms through communication was evidenced by the experiences shared by the nurses in this study, and their identity as a nurse was influenced by their own ideas of what a nurse is as well as what was communicated by other nurses, family, and society. Once they identified with what they felt were the values, beliefs, and behaviours of nurses, they needed to feel they were nurses, which is explained in the next concept.

Feeling like a nurse, the second concept, was impacted by the ability of the nurses to develop confidence and expertise, and gain recognition from others as nurses. Their experiences reflected the premises of symbolic interactionism because their interactions with others contributed to identifying the social norms of nursing practice and the meaning of these social norms to them (Blumer, 1969). The temporal process of social norm development was constantly being reevaluated by the nurses in their day-to-day practices, when they sometimes felt that they were nurses and other times questioning their nursing identities. We can see from the nurses' experiences that they categorized themselves as having similar attributes, values, and beliefs of the nursing profession. Once in their work groups, their interactions with others allowed them to then identify the prototypical nurse. The attributes of a prototypical member may not be present in all nurses but is an ideal of what nurses should behave like and dictate how nurses should behave.

Hartrick Doane and Varcoe (2021) discussed nursing as a relating practice and that nurses' practices are shaped by how they relate to others. All 19 nurses in the sample provided examples of experiences that contributed to their feeling like nurses, such as other nurses asking them for advice, being able to help other nurses, recognizing that they were doing a good job, and feeling confident in their knowledge and abilities. These examples required the nurses to interact with other nurses to give meaning to the experiences. Feeling like nurses was not a stable concept; rather, it was affected by their comfort or discomfort as nurses, as discussed in the third concept.

Feeling comfortable or uncomfortable in their practices impacted their identity as a nurse. Feeling comfortable as a nurse was related to their feeling that they could care for patients competently and knew what to do. The nurses also felt comfortable if others shared knowledge and expectations with them, which contributed to their knowing how to work with other nurses. Comfort also was associated with the nurses feeling they were able to enact the values and beliefs that they brought to nursing and that they aligned with the nurses with whom they interacted. The nurses connected feeling comfortable with an increase in the salience of their identity as a nurse.

For the nurses in my study, feeling uncomfortable was a signal that something was not right. The discomfort often occurred when their own values and beliefs were at odds with the social norms of the other group members, they were not aware of some of the norms of the group and were ostracized for their behaviours, or they could not follow the values and beliefs that they felt were essential to nursing practice. When the nurses felt uncomfortable, they reflected on the reasons and tried to correct them, such as speaking with other nurses to question what they did that resulted in being ostracized. Kim did this when she was not sure what the rules were for

handling critical events. Adele reflected on her own values and beliefs and those of the group about their unwillingness to keep quiet to allow patients to sleep. She felt that they were not following the organizational polices related to patient care and were not supporting the values of putting patient first. The participating nurses were not always able to correct situations that lead them to feel uncomfortable, so they sometimes questioned their identities as nurses.

The fourth concept, identifying unacceptable behaviours, values, and beliefs of nurses, highlighted the impact of attitude on the workplace environment. Behaviours such as bullying, withholding information, criticizing others, any activities such as using cell phones and socializing extensively took away from patient care and the support of other nurses. Many of the nurses found it difficult to address unacceptable behaviours: Some took their concerns to management, but many felt that they could not do anything to address these issues. Unacceptable behaviours prompted the nurses to reflect on their own values and beliefs and consider whether the group social norms supported their own norms. The nurses also felt that the context of a unit contributed to the manifestation of unacceptable behaviours, such as when workloads were high and others were choosing not to support them or were unable to support them. Without such support, the nurses had to decide what care they could provide to their patients if they could not provide all of the care required.

Identifying as a nurse involved the study participants reflecting on their own meaning of nursing and how it was impacted by those around them. Their identity as a nurse became more salient as they moved through the transition, but they also found that their own ideas of what nurses are was sometimes challenged by their own and others' behaviours, causing them to question their own identity as a nurse. There was a flux in their identity as a nurse that was related to their ability to recognize the social norms that gave them knowledge of what it meant

to be a good nurses, feel like a nurse, be comfortable or uncomfortable in the role, and be able to identify their own and others' unacceptable behaviours.

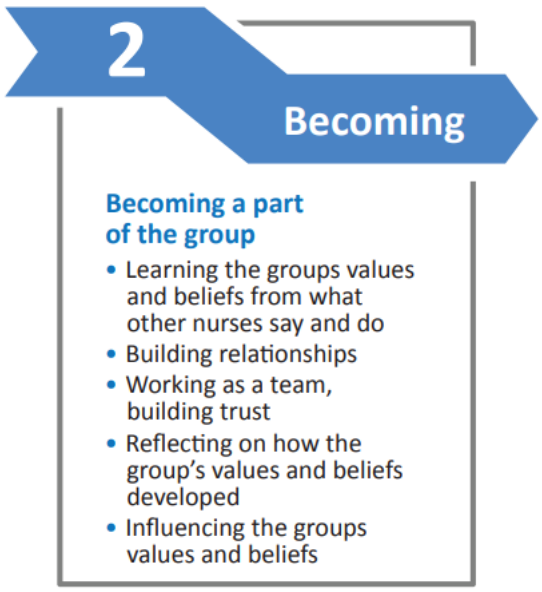
Contextual elements played a significant role in how the nurses interacted with one another to learn and follow the social norms associated with their identity as a nurse. These elements were discussed by the nurses throughout all three transitions and included their own attributes, the work environment, relationships with other nurses in their work groups, and their ability to communicate with each other. Once the nurses were able to see themselves as a nurse, they then needed to become a part of a group.

Transition 2: Becoming a Part of the Group

Becoming a part of the group was essential to the nurses' ability to care for patients, as they explained in their interview responses. Transition 2 holds five concepts: learning the values and beliefs of the group, building relationships, working as a team, reflecting on how the group values and beliefs developed, and influencing the group values and beliefs. The five concepts may occur simultaneously. For example, in learning the values and beliefs of their work groups, the nurses often developed relationships as they got to know the other members of the groups (see Figure 5).

Figure 5

Transition 2: Becoming a Part of the Group



> *I raise the pipe of my being to the rising sun in openness and humility. With eyes closed, I give thanks to the Life Giver and ask for strength to be humble through the course of this day. I smudge myself with scared medicines and give thanks for the blessings that are already present in my life. I ask for nothing. I only offer thanks. Then in gratitude and humility, I enter the journey each day. This is wakefulness, this is becoming, this is ceremony-and I am made more.* Richard Wagamese (2013)

Learning the values and beliefs of their work groups was essential to the ways that the nurses worked within the groups. The nurses talked about the importance of becoming part of their work groups and shared that it took time to learn how to fit into or become part of the groups. Evident within this second transition was the connection to the first transition. This speaks to the process of social norm formation as being fluid, that is, moving through and within the three transitions. The nurses' experiences, interactions, and meanings developed based on their social experiences in and outside of their practices. Throughout this section is a connection to the concepts in the first transition that carry into the third transition of the theory,

demonstrating the fluidity and temporality of the social norm development of the nurses in this study.

Learning the Values and Beliefs of the Group

The nurses commented that learning the values and beliefs of the groups that they worked with was fundamental to feeling that they were part of their work groups. The nurses' experiences varied: Some found it more difficult to learn the group social norms, but others transitioned easily into their groups and learned the social norms quickly. These feelings were impacted by the nurses' previous experiences, such as their confidence in their nursing knowledge and skills, whether they knew some of the nurses before joining the work groups, how group members interacted with them from the start of their experience with them, orientation to their assigned units, and the context and demographics of the units. Some group norms were obvious, or explicit, to the nurses, but other norms were implied, or implicit, and the nurses often learned them by being ostracized for their behaviours.

Sarah explained that nursing is more than knowledge and skills. It also is about watching, understanding, and learning the behaviours of coworkers to fit into the work groups:

> There's definitely no handbook or anything like that. I wish there was that tells you this is how we do it. There's so much when it comes to nursing outside of, this is how you do nursing. This is how you provide your care. And this is how you give this antibiotic. It's a lot of emotion and behaviors and a lot of that stuff that goes on as well. It's being able to watch it, understand it and then learn it from them as well.

Sarah's reflections were identified by all 19 nurses, who agreed that it was necessary to learn what behaviours, values, and beliefs were acceptable and would contribute to the group social norms. Sarah also touched on the challenge that the nurses faced when first working with group members and that navigating their own emotions as well as those of group members was part of learning to work in the groups. It often might have been difficult for the nurses already in

the groups to identify the group norms, many of which might have been implicit, meaning that the nurses just did things and did not ponder why. There was no handbook of group social norms to share with new nurses. As Cialdini (2007) noted, individuals often do not know why they do things the way that they do.

Some of the nurses learned group norms by asking other nurses and being told what the expectations of the group members were. More often, they observed what the other nurses were doing and how they were treated by the group members. Josie explained that the manager had expectations of what they needed to do, commenting that "there is a good impact from our manager in terms of being a leader in setting those expectations and holding to account those expectations. It just trickles down to everybody else. Because that is what is expected of us."

Kim shared that the nurses in a particular work group told her what the norms were. However, she also found that the norms changed from one to another:

> I don't know that I identified it. I think my teachers, or my preceptors identified them. So, on X, I remember like, "This is how we do things." When I got to XX up in [X city], "This is how we do things." And then the same with [another city], "This is how we do things."

Sadie watched what other nurses in the group did, stating that "it was more of just a visual learned behavior, in a way. Each shift, I would just see how people do things, and kind of just make my own routine."

Bev shared an experience with another nurse that happened when she was unable to get her paperwork done:

> I don't know. Or like if you're transferring a patient out, is all the paperwork done? I remember one time I didn't have all my paperwork done because I forgot something, or I didn't know I had to do something, and this nurse came on and oh my goodness. They were so frustrated with me. So, I stayed, and I finished it. But just that little things that really at the end of the day, aren't huge but make your shift go by smoother. I think that... Yeah. So, I guess I would watch and see how people acted, I would see what they did.

Bev was aware that other nurses' responses to her actions taught her what the group social norms were. In this case, the negative response let her know that she had to have her paperwork done before the next nurse took over the care of her patient.

Eden talked about teaching new nurses what to expect on their units in an attempt to share the norms of the group with them. Eden tried not only to tell new staff but also assure them that they would learn from what they did:

> I think it was the knowledge, but also because, and I've been told this, that when people first started in X, I would always go out of my way to make sure that they felt okay. "You're just starting. It's okay not to know everything at this point. It doesn't matter. It's going forward. Take every lesson and move forward with it."

This behaviour of supporting new staff was mentioned by several of the nurses as contributing to new nurses learning the group norms and supporting them as they became members of their work groups. Other nurses talked about learning the group norms from those whom they identified as mentors and senior nurses.

Dave mentioned a nurse whom he felt had been a mentor to him. Their relationship developed over time, and he was able to share knowledge with her:

> *M*entorships [are] a big part of it, too. Um, you know, when I started, I was fortunate enough that my preceptor was, kinda partnered with me again, and so she's remained a mentor figure to me, um, and even though, you know, we have things that, like sometimes I can teach her things, uh, it's- it's always good to have someone that you admire, and someone that you can kinda model your- your practice around.

Dave was able to learn the social norms of his work group from his mentor and model his practice on hers as well as his own values and beliefs. Several of the nurses identified senior nurses as maintaining a consistent level of care because of the group social norms that they expected the new nurses to follow.

Bev provided an example of working with a senior nurse and the nurse's high expectations of her practice:

> Yeah, definitely. And I think that when I started with so many really, really senior nurses within 5 years of retirement being there, I think that was really positive because it really instilled a lot of expectations into me and standards, if you will. And my preceptor, when I first started, who trained me, they were very regimented. And I remember at the time feeling like, oh, they're being a little bit hard on me, but it made me so much stronger of a nurse. And just that the expectation, the bar was set really high. So I always held myself to that standard. So then if I've trained people, I try to keep the bar high, too. Right? Because you want to continue that on, you don't want things to slip down as we go through the generations of the nurses.

Bev has now become one of the nurses responsible for precepting new nurses on a particular floor in the hospital setting. She felt that she needed to maintain the standards set by senior nurses and passes these values and beliefs on to new nurses. The nurses viewed mentorship and preceptorship as ways to gain knowledge of the group social norms to support their feeling that they were part of the work groups and were able to identify as nurses.

There has been a loss of senior nurses on many units. Kim explained, "I also got to work with senior nurses who had been nursing for well over 20, 25 years, which is so rare now."

This change in demographics on the units might have impacted the social norm development of the groups and changed the behaviors of the nurses in the groups.

Adele explained:

> And I work with like a relatively... Like, I would say probably mean age is like 20. Like newer grads, like early 20s to early 30s, like I would say that that's kind of the... So I think that the behaviors of like typical or like the kind of the average behaviors expected at that age, kind of also influence the floor. Does that make sense?

Adele thought that the newer nurses bring different values and beliefs that influenced the way in which the work groups functioned. Her experience reflected that of many of the nurses in this study. Different ages, their experience, and ability to support other group members impacted all of the nurses as well as patient care.

Kim commented on her experience when starting to work with a group of nurses. She identified the norms of the nurses in her group as being hard workers, supporting each other, knowing who needed help, and sharing knowledge with each other:

> Yeah, and I definitely took that as the standard of how a group should function was that first. So I would say, I mean, they were all really hard working. They were so busy, like if you were lazy, it just wasn't going to work. So everyone was a pretty hard worker. If I remember correctly, and I don't think that I'm romanticizing this, but I'm pretty sure everyone was really good at constructive criticism, accepting suggestions. Unit awareness was big having an idea of who was struggling, who was not struggling. And it's like nursing's so interesting. You spend like half your life with these people. And just kind of having even a basic understanding of who each other's were and the strengths and weaknesses, oh, made the team successful.

Kim felt that the group members worked well together because they paid attention to how each of them was doing, one norm of their group. Kim also stressed the importance of communication in learning the social norms of the group. She explained that "communication was big for me because I relied a lot on the senior nurses to help me through those first couple years." Kim felt that she had learned a lot from senior nurses, who had supported her in developing her practice and had helped her to understand the norms of the group.

The nurses learned early on that they would have to follow the rules of their work groups to fit in. Eden stated:

> It wasn't difficult to be part of a team because when you start with people, you know it's much easier. But I've seen people try and come in, especially in intensive care, they used to say that they'll eat you alive. They'll eat you alive if you don't play by their rules, basically.

Eden already knew several of the nurses when she started working with them in their group, which helped her to learn about many of the social norms of the group. She commented that if nurses who joined the group did not follow the norms, they were ostracized or corrected, and either excluded from the group or pressured to meet the group norms.

All 19 nurses realized that they needed to become part of their work groups to care for patients in ways that supported their values and beliefs of nursing, such as demonstrating compassion and empathy, caring, and sharing knowledge. Emily explained her own experience of moving from a surgical floor to a medical floor. She felt that she knew what she was doing as a nurse; however, when starting on a new floor, she felt out of her element and lost confidence in her abilities.

Emily said that it was tricky for her to fit in with a new work group and a new unit, and learn new skills:

> Oh, my God, when I started working on the surgical unit, prior I was a nurse on a medical float, so I had this basic idea of what I was doing. And I thought that it was just going to be kind of the same type of nursing except just the next floor up. And then when I started, I felt like I've never nursed in my entire life before. I felt so out of my element. I felt like I had absolutely no idea what was going on. I felt like it was my very first day ever in the hospital. It was so tricky my very first time getting into a new floor and a new group of people and a totally different type of nursing.

Emily's experience highlighted the significance of knowing the rules or social norms of a particular unit to feel like you are becoming a part of the group and that you know what is expected in terms of nursing skills on the new unit. She knew that she had nursing skills and knowledge, but she was uncertain about what was expected of her on the new unit, so she began to question her identity as a member of this work group and possibly even as a nurse. Ongoing communication with and observation of the nurses in the new work group allowed Emily to learn the norms and decide whether she could identify with them. She shared that it was tricky learning how to work with a new group. The uncertainty felt by Emily when she joined the new group was discussed by Hogg (2018), who attributed it to not knowing the attributes, values, beliefs, and social norms of prototypical members of the groups. Working with the new group allowed Emily to learn the norms through conversations, observations, and questions.

For the study participants to identify as part of their work groups, they had to self-categorize as having values and beliefs similar to those of other nurses in their work groups. This process is known as accessibility of fit, meaning that individuals can identify categories (i.e., values and beliefs) that are important to their own self-concept and that these categories fit with the perceived values and beliefs of other group members (Hogg & Terry, 2012; Oakes et al., 1991).

Josie provided an example from her practice as a student nurse. Before she graduated, she recognized that having more time on the unit on which she had a job would benefit her in fitting in with the group. Josie requested that her last clinical placement in school be on the unit. Josie felt that having the extra time to learn the expectations or social norms of the unit made it easier for her to transition to the role of graduate nurse on that unit:

> And I went back and I said, "I have a job," because by the time I was done, my first X placement, I already had my job offer. So I went back to whoever it was at the time, and I said, "I want to stay on X and have another six weeks, because I'm going to start working there at the end. And I just, I don't need to know something else, because this is where I'm going to be." So I knew that it was beneficial for me to stay there and to continue to work, because it would be an easier transition.

This extra time also allowed the other nurses in the work group to establish a relationship with Josie and support her efforts to learn the norms of the group.

Although the nurses needed to learn the social norms of their work groups, they also had to reflect on how these norms impacted their own values and beliefs. Sarah noted that identifying what the nurses were doing in their day-to-day practices and then adjusting her practice allowed her to meet the group norms in her own way:

> It was already set in stone, but often fluid and moving as well in a changing and adjusting... And you find it in yourself too, okay, that might work for them. But for me and my time management, I'm going to start my shift summaries mid-shift and then amend at the end whereas some people wait until the very end of a shift to write them.

> I'm like yeah, but so much can go on between. So you figure out your own within the set of roles or behaviors that are already there.

Sadie also talked about the unit that she was working on:

> I think that they definitely exemplify the compassion, the caring, the helping hands, I think, for sure. I think it's been very nice to work on a floor that my beliefs of how a nurse should be is also shown by everyone else.

Sadie recognized that the values and beliefs of the other nurses in her work group were the same as hers. Both Sarah and Sadie reflected on the meanings of their interactions with their coworkers on the units and reported that they aligned with their own values and beliefs. Their experiences of learning the social norms of the units and fitting in with their work groups were balanced against what they felt the norms of nursing should be.

The first concept of the second transition was an important step in the ability of the nurses to fit into their work groups. The nurses gave examples of how they learned the group social norms. Through interactions with other nurses, they learn the group norms and developed meanings about how they fit into their work groups. Norms were communicated to the nurses through both verbal and nonverbal behaviours. The nurses often watched what other nurses in the work groups did and how others reacted to their actions. They also asked more experienced nurses what was expected of them, what their role was, and how they were expected to fill that role.

Josie explained that some nurses who join the work group were unable to follow the rules of the group, despite receiving constant reminders and being held accountable for their behaviours. This eventually lead to their leaving the group and the unit:

> Right? So, they're struggling in their day, and it's projecting back out to everybody else. Now eventually, this person got to the point where they just recognized that this is not the place for them. They couldn't do it. And a lot of it was, they were still being held accountable to the expectations of the unit. So, they weren't flipping their MARs [medication administration records], and they weren't giving their midnight meds, and

> they weren't putting linen back on the stretchers, or doing all these things, so it was always like, "Just remember that these are things that we do on this unit." And they didn't like that, so they ended up leaving and going somewhere else.

As a consequence of not engaging with the social norms of the group, the nurse was made to feel they did not fit within the group. Throughout the experiences of the nurses participating in this study, if someone did not become part of a work group, that nurse would lose the support of the group and would be unable to provide effective patient care. Although the nurses in the group explicitly stated the rules, such as checking the MAR, giving medications on time, and changing the linens on stretchers, there also may have been implicit rules that were not easily recognized by the nurses.

Group social norms often were implicit and were not always easy for nurses new to the work groups to identify. It was not until they received negative feedback from other nurses that they realized that they had not followed the group norms. Sarah said that there was no handbook of the rules or social norms of nursing, so they needed to be communicated between and among the nurses in the work groups. Social norms are complex, with nurses in work groups bringing along their ideas of how their values and beliefs support their ideas of what the norms of nursing practice should be. There may be incongruence between group norms and what individual nurses associate with the norm of practice. This incongruence may lead to nurses questioning their ability to remain in the work groups if they feel that they are not prototypical of the group, that is, not possessing the same attributes that they perceive other nurses in the groups as having.

Learning the values and beliefs of other members of the work groups contributed to the nurses being able to build working relationships with each other, a topic discussed as the next concept in the transition. Learning the group social norms were affected by the nurses with whom the nurses in this study worked, whether they shared the rules of the group with each

other, the context of the unit and work environment, and communication between and among the nurses in the work groups. The next concept of building relationships explicates the significance of relationships in learning the group social norms.

Building Relationships

Within the concept of building relationships are two subconcepts: knowing oneself to build relationships and building relationships to support each other. These two subconcepts demonstrate the significance of relationships in becoming a part of the group. Relationships give nurses the opportunity to learn the values and beliefs of other nurses and how they align with their own. The nurses needed to know that other nurses would support them, which was a norm they all explicated in their experiences. They needed to know that if they required help with skills; knowledge; physical assistance with patients (positioning, transferring, and physical care of patients); or someone to listen to their concerns, their colleagues would be there. Trust was built through these relationships. Knowing that others would not support them lead to the nurses not feeling like they were part of their work groups and often lead to distrust. Relationships contributed to the nurses learning the group social norms and reflecting on how these norms aligned with their own and contributed to their identifying as members of their work groups. These elements of personal attributes, work environment, relationships, and communication are woven into this section.

Being and Knowing Oneself to Build Relationships. Building relationships happened over time for the nurses in this study. Many of them found that they had to feel comfortable self-identifying as nurses before they felt comfortable enough to get to know the other nurses on their units. In the section focusing on the first transition, the nurses discussed comfort and discomfort. The feeling of comfort was built on the nurses' salience as a nurse and being able to follow the

values and beliefs that they felt nurses should have and discomfort when they did not know how to fit in or when their own values and beliefs were not the same as those of other nurses in their work groups. In this concept, several of the nurses talked about not being comfortable in new environments where they did not know the values and beliefs underpinning the social norms of the groups. When other nurses in their work groups reached out to ask them to join them at break time, they had the opportunity get to know the nurses and learn some of the norms of their work groups.

Julie explained:

> Yeah. This one nurse would offer me to go for walks on my break, and that's what I like to do, so that made me feel more comfortable with the people because I was really shy. People don't think I'm shy, but I am shy, especially in a new environment like that, and feeling like you literally know nothing. So yeah, just little things like that, going for a walk, or, I remember this one lady asked me if I wanted coffee. I'm like, "Oh, sure, yeah, ok I'll have Coffee." Yeah. It just took those little invites for things that made me feel comfortable. It wasn't even the nursing care that I needed to be and feel inclusive, it was just like the break time, or even how people responded to my questions was a big thing. Because I had so many questions, like I said, with all the new medication and everything, if I had someone that said, "Well, no." Like the... But they were all so wonderful. I think because they really understood it wasn't the same as anywhere else, yeah. So, just being inclusive I guess, and the way that they would respond to questions was another way that I felt comfortable.

Julie felt that being included in her work group gave her the opportunity to gain more knowledge of the social norms and expectations of the group. Getting to know the norms of their work groups allowed the nurses to reflect on how they fit within the groups and assess whether their values and beliefs aligned with those of other group members. Being included by others and getting to know the individual nurses in the work groups contributed to the ability of the nurses to understand how prototypical members of the groups would behave.

Jody shared:

> It's that, I don't know if care Is the right word, but it's more like they want to know how you're doing, always. "How are you doing? How are you doing right now? How are you

> doing today? How are you doing?" They always want to check in and make sure that you're doing okay, always. Always, they ask that.

The sense that others have the same beliefs and values as we do increases our wanting to belong to those groups (Rimal & Real, 2005). Nancy explained that she wanted to work with other nurses that she could count on. She also commented that these were the people who brought their values and beliefs from outside of work to the workplace that she wanted to build relationships with:

> I guess that I think that the people that I feel like are the best workers at work are also the people that I think in everyday life would be the people you know you can count on. I don't think people can fake it in nursing. I think that if you are that kind of a helper and you're a helpful person and you just show up all the time and you're there and you're dependable, I think that's who you are in life. I think you're that way with your family. I think that's the kind of girlfriend that you are. I just believe that's who we are.

Nancy felt that she that she fit in with the other nurses in this group, and she self-categorized as part of the group because there was a high degree of fit between her values and beliefs and those of the other nurses in her work group. Self-categorization is the cognitive process individuals take part in to identify with a group, to see others in the group as having the same values and beliefs and acting in similar ways (Hogg & Reid, 2006). Nurses can build relationships more easily with others with whom they identify, even going as far as comparing them to family.

Some of the nurses in my study found it was difficult to become part of their work groups and to have others see them as a part of the groups. They had preconceived ideas of the ways that nurses on a unit do not always welcome new nurses and listen to what they have to say.

Sarah shared her experience when she started in a work group:

> I remember learning in university and hearing it, he said sometimes nurses eat their young, right? It's tough not to go in with that mindset. Some of these ladies have been nursing for 30, 40 years and they're used to doing it a certain way. And here you come in suggesting or doing something different and they don't like that. And not to say that it

> doesn't happen in other positions also. Because I know that nursing is really known for that as well. And it can be super intimidating. So the first year for sure that you're getting under your belt, you are trying to figure it out, get your way into the inner group or circle.

Sarah said that she had to figure out a way to become a part of the group, or "join the inner circle." Her experience was similar to those of other nurses in the study and demonstrated the need for nurses to become part of their work groups by learning the social norms of the units. It took Sarah time to adapt to the group norms and be able to share her knowledge so that she could begin to become part of the work group. Sarah went into her practice having heard that "nurses eat their young," so was anticipating not being welcomed or listened to. She noted that it took her working with the team for more than a year to become part of the work group.

Norms are temporal and can change because of differences in the context of the work, such as changes in group members, workload, and communication, all of which may see individuals questioning whether they still self-identify as having the same values and behaviours of their work groups over time (Hogg & Terry, 2012). Norms develop through social interactions that are impacted by changes to context, and they can be revised through the meanings that the interactions and context have for group members (Rimal & Lapinski, 2015). Sarah had to develop relationships with others to be able to make suggestions to other nurses in her work group and possibly influence practice.

Several of the nurses talked about needing to feel comfortable with their identity as a nurse before they could develop relationships with the nurses with whom they worked. Nurses who were able to identify with the values, beliefs, and behaviours of the other nurses in their work groups found it easier to build relationships in the groups. Several of the nurses had experiences similar to Hannah's, that is, feeling that they needed to know that they could practice

as nurses before they felt comfortable and not as “uptight” cultivating relationships with the nurses in their work groups.

Hannah explained that it took time to build relationships:

> Just putting in the time. Just kind of getting comfortable with knowing what I’m doing and knowing that my role in my job. Then, once you kind of know what you’re doing and like I said, working in X is very different than working on the floors. So once I felt comfortable with, I knew what to do and I didn’t have to rely on other people to tell me stuff. Then, you kind of know who you like to work with, and you can enjoy your relationship with your coworkers more because you're not uptight about, oh my God, did I forget this? Or how do I do that? Or where such and such? You know what you’re doing in your job, so then you can concentrate, or not concentrate, but you’re more receptive to your relationship with your coworkers.

Hannah also spoke about needing to learn what she was required to do on the unit with the group before she felt comfortable enough to build relationships.

Building relationships also meant recognizing assumptions and their impact on group functioning. Kim gave an example of her assumptions affecting the ability of members of her work group to work together. A patient was suffering from a cardiac arrest, and the group members needed to work together to support the patient.

Kim said:

> For both of us. And he was a new intensivist, too. So it was a really good learning opportunity for him. And then for the ones, for the nurses, I had to do a couple of apologies because I turned into a ginger ninja there for a bit. So did a couple rounds of “I’m sorry,” and then they explained to me that, where in [city], you go in and everyone gets assigned a role. They said that they’ve just been working together so long that they kind of naturally fall into roles. So when I assigned them, it almost shifted everyone one way. So someone that they already knew was going to take electricity and the cart because of where they were standing or kind of the vibes they already had together. I didn’t pick up on that because I hadn’t been working with them. So everyone was just kind of like, “What’s going on?”

Kim was very upset that she had not understood the roles of the nurses and intensivist she was working with and had tried to assign them all to a role. Kim talked to the group after the

experience, and they explained that they had been working together so long that they knew what they were expected to do and were not used to being assigned specific tasks.

This was one of the challenges that nurses encounter when learning the group norms that often are implicit and are taken for granted (Cialdini, 2007). It is only when there is conflict or the questioning of others' behaviours that they become explicit. Kim felt that she missed these rules because she had not been working with this group for very long.

Many of the nurses provided examples of not knowing the social norms until they behaved in ways that were accepted by other members of their work groups. This experience of needing to follow the group social norms was seen as essential by the nurses in this study to become part of their work groups. If they did not follow the social norms, they were sanctioned by other members of the work groups. In Kim's case, the other nurses did not fall into the roles that she had assigned, so tension built up in the group during a critical event. Having the ability to reflect on the situation and work with the group members to helped to build a collegial relationship.

Supporting Each Other, Building Trust. Receiving and providing support were fundamental to the nurses being able to build relationships and trust. Getting to know one another and identifying other nurses who seemed to possess the same values and beliefs allowed the nurses to feel comfortable in their work groups.

Kim explained that knowing the nurses that she was working with and how they would behave when there was an unexpected event made her feel safe:

> Absolutely. You think if you up, a patient rolls in that's like been knocking on heaven's door for however long, and you've got all the right people in there. You feel safe. You feel that your own competence can... Is there because you're calm. You know that if you've missed something, someone else is right behind you. They got you. And someone throws a joke in there at some point is even better. You can handle that. And that's so different than when the wrong crew is in there.

The relationships that she had built with other members of her work group allowed her and other nurses in the study to know whom to trust and not to trust. This was a common theme in the nurses' descriptions of their experiences: They found that working with some groups provided a sense of calm and trust, whereas working with different groups sometimes changed the mood of the work environment to one of distrust and loss of cohesiveness.

The ability of group members to work together to support each other was challenging when factors out of their control existed that impacted the work environment. Working short staffed decreased the ability of group members to support one another. The nurses in the groups relied on their ability to communicate their needs to each other and request support.

Emily stated, "It has been insanely short staffed to the point where at times, we don't even have time to think, yet alone communicate with each other."

Emily explained further that during the COVID-19 pandemic, the unit that she was working on expanded to become the COVID-19 unit; however, there was no increase in staffing:

> I just felt like during that, when X [unit] turned into the COVID unit, and then we expanded onto XX [another unit] and I have like 10 patients and I just felt like I was just like this, I felt very angry. And I hated that, cause I'm tired, it's so unattractive working with somebody that's angry and that's change all the time. So I was just so angry and when people would say "Oh, put your mask over your nose." I would just lose it. I just, I don't care about that right now. I care about this person dying in this room, I just, I couldn't even deal.

Emily felt angry, which had a negative impact on the work environment of her entire group. She felt that she was not doing enough for her patients. Many nurses in the study identified patient care as being central to their values and beliefs around their nursing practice. Emily was very frustrated because she felt that she was not providing the care to patients that she wanted to and was being challenged for not wearing her personal protective equipment (PPE) properly. She did not feel that she had support from other members of her work group. Many of

the nurses talked about the ways that context, such as workload, affected their ability to support other nurses. When the nurses had difficulty managing their workloads, they became frustrated and did not have the capacity to help others. Like other nurses in the study, Emily talked about her work group welcoming other nurses to help on the unit when they were short staffed. The group norm of helping each other extended to any nurses who came on their unit.

The difference between positive and negative work environments demonstrated the variation in how nurses perceived the norms of their work groups, as Bev explained. On some units the nurses checked in on each other and offered support, whereas other units did not, which affected how work got done and how the nurses interacted with each other.

> Yeah. So say even just talking to other friends who are nurses, or like I said, like the nurses who come up if we're short staffed to be extra help, I think that they always recognize just how helpful and how much of a team it is. That's the one thing, even students that come, they're like, "Oh my goodness, this is such a team environment compared to other places." Or nurses will come and say like, oh, you just, you ask for help turning your patient and people just stand up and come and help you. That would never happen on this unit. And that always stuck out to me because I thought like, "Really? Someone would just come and help you?" But no, that's the case. And even if you go out for say a met call type of thing, some units you notice are really all hands on deck or more so than others. And some you do see that divide and I thought, "Oh wow. This is like a real thing."

The nurses needed to know that they could ask questions of other nurses if they were not sure about what to do. However, the response of the nurses affected their perceptions of how they worked together or built relationships.

Bev explained that patient safety came first and that for her to feel that she could care for patients, she needed to know that nurses on the floor had knowledge and experience to support her and would "have her back" if she needed it:

> Even now, even when I go back now, you think like, okay, who's on that's a really strong nurse today who will help me and who will support me if I need help? I think those are the things. So the support and being a team player and I guess being kind, not being mad at me for asking for help, but I was never afraid to get yelled at. The patient always came

> first. I was never putting my ego ahead of my patient's safety or care, which I think was important, because some people care about that. They care about what other people think more than... Yeah. More than. Yeah. They don't want to look like they don't.

Bev also touched on a belief that often undermined the ability to build relationships with other nurses. Nurses who did not seem to put patients first and, instead, valued how they were perceived by others rather than ask for help, were seen as engaging in inappropriate behaviours that were a risk to patient safety. Bev did not feel that this type of nurse would support her. This sentiment spoke to the need for group members to see others in the groups as possessing the same values and beliefs as their own. They had to feel that they knew what the attributes, values, beliefs, and behaviours of prototypical members of groups were, and they had to consider them to be similar to their own. Supporting each other was viewed as an essential behaviour by all 19 nurses in the study and allowed them to work as teams and trust each other.

The experiences of working in groups varied among the participants. Sometimes they worked with other nurses whom they identified as easy or difficult to work with, depending on the individuals' values and beliefs. Some nurses did not seem to want to work together, or their presence and behaviours changed the feeling of the units that they were working on from positive to negative, impacting the entire group.

Nancy shared her experience:

> Yeah. And it makes me really sad when you hear everybody say, oh, my God, look who I'm working with today. Or, oh, my God, look at this and you should trade in and work with me because there's certain people that we work with and it's like, oh we're working short tomorrow. No. We'll be fine because you see who you're working with… Yeah. I think that you read people because I don't feel that way with everybody I work with. You know that there's people that have your back all day, every day and it's not just me because in my department, it's very common to hear the nurses say, oh, it's going to be a great day. I looked at who I'm working with. It's going to be a great day or you're not going to believe who I'm working with tomorrow. There's lots of people say that in my department.

Nancy's experience was similar to those of many of the other nurses in the study. They recognized the behaviours that they wanted to see in their peers that would help them to fill their role as a nurse and support their patients. They wanted to work with nurses who "have their back," whom they could rely on. It was important to the nurses to accept and provide support to each other in an effort to contribute to and build relationships in their groups.

Adele addressed the importance of having good relationships with other nurses that contributed to a sense of connection:

> I don't know. Like, it's nice to go to work and have coworkers that ask you how things are. Like, it's nice to go to work and have people in your corner and, like, that care about outside of your life.

Adele also explained how this connection would change if the amount of time working with other nurses changed:

> I had one more thought. It's just when you work with people for 12 hours a day, like 12 hours is a long time. And like, it's just a really long time. And it's just nice to go for break and have like conversation, right? Or like those like quiet bits of time. Like, it's nice. Like, I think part of it perhaps is that like I crave like human connection. And so like the people that I spent the most time with when I was working full-time, now I work part-time, so my life looks different, but for the better part of a decade, I worked full-time on X and like I saw them more than I saw my own family most week.

Sarah spoke about having good communication with each other as contributing to building trust in knowing what to expect from other group members:

> There's a lot of good communication that goes on and we often will chum around with each other, even outside of work because we get along so well. And that's not to say everybody wants to hang out with their coworkers outside of work or, or whatnot. But I find that a lot of trust goes into working with these people. And then if you enjoy hanging out with them as well, then that's really beneficial. I would say it's a really positive unit.

Several of the nurses connected the development of their relationships as extending beyond the workplace. Members of their work groups became friends outside of work.

Adele connected these relationships to her identity as a nurse:

> So, it feels like it's my job, but it feels like more than a job. It feels like it's woven into my identity. I think sometimes I think I'd like to try to separate that a little bit just for a better work-life balance, but I think that the caregiver healer part of myself is like nursing is woven into my identity. Yeah. And not just because of the job, but because of the relationships I've built through the job. Like, your co-workers becoming your friends, right? So now I have this whole group of people that are only in my life because of nursing that I wouldn't have met without nursing, and they're very dear friends. So yeah, nursing just really kind of became part of my identity.

Adele's experience explained how self-identity can become embedded in social identity. The nurses in my study mentioned that their own values, beliefs, and behaviours aligned with those of other nurses in their work groups whom they believed had the same ones. Nurses often develop relationships with group members outside of work, as Adele described in having friendships with colleagues.

Many of the nurses talked about always feeling that being a nurse was part of their work and personal identities. These relationships outside of work influenced their behaviours at work because they felt that they were more like their friends and, as such, were more likely to identify as part of their work groups, as Adele explained. Social interactions allow individuals to decide whether they have the same attributes as other members of their groups, self-categorize as part of groups, and identify as members of groups (Hogg & Terry, 2012; Willetts & Clarke, 2014).

Attributes such as emotional intelligence and humility allowed the nurses to develop relationships and function as members of their work groups. Dana stated, "Like, it all depends on your personality. Like if, um, you're willing to work, work along each other, then it gives a better tone to the relationships."

Josie talked about being able to sense whether the nurses with whom she was working were coping to do their work:

> I had a nurse, and it was like, she was there, but her mind was somewhere else. I was like to her, I don't know what's going on with you, but you're scaring me. This is basic nursing care, and I don't understand what's going on. It's like, you're here, but you're not here. I barely even knew her, and it was really difficult for me to tell this nurse this. I was scared that she was actually going to hurt someone, so then I think by me just being straightforward and stating facts, she then opened up to me that she has this crazy outside work, like family dynamic going on, that she was bringing to work, that she was trying not to bring to work. She ended up going off on stress leave even before the end of her orientation, and then her being able to own up to that, and for going on stress leave and then her coming back, she was a different nurse.

Several of the nurses identified the ability to sense how other nurses were managing, a skill that contributed to their capacity to support and receive support from other nurses in their work groups. This ability also seemed to support group cohesiveness.

Feeling comfortable or uncomfortable were feelings that the nurses recognized in identifying as a nurses and in building relationships. There was flux in the nurses' ability to identify as a nurse and build relationships that formed connections between the transitions. Nurses are always navigating their own personal norms with those of the group, and they recognize that their ability to build relationships impacts their comfort in the group and as a nurse. Reassessing their identity as a nurse and building relationships was apparent in Josie's experience of working with members of a new work group. She was comfortable in her role as a nurse, but not as a member of the group. She felt that the nurses in the group were "cliquey" and not open to other nurses joining their group.

Josie did not just want to jump in, so it took her time to figure out how to work with the nurses in the work group:

> Yeah, yeah. I would say those are more towards like the beginning when I don't really know the group dynamic yet. So, the first time, like I said, when you're with a group and they're very, I guess, cliquey would be a good word. So, they're cliquey. They work well

> all the time together and you're coming in, you're fresh or you know your job, but you just don't usually go to that unit. So, then you feel uncomfortable and you're not sure how can I effectively work in this group. Like, I can't just jump in. I don't know these people. I don't know how they work. They seem to be really well-tied together and I'm like over here. That's happened.

Not knowing the group social norms can cause stress for nurses if they need to step in to work with new groups. Several of the nurses mentioned that they did not know how to fit into new work groups. They explained that if they had established previous relationships with some of the nurses, they could ask questions about the expectations or rules on the units. Relationships were imperative in allowing new group members to learn the group social norms.

Julia shared how she felt when starting with a new work group. The group members did not support nurses who did not exhibit the same values, beliefs, and behaviours that they supported. The nurses in the group expected the new nurses to know the skills, and Julia said that they ridiculed them when they did not by saying things like, "Oh, how come they don't know this?"

Julia felt that because she had to learn things on her own, it took her time to feel confident and fit in with the group. She questioned why the nurses in the group behaved as they did:

> So yeah, I would have to say that like, and I don't mean to say it like I hate, but like, the not, how do I say this, the people that aren't as strong of nurses, I feel like don't fit in, because it's like that's what they've created. They've created this like, nope, you have to know all your skills and all your assessments, and just be like a really great nurse to work on the X floor, which I think is, like, I wish it wasn't like that, it shouldn't be like that. People should be able to come down, and learn, and feel comfortable, but that's definitely not the environment or the behaviors that we've created. I say, we, because, well, it's me too sometimes. It's hard to assist and help all the time when you're so busy, I guess.

As Julia reflected on her experiences with the group, she wished that they had welcomed other nurses to their unit, but she rationalized that it was because they were too busy to help everyone. They felt that that they needed nurses who were already knowledgeable and skilled

because they did not want to take the time to support the growth of other nurses. The norm of this unit was not to support and mentor nurses new to the unit.

Supporting other nurses was viewed as an important attribute of the nurses working in most of the work groups. Supporting each other made their practices easier, which enabled them to provide better care to patients. Julia did not comment whether there were enough staff or whether they had the support of management on the unit, which would have contributed to the formation of the social norms on this unit.

The nurses in my study did not necessarily have to have close relationships with other nurses to be able to tell if they were managing their workloads and providing safe care to patients. Their behaviours often would lead them to offer support. Being able to offer and accept support is associated with humility. Humility is a personal attribute that impacted all the transitions within the process of social norm formation of the nurses in this study. B. Brown (2021) explained that "humility is about understanding our contributions in context, in relation to both the contributions of others and our own place in the universe" (p. 246). The nurses recognized the importance of offering as well as accepting support. This ability to give and take strengthened the relationships of nurses with each other. Being able to work well with each other improved their ability to provide care to their patients.

Building relationships was expressed by the nurses as paramount to working together effectively to support patient care and establish a comfortable and enjoyable workplace environment. The relationships that the nurses developed in their work groups allowed them to observe the behaviours of other nurses in the groups and ask questions to identify the group social norms or rules. The values and beliefs that they brought to the relationships were part of their own identities nurses and impacted their ability to build relationships with the other nurses

in the work groups. Building relationships is complex and is influenced by the contextual elements of personal attributes, work environment, and communication. Once the nurses developed relationships with the other nurses in their work groups, they found benefits and challenges to working as teams.

Working as a Team. When individuals identify as group members with attributes similar to those of others in the same groups, they begin to develop the group norms, values, and beliefs that influence group functioning (Turner & Reynolds, 2011; van Kleef et al., 2019).

Sarah discussed the significance of becoming part of a work group:

> I do like watching people get better and caring for people, for sure. But after everything that we've all been through over the last couple of years, especially, and the shortages and all of that stuff, I would say the... And it can be very, very bad. And yeah, it's the team that honestly brings us together. And I've heard a few nurses say like, if it wasn't for our coworkers and our team, I would've left nursing a long time ago. So, yeah. It's a huge, huge role.

Sarah's comment echoed the experiences that many of the other nurses in this study expressed. She shed light on the challenges of working as a nurse in the context of staff shortages. She shared that she would have left nursing if it had not been for the team that she was working with.

Josie explained how her group worked together to support each other, even when the unit was very busy:

> You can have the shittiest shift, and it's fun because you get to use your skills and you get to do all those things, and the people around you make it fun, even though... So yeah, I guess that's the biggest thing. It is what keeps me wanting to be in this profession, even in the worst of the worst days, so.

Sarah and Josie perceived team cohesiveness as keeping them in the profession. This sentiment was acknowledged by several other nurses in the study. They knew that their work groups would support them and would strive to maintain a positive environment.

Being there for the team was important to most of the nurses. Josie commented that they needed to be there for each other if they wanted support to be reciprocated:

> Whereas everyone else is like, "I'm super busy, but I'm going to totally come and help you." And then I find that I will always say yes to help. You ask me for help, I'm going to come help you. Because I know that I'm going to get it in return If I do that. In my experience, that's what you do. You say yes, and you drop what you're doing and you go help them. Like, "I'm in the middle of charting. Just let me finish this one sentence, but I'm going to come help you." So that you get it back at the end of it. And I think that's just nursing. To me that's nursing. To be there for your team, otherwise your team's not going to be there for you.

As the nurses learned the values and beliefs of their work groups and how to work collaboratively, they also saw that some nurses did not manifest behaviours that they felt reflected their own.

Gina explained that some of the nurses in the work groups would leave others out and gossip about other nurses; at other times, they would support everyone and work as a team:

> Well, yes and no. I don't feel like it should be negative or there should be gossiping or people should be left out or not supported. Then on the other side, it is good sometimes because we can work well as a group. We don't always work well as a group, but we can work well as a group. When it does work well, it works well and everyone's supportive and caring and there for each other, but then there's moments where it's the opposite. I know that we can work well as a group. That's kind of what I find positive about it.

Dana remarked, "You kind of have to be on the floor for a while and figure out what everyone's strengths are so that you can work it as a team."

Many of the nurses made comments similar to those expressed by Gina and Dana. Working as a team took time to learn the group norms as well as variations in these norms among the nurses. The nurses' experiences supported the notion that norms may be influenced by self-interested individuals and, therefore, are adaptable, depending on the individuals in the group, the context, and the communication between and among members of the group (Boyd & Richerson, 1994; Rimal & Lapinski, 2015).

In Gina's experience, some nurses felt that gossiping was acceptable, so they continued to engage in it. They may have been the nurses who drive some of the group norms. The interactions in the work groups also may have been affected by implicit norms, that is, norms that were not easily explained by the nurses. In Gina's example, nurses in the work sometimes worked well and other times not so well.

Changes in context also can bring about changes to extant group norms and impact the ability of nurses to maintain norms that they feel are important to nursing practice. A decrease in staff on a unit can change the expected behaviours of group members and reduce their ability to work as a team.

Dave discussed his work group's norm of not letting the group down, even when there was a cost to the individual:

> Um, I would say that in general compared to other units, we probably have better attendance because we're smaller, so there's that fear of letting your coworkers down, and having been on the other side of that, and knowing how much extra work it is.

There was an expectation by the group members that they not leave coworkers short. If someone called in sick, others may have stayed to work another shift. This became an expected behaviour that Dave indicated impacted the workloads of individual nurses. Changes in the context of a group, such as a shortage of staff, may change the expectations of the group and put pressure on other to fill the gaps. Rimal and Lapinski (2015) asserted that a disruption in the environment may affect the development of new norms, as was evident the loss of staff from the units during the COVID-19 pandemic.

Several of the nurses shared examples of how life outside of work affected their ability to work with their groups at work. The norm for the groups was that they should support one

another and act kindly and compassionately toward each other. When this did not not happen, they began to question why their group member were not behaving appropriately.

Eden explained, “And then sometimes some people lose it and you think, “What? What just happened?” And then you realize, like I’ve witnessed many people cry. I know when they divulge the information, it’s about their home life.”

Julia explained what she had experienced regarding the personal lives of the nurses in her work unit:

> There’s been many breakups in our unit. There’s been so much stuff. It happens everywhere, but whatever goes on in your personal life, really does affect your work life. And if you don’t have a good work life or vice versa, you don’t have a good family life.

Eden and Julia reflected on the ways that the individual attributes of the nurses in their work groups impacted the ability of the team to function. An attribute such as emotional intelligence was related to their emotional stability and their capacity to separate their personal and work experiences.

Emily said, “I always have this idea of what’s happening outside in their personal life, even though I don’t really know them, because it affects the way that they work in the hospital setting.”

The participating nurses remarked that as the nurses in the work groups tried to support each other emotionally, this support affected the work environment in positive (they could depend on group members to support them, have someone to talk to that knows them) and negative (could affect feelings of the workplace, such as tension, negative emotions, increased workloads) ways.

The way in which health care organizations coordinate nursing staff and the units for the delivery of patient care also affects the ways that nurses interact, communicate, and become part

of their work groups. In my study, some of the nurses expressed having experiences with different care delivery models, such as a team-based approach (i.e., teams of nurses provide care to assigned patients) and a primary care model (i.e., one nurse is responsible for all of the care of their assigned patients). There are risks and benefits to both approaches, but the nurses in this study who had experience with both models felt that the team approach supported nurses and patients.

Patricia explained that with primary care, "it was very difficult to find somebody to help sometimes." She elaborated:

> I believe that. I think it took away the teamwork out of nursing. And I think that in nursing, you need to be a team to work together. You can't do it all on your own. And I think that's a major issue right now, a lot of nurses are working on their own, right.

As evidenced by the experience of many of the nurses in the study who worked on units, a primary care model for patient care helped the nurses to work together to support each other and as a team to provide care.

Sadie commented on her feelings about her group:

> I think a lot of it has to do with just feeling ... Everyone's always like, "If you need something, let me know. If you need help with this, let me know. If you don't know where this is, let me know." I think that's a big thing for me when I started nursing was I am a question person. I'll ask questions. I'll clarify things. I always just like to make sure that I'm doing things the right way. Even if I feel like I know what I'm doing, it's always nice to just get that second reassurance that this is it. I feel like, with them just offering that helping hand or offering to assist me if I needed anything just made me feel very comfortable in asking, and not scared to ask a dumb question or reach out if I needed to. So I think that was the main thing is they offered to.

Sadie felt that she could ask questions and ask for help with physical care because she knew that her group was there to support her. Based on the nurses' experiences, the model of care did affect their ability to support each other because it depended on the relationships that the group members has with one another to work effectively using a primary care or team approach

model. Working as cohesive teams was dependent on the groups; social norms, with some groups, but not all of them, feeling obligated to work as teams. Legros and Cislaghi (2020), in their review of social norm literature, connected obligation to three pathways, namely, "norms offer value neutral information norms creating external obligations and norms becoming internal obligations" (p 77). Some of the groups felt an obligation to support one another, but other groups did not. This may be an area to further investigate how group norms impact nurses' sense of obligation.

Sarah discussed a physical change in the layout of a unit. The unit held two populations of patients, and during the pandemic, the unit was divided by providing each half with its own nursing station.

Sarah provided details:

> I think sometimes, because of COVID, the A and the B ... The wings have been separated. The A wing has their own nursing station now, so sometimes people will treat it as different units, whereas I think maybe sometimes people need to be reminded that we're all one unit, and we all help each other out. So maybe because I've worked on both A and B, I know how both sides work, and I know people on both sides. So sometimes maybe the experienced staff on the A side forget about the B a bit, and so maybe my difference of opinion or difference will come when maybe somebody is complaining about the B side being ... This is something very simple, but at the end of each day we count. We go into the medication room, and we have to count, is what we call it. So there's been times where the A side will be like, "Oh, B hasn't counted again today," but we have to remember that we're all in this together. Maybe they've been busy. So I think people that haven't worked on the B side in a very long time forget that it is just as busy. Working as a team is complex for nurses as we see in Sarah's experience. Dividing the nursing stations prevented the nurses from recognizing how busy the nurses working in one area were as compared with theirs. Before the division they were able to touch base more often with each other over the shift as they all used the same nursing station. With the two nursing stations they now must physically go to the other station to ask them if they need help or go to the other side to ask for help. The ability to the nurses to interact with each other and develop relationships is paramount to their ability to learn the norms of the group and feel they are becoming a part of the group.

Shared norms are socially constructed rules under which groups function, maintain the order of the groups, and allow group members to become part of the groups (Rimal & Lapinski,

2015). Communication between and among group members is essential for all of them to learn the norms and take part in their maintenance, development, and change (Rimal & Lapinski, 2015). Changes in the ways that nurses provide care, along with changes to the physical layout of a unit, can impede communication with each other and pose an issue with the nurses in learning, following, and influencing the group norms. Knowing the group norms and identifying with these norms are essential for the nurses to feel that they are becoming part of their work groups.

Sadie summed up how many of the nurses in the study felt when working with nurses in their work groups who supported them and upon whom they could rely:

> I think if people weren't so up to helping one another and everything, I mean, I'm sure more chaos would happen. I mean, like I said, we've all had very, very busy days, and we've all been running our butts off. But just even having that subconscious feeling that, if you need something, somebody will be there for you, it definitely brings some ease and calmness to the floor, in a way. Even, like I said, after I had that code and it was nuts for two hours, it was crazy, just knowing that I had this group of people that has my back and is able to take care of people that I can't at that moment, it brought some ease to me. I was like, this is what I need to focus on, and I know that everyone else is doing okay. So even within chaos, it just brings a positive environment.

As Sadie pointed out, her knowledge that other members of her work group would "have her back" impacted her ability to work. Even when the unit was chaotic, her group made her feel that she could trust the other nurses to care for her patients. The significance of teamwork in nursing should not be underestimated. As the nurses described, they needed others to help them to provide care.

Josie explained her experience:

> I mean, even in places where I haven't had a great team, you still have teamwork because you have to have teamwork in order to get a lot of this stuff done. You can work in a group of nurses where you're like, "Oh my God, I hate half of you," but I'm still going to work with you because it's not me at the end of the day, it's not you at the end of the day, it's the patients in the bed and we have to work together in order to do it.

The 19 nurses recognized the impact of work groups on patient care and often worked with others to maintain patient care, despite not having yet built relationships with the other nurses. It was difficult to work consistently without the support of other group members, as Josie, Sadie, and Sarah attested. They need to work together to maintain a positive work environment that contributed to their ability to provide patient care and reflect the values and beliefs of the nurses and their work groups.

Reflecting on How Group Values and Beliefs Developed. The nurses were asked how they thought that group values, beliefs, and behaviours developed. They commented that the nurses in their work groups either worked very well together or did not and that they were tightknit groups that either did not accept new staff easily or were open to welcoming new nurses into their groups. Each group seemed to vary in some of the ways that they behaved. They felt that these values and beliefs were already a part of the group and may have been present because of the mix of new and experienced nurses and the nurses who had been a part of the unit in the past.

Jodie mentioned having a role model who behaved in a way that she felt exemplified what good nurses should be. Jodie wanted to be a nurse just like this to create an atmosphere specific to the unit:

> I think if it was like a group of new grads, like nobody would really know. They wouldn't have that expertise to be like... You know what? They wouldn't have that person to say, "You know what? I want to be like that nurse one day, or maybe I can learn something from that nurse." I think that having all three of those kind of levels is really good to have together. And that really creates the atmosphere of how a nurse should be on the unit or team.

Eden remarked that the members of the work groups influence the behaviours across a unit by meeting to reflect on what is being done and what should be done. She stated, "And some things were revised, some things work better for us as a unit. You have to keep revisiting it, and

is it working? What's the use doing things if you don't re-evaluate it?" Group members develop the behaviours that they feel are important by having ongoing communication with each other.

Sarah described the ways that the mix of new and senior nurses on the unit affected the behaviours of the nurses.

> You've got your new grads over here who are so eager and excited to learn. And then you have nurses who have been doing it for 30 or 40 years and so much time. And so many things have changed, and so much time has gone on and they're tired of shift work and all of that stuff.

Sarah felt that the changes in values and beliefs may have been a reflection of the changes in nursing, such as increasing acuity and staffing. Sarah noted that "it used to be so much better, it used to be so different and now it's pretty intense. So I think time has a lot to do with the changes and the people's behaviors as well as background."

Sarah continued, stated that it was difficult to tell what was influencing the changes on the unit:

> That's a good question. I would say primarily the older nurses and management maybe, but it's, again, it's changed so much. I think figuring out what worked for the unit and yeah, I don't know. Cause it's like you show up one day and then this is how you do everything. And then you're like, but why do you do it like this and not like this? And it's like, I don't know, it's just how we do it. You know what I mean? So it's like, oh, okay. And like I said, every unit or floor and every hospital does things so differently, you just came in and it was the set of rules or behaviors and ways that the floor worked.

Not knowing how and why the norms of a unit developed made it difficult for some of the nurses to feel that they were becoming part of the work groups. As Sarah explained, not every unit did things in the same way or had the same behaviour or social norms.

Gina felt that senior staff were influencing the values and beliefs of the unit. She said, "I think every time there's new staff or a new group that behaviors change based on kind of hierarchy and seniority. Senior nursing staff tend to dictate what the group is like."

As Gina continued to think about the question about the development of values and beliefs, she added:

> Yeah, because most of the senior staff left and then we were all pretty much new grads, but then maybe I don't know what it is, maybe it's age because then we had a nurse transfer to us that was older and had experience elsewhere, but not in our location. Then she kind of influenced the group a lot too, so also personality. I don't really know what it is, age or seniority or personality. I'm not really sure.

The nurses had difficulty identifying how group values and beliefs developed.

Dana posited:

> But how it's developed in the first place is a really good question because I wasn't there. Right? I kind of jumped in and learned the dynamic. But I think it grew again over time with having your first staff members. I'm sure that they had to work as a team at some point.

Many like Gina and Dana felt that senior nurses influenced the groups, but Gina believed that it could sometimes be the nurses' personalities. All 19 nurses recognized that the work groups that they were a part of already had specific social norms that directed their behaviours. Most of the nurses felt that their values and beliefs matched those of the other nurses in the work group for the most part. Dana reflected on her values and beliefs, asserting that "nurses should be polite. They should be respectful. They should be honest. Um, they should be patient and they should be good listeners."

> **Memo**
>
> I had asked the question of whether the nurses knew how the norms developed as knowing this may help them to understand why they had the norms as those Dana and others talked about. At first it was surprising that they could not really answer the question although they did try and think about it in relation to their own experiences with the group. They do talk about them changing as the group changes, as senior nurses retire, and newer nurses join the group. They also acknowledged that some nurses were able to influence the norms and related this to their personalities. There may also be a connection to norms being implicit the nurses may not have been able to think of how specific norms came to be. For me thinking that social norms are socially

> constructed by the group it was interesting that the nurses did not feel they had input into them. (May 2, 2022)

Most of the nurses talked about the other nurses in their work groups driving the development of the social norms. Jody recognized that even though a unit manager had influence over the development of norms, nurses who were willing to speak out also could change what the manager was requesting the nurses do:

> You could say management could have a big role in it, but I found that... I could say that. Like probably to the start because they're the overseers or the ones who go in and they're shaping that dynamic. But I do know that, on occasion, depending on how strong the team member is, if a manager came in and was not a very effective manager, they usually get spoken... They end up leading the situation because like, "No, no, that's not effective. That's going to negatively impact." Like they speak up, the group of nurses. They'll speak up and say like, "This is why that's not a good change or this is why not."

Learning from the manager that they could speak out about changes that they did not feel positively affected practice may have been the norm of this group that they could influence requests by the management. Only a few of the nurses talked about management setting the rules or norms of the work groups. The age range on the units also had changed and may have impacted the values and beliefs of the nurses.

Emily shared:

> What helped develop that? Well, social media has definitely helped. You can get to see as who somebody is before you even meet them. Then it's X city like it's such a small city. Everybody knows everyone. Words spreads if you're a good person.

The widespread use of social media also was identified as having an impact on the work groups, according to Emily. Sometimes, social media presence may influence how potential group members treat individuals as they join their group. They may feel that they already know things about the new person that could influence their perceptions of them either positively or negatively.

The concept focusing on how group values and beliefs developed was difficult for the nurses to identify. They felt that it was the combination of the age, seniority, and personalities of the nurses in the work groups. It also may have been because many of the group norms in nursing are implicit and are not discussed, making it difficult to identify their origins. This was an important concept in the development of social norms because it emphasized the difficulty of groups to change norms if their origins were unknown. The next concept examines ways that nurses tried to influence the norms of other nurses and the group.

Influencing Group Values and Beliefs. All of the nurses in the study had experiences that involved trying to influence the behaviours of other nurses in their work groups. The experiences were either successful or unsuccessful.

Gina spoke about trying to be positive and influence nurses through her own behaviors:

> Because I want it to be a positive work environment and I want new nurses to feel accepted and have room to grow and I just want it to be a positive work environment and try... Although I might not be able to change behaviors of others, I try and make it as positive as I can.

The nurses also used formal strategies to influence the behaviours of the other nurses in their work groups. Eden noticed that there was no consistency in the care delivered to patients each day and that senior staff did not always share expectations with newer nurses. This observation prompted them to develop a standard of care to ensure that the nurses knew what was expected.

Eden said:

> And then we found a lot of the senior staff, not really being upfront with people about it. So we did the standard of care to put it out there to make sure that everyone's checking what they should be checking.

Nancy explained that if other nurses' behaviours were inappropriate, they should be told because problems should not negatively impact the entire group, just the person not following

the rules. Nancy felt that norms should be enforced by the nurses in the work groups by sanctioning the actions of the individual. Social norms are socially negotiated to maintain group order (Rimal & Lapinski, 2015). As Nancy explained, rules need to be communicated to the individual nurses in the groups.

When I asked Nancy if she was able to influence the values and beliefs of her work group, she did not think that she could. However, she did share this experience:

> No. I never felt like that was something I could change. I feel like that was... I'm a believer that if you think... They used to say sometimes the report went on too long and some people were too wordy. Well, I'm a believer that you should go to that individual and say, okay, your report's too long, you need to smarten up, you need to do it. Don't make the entire group suffer for something, focus in on who's creating the problem. And I still think that today. If you have someone that is dragging everybody down or not working as a team or not being helpful or doing things that are questionable, focus on that person instead of sending out a generic email that said, just a reminder to everybody that leaving work early is stealing time from the hospital. Okay, well, we all know that there's two of us that are doing that not the rest of us. So I don't think we all needed the email.

Sarah described her approach to changing other nurses' behaviours by mentioning that it took knowledge of the individuals to know how to influence them. Sarah found that she would adapt her approach, depending on how the nurse reacted to previous suggestions to bring about a change:

> So definitely some situations where you have to step up or stand up for yourself and figure it out and get creative with it too. Because sometimes people, and it's not criticism at all, but it's just telling them like, I might do it this way or I would do that. And sometimes people don't take that well. So it's all about how you approach the person and the situation.

Kim attempted to influence nurse's behaviours when she saw that they were not practicing based on what she considered the values and beliefs of nursing. She suggested to these nurses that they take a break from the group and work in a different group or a different community:

> Because they'd be getting to a point where they're kind of not great nurses anymore. And so the values that I think, I feel, they at one point had, they're not practicing anymore. It goes against what I think is good practice too. So tap out. Come back if you want. And if you don't come back, then that's great. You've found a different area of nursing, which is awesome. And you have all this critical care experience that will be helpful wherever you go.

This strategy worked for Kim. She explained that she moved around, so that when she came back to the group, she felt refreshed and able to work as a team member.

Some of the nurses expressed not wanting to actively influence others' behaviours. Adele spoke about not wanting to address other nurses' practices, as long as they met the needs of patients. If she felt that their behaviours were going to have a negative impact on patients, she would talk to the nurse manager, not necessarily the nurses. Adele did not feel comfortable talking to other nurses about their unacceptable behaviours:

> So, no. I try to keep out of. I think it's important to know when you're not going to... So I've definitely talked to like a newer staff in the context of like, "Hey, this is maybe something you wanted to do, this is like a learning opportunity. Like, take it or leave it. I'm not mad. You're not in trouble. Like, this is just a learning opportunity." In terms of like, I'm going to nurse like how I think I'm comfortable in my practice. And as long as like I'm meeting my standards and the other staff is meeting their standards, I don't really think it's my business to be influencing how they practice. If I think it's something major that like borders on neglect, I just talk to the manager about it because I don't think it's my sort of responsibility to...

Adele felt a responsibility to inform new staff about the expectations of care that she had, so she tried to influence them in ways that she felt they would accept. The nurses were aware of how other nurses may have reacted to their input or suggestions. Like Adele, they did not always want to influence a change in care directly.

Cornelius tried to influence the behaviours of some nurses:

> And we're just carrying on doing what we've seen done, but it wasn't passed down because there's not enough of us and not enough of us left, it's all new people now and they didn't want to listen to you. Takes too much time. The workload is so great. Like it's hard to do everything today like to nurse today as we did on X unit. It's impossible.

Cornelius felt that sometimes, the nurses did not have role models who passed on the values and beliefs of nursing and that the context such as increased workloads made it difficult to influence practice. Cornelius felt that the younger nurses did not want to listen to her. The context of the units also affected the way in which the work groups worked, such as the mix of junior and senior nurses, workloads, patient populations, and the emotions and values and beliefs of individual nurses.

Relationships mitigated the effect of context, allowing the nurses to feel more comfortable influencing others to behave in ways that they felt reflected the values and beliefs of nursing. Sarah talked about it in her experience:

> Because I want a good work environment for myself, I want people to get along. It's a hard, hard career to be in right now. And so I want to go in as positive as I can and try to create a team environment where people feel comfortable, because I want us to be a well-rounded team and for people not to feel left out or hurt or what can go on personally as well. Because it's just such an interesting job and position to be in, I find, because I can't think of another place where you would go to work and be spat on or sworn at, and it be accepted, and then try to talk another nurse down after experiencing a code situation.

Sarah talked about the importance of working as teams. Nurses could then engage in relationships to support each other in being comfortable, share knowledge, and provide emotional support during stressful times. As she and many of the other nurses in the study explained, nursing was difficult but rewarding. Their ability to support patients together and improve outcomes was a major factor in their becoming part of their work groups. All of the nurses talked about trying to influence other nurses' behaviours, but they were not always successful. As they talked about their experiences, their relationships with their work groups, and the context in which they worked, they acknowledged their impact on feeling that they could influence others' behaviours.

Summary of Transition 2: Becoming a Part of the Group

Throughout this transition, the five concepts of learning the group's values and beliefs from what other nurses say and do, building relationships, working as a team, building trust, reflecting on how the values and beliefs of the group developed, and influencing the group's values and beliefs reflected how the nurses became part of their work groups. They spoke about the significance of knowing that they had the support of other nurses not only helping with the physical care of patients but also sharing knowledge and providing emotional support. They knew that others would either help and ask them how they were doing or that no one would help.

Kim explained:

> I mean, it's quite like we always say, you can have a really busy, crappy day, but you have the right crew on and it's not that bad. You know what I mean? Or if you can be really slow and you have not the right crew on, it's a crappy day. The way that the group behaves and interacts makes or breaks the whole day. And I think it goes back to those behaviors that we just all appreciate, which is that they're going to help you out. They'll ask questions. They're not going to leave you drowning. Add maybe some humor in there too, that make the day... enjoyable. And as far as interdisciplinary, when you have a physician that you feel safe with and RT (respiratory technologist) that you know can... Isn't going to like, ugh, every time you call them for something, is the whole shift. Kim

Although Kim's groups supported her, Bev's experience with her work group was different. She knew who would help her and who would not, something that set the tone for the entire workday:

> When you maybe work with people who aren't really so much interested in helping out as part of the team. As soon as you start that shift, you're like, okay, this isn't going to be as good. You have that feeling. Or you're like, I remember being new and thinking, okay, if something goes sideways, who am I going to ask?

Kim and Bev acknowledged that the behaviours of the nurses with whom they were working either supported them in caring for patients or did not. When they felt unsupported by other nurses, they struggled to become part of their work groups. All 19 nurses discussed the

positive and negative differences that other nurses made to their practices, depending on what values and beliefs of other nurses were and how they aligned with their own.

For most of the nurses, becoming part of their work groups was not an easy transition. Some interactions, such as others recognizing them as nurses on the units and as individuals outside of the groups, increased their sense of becoming part of the groups. Other interactions, such as not asking if they needed help or leaving them to figure things out on their own, made them feel that they did not belong to the groups. If they felt that their own values and beliefs did not align with those of other members of their work groups, they had difficulty feeling like they were part of the groups.

The nurses were able to identify how some group norms may have developed while they worked with the groups. Some of them felt that senior nurses on the units directed how care was provided and the behaviours that they felt represented good nurses. Other nurses in the study felt that behaviours were the result of some nurses in the work groups bringing their own values and beliefs to the units that supported behaviours already present in the groups. The nurses' experiences supported the notion that social norms are fluid and may change (Rimal & Lapinski, 2015). For nurses to become part of the work groups, they had to learn the social norms by watching, asking, and interpreting the actions of others to their own behaviours. If the nurses did not learn the group social norms, they often did not feel that they fit in and sometimes left the units.

Adele found it difficult to fit into a work group:

> Yeah. I think fitting in has always been a struggle for me. I don't know. You know, some people are just like really naturally good at fitting in. That's not me. I asked a lot of questions. I probably was like overzealous in my need to ask questions. But I think that that's also like partly I was a bit of a perfectionist, so I asked a lot, a lot, a lot of questions. And like I'd say like you build a professional relationship, but I think that the

> reason that we built like kind of personal relationships happened outside of work. So we spent time like outside of work together.

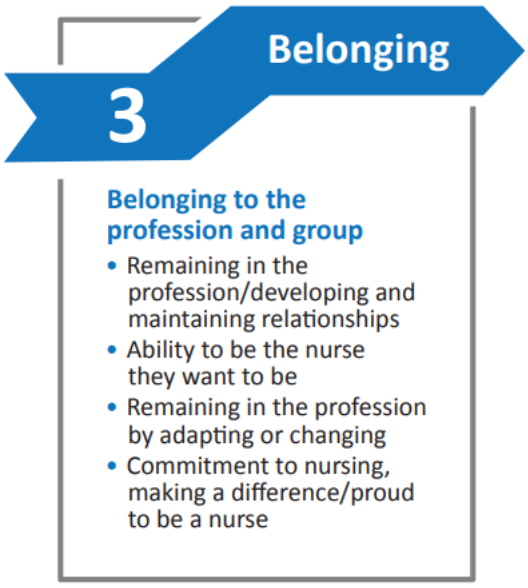
Adele talked about building professional relationships when first becoming or trying to fit in as the member of a work group. In regard to this transition, the nurses shared that they had to figure out how they needed to behave to fit in with the group and that as their identities as nurses made them more confident in their own abilities and knowledge, they felt more comfortable being in the work groups. Once their energy was not focused on filling their role and providing good care to patients, they could develop relationships with the other nurses and begin to influence the behaviours of others. These changes in the nurses themselves allowed them to feel that they were becoming part of their work groups. The next transition discusses the progression of the nurses in feeling that they were part of their work groups to feeling they belonged to the groups and the profession of nursing.

Transition 3: Belonging to the Group and the Profession

Transition 3 holds four concepts: remaining in the profession by developing, maintaining, and fostering relationships; inability to be the nurse they want to be; remaining in the profession by adapting or changing; and commitment to nursing, making a difference/proud to be a nurse (see Figure 6).

Figure 6

Transition 3: Belonging to the Profession and the Group



"We have to belong to ourselves as much as we need to belong to others. Any belonging that asks us to betray ourselves is not true belonging." B. Brown (2021, p. 155)

The memo describes my ideas about the difference between nurses feeling that they had become part of their work groups and feeling that they belonged in the profession.

> **Memo**
>
> The nurses talked about becoming a part of the group which meant they had to learn the rules of the group the social norms, they said there was no handbook. I reflected on this as not having a handbook or someone telling them what the norms of the group were difficult as it took them time to learn the norms and then to reflect on whether the norms of the group matched their own. Once they knew the norms, they either felt that they fit in with the group, became a part of the group or did not. Belonging for the nurses in this study meant that the nurses' values and beliefs aligned with the group, they felt comfortable and felt that they could influence the group. This for me clarified the difference between becoming and belonging.

Remaining in the Profession

Most of the nurses felt that being in work groups and the relationships that they had built and maintained within their groups kept them in the profession. Through these relationships, they felt that they belonged to the groups and the profession. They identified challenges that they faced in their practices and how they decided to remain or consider leaving the profession. The nurses spoke about adapting their practices to feel that they could stay in the profession. Some of the nurses even mentioned that they were considering leaving the profession.

Victoria explained:

> Um, to be honest, since the pandemic, I've, I've been looking at leaving nursing, um, I just, I realize how little, I don't know how to word this, [laughs] so it's not terrible. I, I just, I realized how little society really cares about nurses since the pandemic. Um, and even just like workplace in general, I find a lot of our management, um, they just, it doesn't matter how much you're doing. You're just not doing enough. Um, I, I just, yeah, I, I feel, I feel now just with everything that's been going on that, especially with the work so- shortages and things like that, people are doing too much than they can handle. And I don't know.

I asked Victoria how the attitudes, values, and beliefs of the group impacted her decision to remain in nursing. She asserted that overall, society did not care about nursing and that management expected nurses to pick up work because of staff shortages. Victoria's perception of how management and society felt that nurses needed to do more impacted her ability to provide the care that her patients needed:

> Um, I, I just wanna be able to actually support my clients. That that's my biggest goal. Um, and not being in a work environment that supports that, I, and it's hard 'cause I, a lot of nurses that I talk to, they feel like that all around. So it doesn't matter what type of nursing 'cause I was looking at just switching the field. But people who are in public health are feeling the same things. They're not doing the programs that they're doing anymore because they're, um, you know, they're, they're being forced to do, do a shift, which I get we're in a global pandemic. We need all hands on deck for, you know, things that are more urgent. But um, also putting those things on the back burners, um, causes other health issues.

I could hear the frustration in Victoria's voice as she shared being unable to support patients in ways that would be the best for their health outcomes because of staff shortages. The 19 nurses whom I interviewed talked about the impact of the nursing shortage on patient care. The nurses tried to mitigate the situation by supporting each other to build strong relationships on the units so that they could help each other to meet the needs of other nurses as well as patients. Although this strategy helped the nurses to provide care, it was not sustainable because they continued to take on more and more patients with fewer staff.

Sarah mentioned the challenges in her nursing practice. She became emotional as she shared what it was like to be a nurse and the impact of the pandemic on her practice. Having the support of the other nurses contributed to Sarah giving the best care that she could while also providing and receiving emotional support from her peers:

> Nursing, I say this all the time, isn't just physically tiring or exhausting, it's also mentally and emotionally. And especially over the last couple of years. Everything's ever changing in the middle of a pandemic and you're just trying to get through your shift a lot of the time. So whether it's bouncing questions or ideas off of your other nurses. So this patient isn't reacting to these antibiotics, what do you think I should do? Should I call the physician first? Should I switch upbeat? Get the other order that they have? Attempt to do that. They're still spiking a fever. It's a sounding board to bounce ideas off of and to get some suggestions and recommendations.

Being able to go to other nurses in their work groups to ask questions and receive support contributed to the nurses remaining in the profession.

Sadie commented that communication was a significant contextual element that allowed the nurses to develop and maintain relationships to remain in the profession:

> I think, for sure, it's just keeping that open line of communication with the group, so ensuring that everyone is ... It's almost like you focus on your patients and you focus on your tasks, and then when that's complete, you see if anyone else needs a hand. A lot of it is, as much as we have our job as a nurse with our patients, you also want to make sure that everyone else is doing okay. So I think, at least on my floor, it's important to ... Before you sit down and aren't doing anything, you just want to make sure everyone else is doing good.

Several of the nurses echoed Sadie's experience that if other nurses in the work groups took the time to check in and offer help, they would feel more like part of their work groups. For most of the nurses, communication with other nurses helped to establish relationships and build a cohesive understanding of the expectations or norms of the group members. Checking in on each was a norm of Sadie's group. All 19 nurses mentioned the support that they received and validation from the group members that they were nurses.

Sarah explained that she remained in the profession because of the team that she worked with:

> But a lot of the nurses that I work with, and myself included, will say like the main reason why we haven't left the profession or the floor or different things like that is definitely our team. For the most part, if not all.

Kim described how she felt when other recognized her strengths as a nurse, making her feel needed in the group:

> "You're the nursing VIP today." And I was just like, "Thank you." I'm just like, I don't know. Validation from my peers is probably the one thing that I feel most part of the profession. So that was a really cool moment to the compliments or when they asked why I didn't apply for flight nurse to those who were asking, what are you going to do with your masters? I think you would be good doing this, that, and the other thing. To the thank yous from nursing students to say, when you get the email like, oh, I got a job here, thank you for everything. And you're just like, oh yeah, I was supposed to be part of this profession. I'm supposed to be here.

Nancy spoke about finding her people, namely, nurses who shared the same values and beliefs that she had. The nurses with whom she worked made her feel that she was still contributing to nursing, which increased the value of her identity as a nurse. She said, "This is still who I am." Nancy also explained that along with the nurses in her work group recognizing her as a nurse, they also liked her as a person. She was able to build strong relationships with them. These relationships and this feeling of others knowing you was mentioned often as the central reason given by the nurses as contributing to their decision to remain in the profession.

Nancy commented:

> Finding your people with the same values as you make me see my place is still in nursing. I'm at the point in my life where I could retire. I have enough years in the pension to retire. I tell people if I ever seem cranky or I'm not nice to a patient tell me to go, but when I see people who have the same values as me and you've found your people who think like you, and I think I can still be a nurse then I can still do that because I still love it. So as long as other people... Because I think that people have the ability to make you feel like, oh, this is a lot of crap. I just don't know that this is worth it anymore. So I'm not there yet. I found my people at work who make me still think I want to be this, this is still who I am.

Julia discussed her practice experience over the past few years. She described the challenges of being a nurse because of the acuity of patients and the changes in policy and care during the pandemic. Julia tried to remain positive and hoped that the environment would change so that she would be willing to stay in the profession:

> I've kept the same. I've definitely hardened a little bit, I don't go to X and cry every day. I mean, that hasn't changed how I view to be a nurse. I do know that I stay very positive and I try to remind myself of why be a nurse, but I can't deny that the last couple of years have really been challenging on even just my mental health. And not even just the acuity of patients, just like the constant COVID changes, and the constant, you know, I don't have time to read my email when I go into a 12-hour shift. I already go in a half an hour early, so the fact that they expect me to read eight emails, like, I'm sorry, I don't get paid for that time that I go in before work, and I miss my break, and I don't have time. It's just like all these things, and I'm sorry, my work email is the last thing I want to read on my day off. I think all of those things have contributed to just a tougher work environment at the moment, but that'll change hopefully.

Many of the nurses felt the same way as Julia. They mentioned organizational expectations of what constituted nursing practices. Julia had to check her emails to keep up to date with communications from the organization about policy changes, education, and practice information. This was an injunctive norm: The nurses were expected to check their emails regularly, but Julia said that she was too busy to check them, which was a descriptive norm. The context of the unit may have contributed to the development of the descriptive norm of not checking emails.

Eden shared her passion for the profession and that she was dedicated to being a good nurse by following the social norms of caring for her patients to promote good health outcomes. Eden felt that even after work, others identified her as a nurse, indicating that the social environment of their jobs as well as others' perceptions outside of work impacted their identities as nurses. As Rimal and Lapinski (2015) noted, there are factors that affect the group social norms that occur at the microlevel, that is, individuals' ideas of what they perceive as the norms in the social environment they are part of but also the macrolevel context and determinants. Macrolevel factors impact what others outside of the profession, that is, family, friends, the media, and society, perceive as the norms and behaviours of nurses. These factors influenced the decision of the nurses in the study to remain in the profession.

Eden explained:

> I just think being passionate about your work, passionate about the people you care for, being diligent with your work, you have to be dedicated to be a good nurse. You have to dedicate your life to that profession because it was day and night. Even after work, people identified you as a nurse.

Having others recognize them as a nurse outside of the practice environment may have been a determinant in their decision to remain in the nursing profession. Several of the nurses recognized that when their values and beliefs fit with the group's values and beliefs, they felt like they belonged and were able to build relationships.

Julia shared that she now felt like she belonged on this unit and was a nurse:

> Yeah. I think just by having common goals and sharing the ones that I believe to be a nurse, the knowledge, the kindness, the patients, remembering that they're at the most vulnerable and you're here to assist them. I think when I surround myself with those same people, I really do feel like I belong and I'm a nurse.

Julia described the passion that the nurses felt for the care that they delivered to their patients. For them, it involved seeing patients' health improve, supporting patients and families

during difficult times, providing health teaching, and working with nurses who felt the same as essential to their remaining in the profession.

Inability to Be the Nurse They Want to Be. The inability of nurses to follow the beliefs and values that they feel are at the core of their identity as a nurse often makes them reassess their decision to stay in the profession. Jones-Bonofiglio (2020) described moral distress as the inability to carry out the obligations for which one is responsible and is uniquely related to the individual and the contextual factors that they are part of. Contextual elements such as workload and the emotional responses of nurses impact the way in which they provide care.

Julia spoke about the effect of staff shortages on the unit and patients:

> A hundred percent, a hundred percent. I had one nurse at work yesterday, scream, "There's only three of us on the floor." And one of my patients heard and she was very upset about it. She was saying it to another co-worker, but it really hurt my patient's feeling because she felt like she couldn't ring the bell. A lot of the nurses feel like they don't have time to give what they should be to their patients. So, their beliefs are, "Well, I can only get what I can get done in a day." And it doesn't help that we have our directors and VPs saying like, if we're so short we can leave dressings and stuff like that. That's just absurd to me. And so, yeah, it's a really negative belief system of like, and their values of what they need to be doing when they go into their day. They're just like, "Oh, well, I'm short, you know." And I'm not saying everybody takes it out on their patients either, but the beliefs of like, why they're there in the first place just doesn't really come to fruition very often.

One of the nurses was unable to manage her emotions on the unit when it was short staffed, leading to patients feeling that they were a burden to the nurses. Staff shortages not only affect frontline nurses but also management. Management may have to give direction regarding what care can be the most safely left until the next shift. This type of situation is frustrating to all parties involved: nurses, management, patients, and families. If shortages are ongoing, they challenge nurses' ability to follow the values and beliefs that they perceive as being important to the nursing profession.

Julia commented that they could not do everything that they wanted for patients. Cornelius echoed Julia's concerns and added that the availability to equipment also played into the frustration of nurses when providing care:

> Workload. Greatly, greatly, greatly workload. And I don't know why they're so... On X, there's never any supplies, there's never any linen, faulty equipment, which is just ridiculous, you know? And I would refer it to, I got to run to Quebec for a thermometer. Like, come on, you know? If I'm in an isolation room and I look and the thermometer's not working on the vital sign machine and I've got to take all this isolation stuff off, run to Quebec, find this thermometer that actually works, how much time have I wasted on faulty equipment, right? Or scale that doesn't work? You get in the room, scale doesn't work, right?

The changing context on the units impacted the ability of the nurses who participated in this study to practice in the ways that they felt nurses should. Most of the nurses' experiences reflected the challenges of understaffing, lack of supplies, and lack of support from group members and management.

> **Memo**
> As I read the experiences of the nurses in the study, I saw that they tried to provide care to the patients in a way that reflected their values, beliefs and the social norms of the profession. They felt an obligation to provide care no matter what happened on the unit and in their groups. This feeling that they must take on more and had no option of saying no was a strong norm for them. Not being able to meet their obligations was one reason they could no longer remain in the profession. Nurses felt they were expected by the patients, the organization, their professional organizations, and the public to take on more work, they could not say no. (May 17, 2022)

Nursing obligations are complex and are influenced by individual nurses, interactions with others, education, licensing bodies, societal expectations, the context in which nurses practice, and so on. The nurses talked about the stress that they experienced when they could not provide care to patients that reflected their and the group members' values and beliefs. As Hartrick Doane and Varcoe (2021) argued, competing challenges in nurses' day-to-day practices

highlight the conflict between what nurses feel obligated to do and what they actually can accomplish in practice. This incongruence may lead nurses to feel they cannot be good nurses because they cannot meet obligations that they feel they should. As a result, they may feel that they cannot stay in the profession.

The nurses in the study felt an obligation to take on more work to ensure that patients received good care. Victoria stated, “Um, they like not having that being expected to take on more than any human should. Um, yeah, I just that’s yeah. That’s made me more want to leave nursing.” Not only did the nurses feel this obligation but others also expected them to take on extra work. The nurses believed that they could not say “no.”

Adele explained:

> I myself felt burnt out last fall and took a couple months off for like not just work-related, like I had some personal issues, but it’s a job that doesn’t give you the capacity to say, “No.” So like, you can’t have any boundaries. So it’s like, if the physiotherapist can’t see your patient today, they still have to get out of bed. So, you have to do that. Like there’s no “No” in nursing. Like if my manager wants me to do four bed moves after 4:30 and I’m only there till 7:30, I can’t say, “No.”

Adele shared that her inability to say “no” contributed to her feeling that she did not want to work as a nurse. The pressure that many of the nurses felt to take on extra work while also having to decide at the same time which care they could not complete for their patients lead them to feeling burned out. Gina shared that she had to decide which patients needed the most urgent care, so she would try to complete the care before the end of her shift. She said, “No, I find it harder and stressful, difficult and stressful to try and plan your day knowing that you can’t get everything done that you want to get done and triaging, which patients require more care, which ones don’t.”

Dana confirmed that Gina's experiences were similar to her own. She stated, "Yeah, it, it hurts. It, it, it upsets me when I don't have time to give the patients the care that I deem appropriate."

The nurses knew that they had to make decisions about the care that they provided to their patients based not only on their workloads but also their norm of putting patients first. Their decisions contributed to their ability to be the nurse that they wanted to be, which often was controlled by the context in which they worked, such as workloads, expectations of managers, and patient acuity. Cindy remarked, "Um, which could, in turn, kind of affect my practice because I'm putting things off that I know need to get done. But having to prioritize is a huge part of nursing no matter where you are." The experiences shared by Cindy, Gina, Dana, Victoria, and Adele highlighted how the ability of nurses to maintain their own and the work groups' values and beliefs could impact the outcomes for patients in their care. The nurses recognized this conflict in not being able to provide excellent patient care in practice, which contributed to their not wanting to remain in the profession.

The ability to work as a group influenced the nurses in positive and negative ways. Dana explained that some of the nurses did not want to work together, making them feel that they did not belong:

> Yeah. When I'm floating more, it's harder. Uh, like you don't know everyone's names, you feel kind of on the outs side, it's hard to find your books because you're looking for these nurses and you're like, you're just overwhelmed because it's somewhere new. Um, like when you don't even know where the rooms are for the patients, you don't feel like you belong when you don't know where you're headed to find your patients.

Nurses do not always support one another, and as Dana mentioned, it was very difficult when they did not normally work with some groups and some group members were not open to welcoming them.

Victoria spoke about not knowing exactly what nursing work entailed, even though some of her family members were nurses. She thought that nursing meant working as a team, but she found that it did not always work that way:

> Yeah, so I, I wouldn't say that like a lot, even though my family's nurse, a lot of nurses, we don't really discuss, we don't really discuss what they do. So me going to, like, from my education to me actually working, I realize that there is a very, very big difference (laughs). Um, 'cause in nursing school they discuss like how we're all part of the team and it's all collaboration when in reality, it's really not like that. Um, it was a big wake-up call.

Most of the nurses provided examples of when teamwork did not work in their groups. At the same time, they gave examples of groups working to support each other. Gina explained that she tried to support new nurses when they joined her work group. She wanted their experiences to be positive, so it was important to her to make their transition into practice smooth:

> So I think that's important. I think that definitely things around all this transition to practice stuff is really important. And bridging the gap between nursing education practice is important and how my experience can help me to now come full circle and help other people who are becoming nurses for it to be easier and smoother for them, I think is important.

Supporting other nurses was a strong social norm among most of the groups that the nurses in this study worked with. Supporting each other and building relationships is a norm that is taught in nursing school, as the nurses in the study talked about, and one that was evident throughout the CNO's (2020) standards of practice.

Hannah discussed the importance of helping members of the work groups when possible because she knew how nice it was when others came to help her:

> I will go to the manager and say, "I'm going to stay because they need that extra body there," or you'll have someone who comes to help you, like say urology is a very heavy clinic. The surgical girls will maybe finish or fracture clinic they'll finish, they'll come over and they'll help you, which is really nice. I always do it. I always do it because I know what it's like when they come to help me. So I always reciprocate and I will go and I will do those clinics.

This give-and-take process of receiving help from other nurses in the work groups strengthened the nurses' sense of belonging by developing relationships and building trust. Although members of the groups dramatically impacted the nurses' sense of belonging and ability to fill their nursing role, patients also affected their ability to be the nurses that they wanted to be.

Cornelius discussed the treatment of nurses by patients and stated that policies were in place to educate patients about acceptable behaviours toward nurses. She described a situation when families were yelling at the nurses. She felt that the patients and families did not respect the nurses, adding to the stress that nurses regularly face in providing care:

> Yeah. Family yelling at them, upset them. And the patients, patients don't respect nurses. And patients are screaming and yelling and cursing and swearing and throwing stuff at the nurses, and sometimes they're scared to go in the room. Like, the patients are so aggressive. And you can go in and say, "Oh, we got a policy here that you're not supposed to be yelling and screaming at us," and they're just laughing at you, you know?

Dana explained how the behaviours of patients influenced her decision to remain in the profession. She became intolerant of patients, despite knowing that she should not:

> Probably a little bit more intolerant because some patient, because like you get tired and it becomes hard work every single day doing the same thing. And when people don't respect you because patients don't always wanna be there, it's hard to, um, stay in the same mind frame.

Many of the 19 nurses shared experiences related to the behaviours of patients toward them that impacted their ability to enact the values and beliefs that they felt supported their norms, such as building therapeutic relationships with patients. If patients were aggressive and did not respect them, the nurses felt that they could not provide the level of care that they felt reflected the values and beliefs of the profession.

The inability of the nurses to be the nurse that they wanted to be was affected by many things within the context of the work environment that impacted the nurses' belief in themselves and their identity as a nurse.

Julia was passionate when she described the following experience:

> Absolutely. I think just being patient, you can't be patient when you have that many people, and they want to talk, because you're like, "Nope, sorry. I don't have time." Just the other day, so typically on the unit that I work on there should be four RNs because we have vented clients and peritoneal dialysis on the unit, so, the RNs are the ones who do that. And it's very wound-heavy as well, so lots of vac's. So, things that take time. And so, when there's only two of you, that means on lunchtime or coffee, there's only you on the floor. So, if a vent alarm goes off while you're doing a vac dressing, well, oh my God, it's not fun, you have to prioritize. So, there's a lot of that.

Julia's account of her experience highlighted the complexity of the nurses' practices. She recognized that she could not provide the care that she wanted to provide, but she also knew that some patients were not safe if she was away from them, so she had to choose. She was unable to be compassionate and empathetic because of her patient workload and could not spend time speaking with patients to support them. She noted that with the work reality of only two nurses on the floor, there would be times (e.g., bathroom, breaks, and lunch) when only one of them would be available. What will she do then? This story represented the struggle that many of the nurses were experiencing as they considered leaving the profession.

Remaining in the Profession by Adapting or Changing. Many of the nurses discussed the concept of adapting. They had to adapt to changes in the context of their practices, such as workload, availability of supplies such as PPE, and support from managers and the organization. The ability to adapt to these changes impacted their ability to be true to their own values and beliefs about nursing. They had to be true to themselves to feel that they belonged. The nurses spoke about the need to adapt to stay in their work groups and the profession.

Memo

In the first few interviews I had with the nurses they referred to adapting to remain in their groups they talked about how they often made changes to their behaviours to reflect the values and beliefs they saw most of the nurses on the unit participate in. Many of the nurses used the word change to describe how they were able to adapt to fit into the group. You can only adapt and change in as much as you are comfortable with the changes. That they were true to their own values and beliefs. Throughout the interviews the nurses talked about making changes to their practices and behaviours to become a part of the group. To belong to the group, they had to feel that their own values and beliefs matched those of the group. If they were always adapting this made them consider whether they should belong to the group. To me the idea of becoming and belonging connected to the nurse's values, beliefs and social norms of the group. (November 2022)

To the nurses, adapting sometimes meant changing their values and beliefs to fit the reality of nursing and remain in the profession. Gina explained that she was unable to meet all of the needs of her patients. She had been taught in nursing school that nurses could "fix" all of the problems that patients presented with, but the reality of her nursing practice was that she could not. Gina concluded that she had to adapt her thinking and do what time allowed her to do for each patient, not necessarily all that they needed:

> No, because at the beginning of nursing, I thought, I don't know, basically that you could fix every patient and every patient would be happy and care for every patient. At the end of nursing school, that's not the reality. You're not able to address every single one of each patient's concerns and that kind of causes stress. You have to kind of readapt your way of thinking to what's the best I can do, what's the best outcome that we can do with what we have and what time we have, not like what would've been the best outcome, but what can we do.

Although Gina spoke about adapting, it did not "sit right" with her. She was doing the best in her job that she could, and she was not sure how she could improve the situation. Gina's uncertainty was reflected in the statements made by many of the other nurses that they could not

provide optimal care to their patients. The care that they did deliver did not align with their values and beliefs, but it was the best that they could do. The nurses experienced moral distress, the result of not being able to carry out the obligations that they felt responsible for that were often related to contextual factors unique to each interaction, such as staffing shortages, increasing acuity of patients, and support from colleagues (Jones-Bonofiglio, 2020).

Emily viewed adapting as a way that allowed her to improve her practice. She was not always open to change or to asking for help. She felt that nursing school supported her ability to remain calm and ask for help, which she did now in her practice as a nurse.

Eden explained:

> Well, it made me a lot more resilient, a lot at adapting to change. It made me be not as hotheaded and more calm during stressful situations. It made me utilize my peers for help because sometimes I feel like I'm very stubborn and I don't ask for help sometimes, but I'm always, help me, help me, help me. So, yeah, you learned a lot in nursing school for sure.

Sarah reflected on what is happening in the nursing profession. She contended that the behaviours of nurses have changed. She identified frustration, tiredness, and upset as behaviours related to the pandemic and staff shortages. She acknowledged the importance of nursing reflecting on what brought them to nursing and examining what they still enjoyed:

> A lot of behaviors have changed, a lot of frustration, tiredness, upset. It's not an awesome time to be a nurse right now just with the pandemic and staffing issues all over the place too. I think it's trying to remember what brought you into nursing, why you still enjoy to do it. It's a great paying career, but you're often doing it for reasons other than that, because you wouldn't just stay if you were just interested in the money.

There is a risk to nurses feeling that they belong when they cannot provide the care that they feel patients should have. If they see no hope of changing the context of their practices that conflicts with their own values and beliefs, they may choose to leave the profession.

When some of the nurses felt that they were burning out, they chose to move to different units or hospitals, as Kim and Cornelius did.

Kim provided details:

> I tapped out of X unit a couple times to be like, "You know what? I need a break." And then I go and do clinical teaching for a couple months, or I go up north for a couple months. So I always seem to get to come back a little bit rejuvenated with a tolerance for some of the stuff. But if you don't do that, then the system problems are very heavy, and I find that the majority of the people are feeling that. And they're not functioning at the way that would be aligned with my values or theirs.

Kim found that being able to work in another area allowed her to come back to the unit feeling rejuvenated. She took this step when she found herself not treating others well or not practicing in relation to her and the work group's values and beliefs, such as supporting one another and making patient care the priority. She adapted her practice to support her provision of the best care to her patients and support for other nurses in her work her group.

Cornelius moved to another unit and found that she could work with the nurses in the work group better and found the environment easier to work in. She felt that on the other unit, they had a higher patient load and that the rotation had changed, making it more difficult to work.

Cornelius explained the reason for moving to another unit:

> And at first I was, "Oh my God, what have I done?" But I totally love it. I love it. Yeah, it's eight-hour shifts. The eight-hour shifts is a big part of it, but the people I work with, they're a great group. And they're busy, but they're not as stressed as what I see on X unit. What they're making the nurses do on X unit right now, I don't even want to go back to it. I don't. They've changed the workload, they've changed my rotation. I was eight hours and they changed me to 12. I wasn't sleeping during the day, so I was having trouble pulling off 12-hour nights because I couldn't sleep in the day. But the workload, they've changed the workload there, so it's not even fair to the nurses.

Several of the nurses described changing units to stay in the profession, but moving to other units did not always work to support their desire to remain in the profession. The new units

had to reflect the nurses' values and beliefs for them to feel that they belonged to the work groups. Kim mentioned that nurses had to adapt to the cultures of the units, along with the rules that they had developed and expected all nurses to follow. The turnarounds that Kim spoke about were times when all the nurses worked together to provide patient care and discuss how the patients were doing. Providing care together built relationships and allowed the nurses to gain knowledge through informal discussions of patients' conditions.

Kim explained:

> Or if you're not, if you haven't picked up on the fact that everyone seems to be inquisitive, ask the questions, we don't want anyone trying to do this on their own, you probably won't do well in the ICU. All of these things. And it kind of really does sort of all happen on turnarounds. But the culture that has been laid out, if the nurse can't really adapt to it, then I don't know, they usually don't end up doing very well. But yeah. Does that answer the question, like the culture that's laid out affects.

At times, the nurses adapted their own behaviours to make it easier to work with members of their work groups so that they could remain in their preferred areas of nursing. Judy tried to make an effort to build a relationship with a group member, but she found it difficult and had to adapt her behaviours merely to discuss patient-related information with her. Not being able to communicate openly resulted in tension and a decrease in trust between her and the other nurse:

> Um, maybe in the beginning when she first came back, um, pretending like she knew everything, when literally everything changed (laughs) while she was off. And maybe at that point, I tried to be that friendly coworker, and then I realized a few months in, like, she's not gonna truly warm up to me, and I just kind of stopped making so much of an effort. Yeah. Like, she has her good days, of course, but…

Adapting their behaviours to fit with their work groups may have resulted in some nurses not feeling that they belonged because they could not be themselves to work well with some other nurses. Gina said, "I don't know, fear of conflict and of making the situation worse and

instead kind of, I guess they kind of enable it and learn how to adapt to different personalities." She felt that behaviours were being enabled, not changed.

Adapting to the ways in which group values and beliefs are followed was important to the nurses' perceptions that they belonged. Dave identified the values, beliefs, and behaviours that he felt were important for the nurses in his work groups to have:

> Patient, uh, compassion obviously is- is huge. Um, and then adaptability, and, I think, curiosity. Um, you really can't teach curiosity, and so whenever I see that in one of my students, or a coworker, it's- it's just such, um, such a good thing to see.

Throughout this concept of adapting, the nurses felt that they needed to find ways to remain in the profession. In many ways, it resulted in their finding opportunities to build on their knowledge. For example, Kim and Cornelius tried other areas of nursing. Other times, the nurses felt that they had no choice but to adapt to difficult situations; otherwise, nothing would change, as mentioned by and Gina about their experiences with nurses who were not supportive or welcoming. The nurses also explained that they had expected that patients would treat them with respect; however, once they were in practice, they found that patients' responses varied. Sarah explained the shift in her perspective:

> It's a lot harder than I expected. I knew it was going to be hard, but I didn't put into perspective the way that I would be treated by my patients. I thought because I was trying to help some that they would always be appreciative; however, that's not the case.

Josie discussed the ways that some patients responded to her. She accepted that they were vulnerable and lacked power, but she still provided good care to them. She accepted the fact that people were going to treat her in a disrespectful, hurtful way:

> I think, I don't know, this is going to be a weird answer. I mean, I love my job, that's one. Essentially over years, I've just... And this is probably bad practice, but I've just accepted the fact that people are going to treat you that way. A lot of it is when you look at it, they're doing it as a response because they're vulnerable. They're not doing it... Some of them might be doing it because they want to hurt you in some way, but a lot of it is, they're out of control, they don't have the power in the situation. They're doing it

> because they're vulnerable in their situation. When you look at it that way, you're there to protect them while they're vulnerable, so yes, they're going to be an asshole, and they're going to say something to you, but the reason you're there is because you're going to make sure that they're safe and that they have good outcomes.

Several of the 19 nurses mentioned that even though it was acceptable for patients to be disrespectful to them, their values and beliefs to support patients may have acted as barriers to preventing them from better addressing the issue of violence. Josie spoke about patients being vulnerable, even though their behaviours toward her were disrespectful. Nurses are trying to adapt to the changes in patients' responses as they struggle to remain in the profession, but this strategy may not be successful in the long term. There is a disconnection between the values and beliefs of nurses and patients that allows patients to behave in unacceptable ways toward nurses. According to Sarah, "So it's just experiences as well. That will change you and your nursing career."

Commitment to Nursing: Making a Difference, Proud to Be a Nurse

Most of the nurses talked about their commitment to the profession. When they felt that their values and beliefs aligned with those of other members of their work groups, they felt that they belonged to the groups as well as the profession. The ability of the nurses to practice in ways that align with their values and beliefs is impacted by the contextual factors such as personal attributes of individual nurses, work environment, relationships, and communication. Belonging is a complex process, and when the contextual factors supported the nurses in practicing in an environment that supported their social identity as a nurse, they felt that they belonged, which influenced their decision to stay in the profession.

Jody shared her own experiences in practice that contributed to her feeling that she belonged in the profession:

> Oh, well, the fact that we're carrying out all those nursing skills together and we're all working with those patients together, I think that that's a huge thing because we're carrying out nursing practice. We're talking to our patients together. We're caring for them. We're informing them. We're doing skills that are all within nurses' scopes of practice. You know what I mean? Like per clinic or per shift or per unit, I think doing all those classic nursing skills and communications with our patients together, I think that's what makes me feel like I'm belonging in nursing practice.

All 19 nurses commented that caring for patients was central to their practices. This belief continues to direct many of the values and beliefs of individual nurses and the profession. Being able to practice in ways that were prototypical or the same as the group members influenced the nurses feeling that they belonged and their decision to remain in the profession.

Julia talked about watching the members of her work group and identifying how they were able to provide empathetic care to patients who were dying. She was able to learn from their behaviours as they took pride in their ability to provide end-of-life care to patients that reflected their values and beliefs.

Julia explained that it took time for her, as a new member of the work group, to learn the norms of the unit and see how much pride the nurses took in their practices:

> So yeah, so their behaviors and beliefs, like the one nurse that I worked with, she was so wonderful to her patients that I'm like, I will never be able to be like this. She was just so lovely that I'm like, "Oh my gosh, how is she..." Just the things that we were seeing, I'm like, "How can you keep your composure and just be so empathetic when I just felt like I wanted to cry." I don't know. So yeah, it took a while to figure out what they believed in and their values on the unit. But once I understood that, it was just like a very nice group in the sense that they all took pride of being a X nurse, which I think was really nice to see.

Julia described having to learn the values and beliefs of the members of her work group and determining whether they matched her own before she became part of the group. Once the nurses were comfortable with their identity as a nurse and felt that they belonged to their work

groups, they felt that they could share their knowledge with others. Sharing knowledge gave them a purpose in their work groups.

Nancy discussed her experience:

> Well, I feel like I still have... I feel like I belong because I feel like I still have a purpose there. I can still teach people things. I can still orientate people. I can still help people learn the job. And I know that people come to me to ask me questions. So it still makes me feel like I have a value in that group because I like knowing some things. I like paying attention and knowing where things are. I thrive. I thrive on feeling like I can help in some way.

Many of the nurses felt the same way that Nancy did: They had things to contribute, group members came to them for advice and knowledge, and they were able to act as role models and support new nurses in learning the norms of the work group and the profession. According to SIT, a basic assumption is that people move along a continuum from individual to group member (A. D. Brown, 2019). As the nurses shared their experiences in developing the group social norms, they were able to see how the values of the other group members aligned with their own, such as being willing to share their knowledge. Nancy explained that she felt that she had a purpose within her work group because of who she was as a nurse, and she believed that her knowledge and experience were beneficial to the members of the work group. Many of the nurses felt as Nancy did, stating that they could influence the group norms by orientating and teaching other nurses. The nurses asserted that they were proud to be a nurse.

Josie described the contribution of her practice to her pride in being a nurse:

> I guess all along... Right now it's because I am, I do it and I do it well. If I go back to when I was in school, I think it was just the drive behind it. Starting to learn it, it was very interesting to me. I became very passionate about it, I wanted to apply myself more, I wanted to achieve those things and I wanted to be successful at it. So in terms of getting through school and getting to the end, doing it well and understanding it, then it was like, "Yeah, I'm a nurse," because I understand this and I do this job well. I guess reflecting it that way, I would say, I guess essentially the same thing now. I'm proud to identify as a nurse because I do it well.

As Josie became more knowledgeable about nursing and understood how her practice impacted the patients whom she cared for, she acknowledged that doing the job well made her proud to be a nurse. Sadie commented about being a nurse that "I think it makes me proud. It's like I'm doing something right in the world, in the crazy world we live in."

Celebrating being a nurse was important to the 19 nurses in my study. As Eden explained, "Okay. I think Nurses Week. Nurses Week comes up, I'm so excited for Nurses Week. I make a cake, bring it to the unit. I'm so proud of being a nurse that that's what I would do." It was very emotional for some of the nurses. As they developed in their practices and were able to provide excellent care to patients, they felt more positive and connected to their identity as a nurse.

Sarah shared how she felt after a shift:

> Okay. Yeah. So there's a lot to like and a couple things that people probably don't like, but to start off, I like the fact that it's rewarding. So I can go to work and I can care for people for a 12-hour shift. And then when I leave, I can think to myself like, "Wow, I just cared for five or how many other patients we have that day." And I felt like I did a good job. And so I think it's rewarding too, as you see, hopefully your clients or patients start to improve or get better.

Summary of Transition 3: Belonging to the Group and Profession

B. Brown (2021) referred to belonging as "any belonging that asks us to betray ourselves is not true belonging" (p. 134). Although the nurses became part of their work groups by identifying the prototypical behaviours of the group members, they did not always feel like they belonged to the work groups or the profession. To belong, they said that they needed to continue to build and maintain relationships with other nurses in their work groups. They needed to feel that these relationships reflected not only their values and beliefs but also those of other members of their work groups. In other words, they needed to remain true to themselves to feel that they belonged.

These relationships were not only professional, thereby allowing them to feel part of the teams, but also social in that other nurses knew about their personal lives and were interested in them. Belonging to the work group and the profession required that the nurses interact socially with other members of their work groups. These interactions supported the nurses' belief in their identity as a nurse and that they were able to make a difference in the lives of their patients. They were proud to be a nurse.

It was evident from hearing about the nurses' experiences that those relationships had a substantial impact on their feeling of belonging. If their values and beliefs aligned with those of other nurses in their work groups and the profession, the nurses felt that they belonged. Not being able to follow the values, beliefs, and behaviours that they associated with nursing contributed to their not wanting to stay in the profession. Adapting and trying to change their behaviours or values often worked in the short term, but if the nurses felt that they were always adapting, they would choose to leave their current work groups and even the profession.

Victoria confessed that she had thought about leaving the profession. The workload and expectations of management did not allow her to provide the care that she felt that her patients required:

> Um, to be honest, since the pandemic I've, I've been looking at leaving nursing, um, I just, I realize how little, I don't know how to word this, (laughs) so it's not terrible. I, I just, I realized how little society really cares about nurses since the pandemic. Um, and even just like workplace in general, I find a lot of our management, um, they just, it doesn't matter how much you're doing. You're just not doing enough. Um, I, I just, yeah, I, I feel, I feel now just with everything that's been going on that, especially with the work so- shortages and things like that, people are doing too much than they can handle. And I don't know.

Although several of the nurses felt the same way as Victoria did, they found ways to change and adapt to try to adhere to the values and beliefs that they felt depicted nurses. All the

nurses relied on their relationships with other nurses and their ability to support one another to feel that they could remain in the profession.

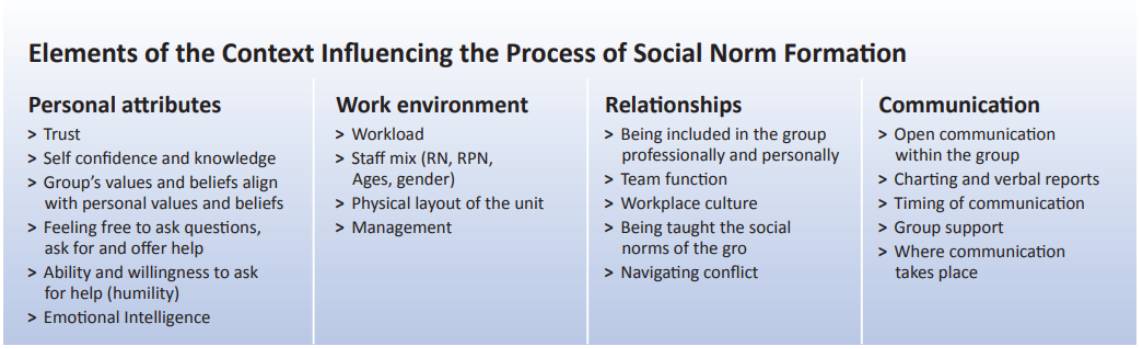
In this third transition, the nurses' experiences highlighted four concepts: remaining in the profession by developing and maintaining relationships, ability to be the nurse they want to be, remaining in the profession by adapting or changing, and making a difference/proud to be a nurse. These concepts contributed to how strongly the individual nurses felt about themselves as nurses. Their relationships with other members of their work groups, their ability to be themselves (their values and beliefs aligned with the group), and the belief that they made a difference in their practices all contributed to their social identity as a nurse. Elements of context, such as increased workloads, poor relationships with other nurses, changes in their self-confidence, and poor communication with the group, affected their ability to support patients. If the nurses were not able to practice nursing that aligned with their values and beliefs, they felt that they did not belong. They tried to adapt or change to continue to belong.

Part 3: Introduction to Elements of the Context Influencing the Process of Social Norm Formation

Each of the three transitions that the nurses moved through was influenced by the elements of the context surrounding them in their practices. Figure 7 illustrates the elements of context that comprised four categories: personal attributes, work environment, relationships, and communication. Under each of these categories are the supporting concepts, all of which facilitated or limited the progression of the nurses through the transitions.

Figure 7

Elements of the Context Influencing the Process of Social Norm Formation



The elements of context produced flux in each transition and affected the movement from one transition to the next. The experiences, interactions, and meanings were temporal, affecting the ability of the nurses to self-identify as part of the group, align their values and beliefs with the group's values and beliefs, identify what it was to be a prototypical member, and increase their nursing and group identity. Additional data sources such as memos and the researcher's journal were integrated into the analysis to support the decisions made in developing this theory of being, becoming, and belonging. The following memo presents my reflections about the analysis of the context influencing the process of social norm formation of nurses working in groups.

> **Memo**
>
> Throughout the experiences of the nurses in the study I found that many things outside of their direct control impacted the social norms of the group in all the transitions. The nurses acknowledge a change in their behaviours in relation to the context. They found that the context would contribute to or inhibit them in enacting the values and beliefs they felt were important to them as a nurse. Context directly affected the nurse's ability to work together and build relationships. It frustrated the nurses at times that they could not effectively change the context. (May 24, 2022)

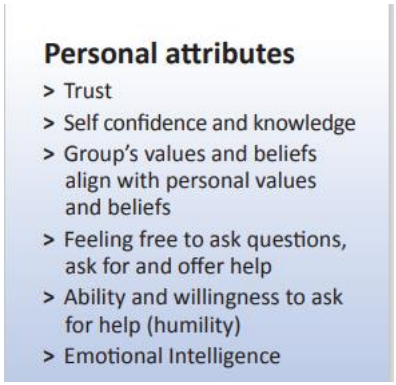
Included in the following section are descriptions of the categories of the elements of context influencing the process of social norm formation of nurses working in groups and the 20 concepts supporting each category in the elements of context. I describe each element of context in detail, supported by the participants' experiences, meanings, and interactions with self, others, and the environment. Constructivist grounded theory is influenced by the premises of symbolic interactionism that emphasize the meanings that individuals develop based on their interactions with others through language and communication (Charmaz, 2014).

Personal Attributes

The nurses identified personal attributes that contributed to their ability to transition between the categories and develop the group social norms. These attributes listed in Figure 8 were trust, self-confidence and knowledge, group values and beliefs that aligned with their personal values and beliefs, feeling free to ask questions, ability and willingness to ask for help (humility), and emotional intelligence.

Figure 8

Personal Attributes and Concepts



Trust

The personal attribute of trust was important to the nurses in developing relationships with the nurses with whom they worked. They needed to know that they could trust others and

others could trust them. The CNO (2023) identified trust as one of the six codes of conduct of RNs in Ontario. Building trust with each other helped the nurses to feel comfortable asking about the rules of their work groups and identify with or question the group norms.

Cindy stated that it was important to trust others, especially in small groups, because the group members relied on each other. Not being able to trust one another resulted in group members not working well together.

Cindy explained:

> Um, yeah. It just makes it really, really challenging, 'cause then it kind of snowballs into this whole thing of, this person's always doing this, and we can't trust them, and it's really hard to work with a small group when there's tension in the small group.

Unlike Cindy, Victoria identified being able to talk to each other to get to know the other nurses, understanding what their values and beliefs were, and learning how they built relationships as being important. Victoria stated, "Uh, we, we actually get to talk to each other a lot and I think that has built trust." Victoria's sentiments were echoed by many of the other nurses in the study.

The nurses talked about others needing to trust that they would implement the proper treatment and assessment protocols. Trust contributes to the concept of in-group prototypes and the way individuals are expected to act in their particular groups. Hogg et al. (2017) asserted that as human beings self-identify with specific groups, they assume the prototypes of the groups that define their values and beliefs and how they should act as members of those groups. When group members break this trust by not following the beliefs and values of the other group members, relationships within the groups can be affected.

Josie shared:

> if you cannot rely on someone to help you even if you helped them there is a feeling of distrust, you cannot depend on them which undermines the groups' ability to work together., whereas if you have a group where you're going to say, "I'm drowning," and nobody comes to help you, it's going to be a shitty day, it's going to be a shitty group, and you're going to distrust the other members of the group. "Well, I can't rely on these three people to come and help me when I have a bad day, how do I then drop everything to help them when they're having a bad day?"

Self-Confidence and Knowledge

The personal attributes of self-confidence and knowledge often worked synergistically to support the ability of the nurses to become a part of their work groups and belong to the groups and the profession. Many of the nurses gave examples of the ways that their knowledge affected their ability to be the nurse that they wanted to be and contributed to the confidence that they had developed in their own practices. The development of confidence took time and was affected by how they saw themselves, how others saw them, and the context of the work environment.

Kim talked about the time that it took to feel confident and how that impacted her practice, sharing that "I think that there's a sweet spot that we all hit a couple years into nursing where we're not scared at work anymore. We feel confident in our practice."

The confidence of experienced nurses contrasted with the experiences of nurses new to the workplace when they were unsure of their knowledge and ability to manage their workloads. Julia felt that she was always checking on her care, did not have time to interact with other members of her work group, and felt that she had a lot to learn in her practice. She felt that the other nurses were relaxed because they felt more confident in their practice:

> Yeah. I would just think of like when I went down to this unit, because I wasn't confident, there would be a lot of nurses on night shifts being able to take their break, or relax at the desk, or do lots of chit-chat, but I felt like I didn't fit in because I had so much stuff to do still, or like, I was so anxious for the morning. I'm like, to do my PD (peritoneal dialysis), to do my trach care and everything with my vents (ventilators) that like, I felt awkward. I felt, on the night shift, I was just kind of keeping to myself, and

> then I thought people thought I was this little keener, I don't know. But it's more like, because I didn't know what I was doing. I was just constantly checking things or rechecking, whereas I found that lot of other people were more relaxed because they'd been there and were confident.

As the nurses built their confidence, most of them felt increasingly comfortable with the other nurses in their work groups and were able to ask questions and let others know that they did not have all of the answers. The participants stated that as a nurse, they needed to acknowledge when they did not know something. This statement built on the personal attribute of trust that opened this section. Recognizing when they made mistakes and supporting others was much easier for the nurses as they gained knowledge and confidence in their practices.

Julia shared the following experience:

> Yeah, I feel like over the years that I've worked, I've become confident in my own practice, and I feel like my beliefs are very important to me, so I'm not afraid to ask questions if I don't know, I'm not afraid to admit when I had made a mistake or wrong about something or anything like that. And I am the person on the unit that people go to for help. People will text me when I'm off and ask me questions, and I'm like, "Oh, listen..." And so, I feel very valued amongst my coworkers because of that. (Julia)

Kate confirmed Julia's experience because she also had experienced nurses coming to her for information. She stated, "They'll come to me and be like, 'Hey, have you done this recently? I haven't,' so it also enhanced my confidence as a nurse." When the nurses spoke about their self-confidence and knowledge, the social context of their work groups and their interactions with other nurses in the work groups contributed to these feelings. The ability of the nurses to see themselves as having the same knowledge that other nurses in their work groups had helped them to feel confident in their practices and their fit in the work groups. Having the ability to self-categorize as being part of groups contributes to sense of identity and connectedness, and gives meaning to individuals' identities as group members (Hogg et al., 2017).

Group Values and Beliefs Align With Personal Values and Beliefs

Sharing the same values and beliefs as other group members increases individuals' social identities (Hogg & Rinella, 2018). Hogg and Rinella (2018) wrote about shared prototypes being activated by self-categorization, which results in a sense of shared reality with other group members. This notion of shared reality may have influenced the movement of the nurses through the process of social norm formation.

Many of the nurses identified their own values and beliefs as being the same as those of other members of their work groups as well as the profession. The nurses' comfort and connection within their groups resulted from their identifying and following the group norms.

Kate explained how her own values and beliefs were strengthened by working with other nurses in her work group. The group norm of helping and supporting each other added to Kate's comfort in the group:

> Yeah. I mean, I think the type of person I am, as much as I want to help the patients, I also do want to help the nurses. I want to make sure that all of our experiences that day is a positive one. So I think it just enhanced me, if that makes sense. Like I said, my beliefs, my values and my practice as a nurse just increased due to the other nurses as well. Them doing the same thing that I wanted to do, like I said, made me comfortable in actually doing it, so obviously I want to help them out. Me knowing that, that's kind of how we work on the floor. I was like, perfect.

Cornelius shared a similar experience with her work group:

> Yeah. I mean, I think the type of person I am, as much as I want to help the patients, I also do want to help the nurses. I want to make sure that all of our experiences that day is a positive one. So I think it just enhanced me, if that makes sense. Like I said, my beliefs, my values and my practice as a nurse just increased due to the other nurses as well. Them doing the same thing that I wanted to do, like I said, made me comfortable in actually doing it, so obviously I want to help them out. Me knowing that, that's kind of how we work on the floor. I was like, perfect.

The experiences of the nurses demonstrated the importance of their values and beliefs aligning with those of other members of their work groups for them to function well together.

However, it is important to note that their values and beliefs did not need to align with those of other nurses in their work groups for them to follow the group social norms, but it did affect their comfort and sense of belonging. How group members behave together and how individuals influence and are influenced by others can be seen to be directly related to the group norms (Hogg & Reid, 2007).

Feeling Free to Ask Questions, Offer and Ask for Help (Humility)

Most of the nurses shared their feelings about having the ability to ask for or offer help to other nurses in their work groups. Zinan (2021) described the attribute of humility as the ability to seek and offer help to others, be open to new ideas, and be associated with positive relationship building. Most of the nurses described the need to ask for and provide support during their day-to-day practices. Dana said, "But the majority of nurses that I've worked with are very willing to help you, willing to walk you through things, willing to explain things to you."

For many of the units that the nurses worked on, the norm was to check in on others to see if they needed help. Jody commented that it was unfair to others if they did not go around and check once they had completed their own work:

> But most of the time, most of the time, you'll finish in a clinic, and you do a circle. You check on blood, you check on urology, you check on surgical, you check on fracture, you check them all. And you say, "Are you guys, okay? Do you need any help?" Right away, because you don't want that person who's last to be there, to be there past their time. It's just unfair.

Some of the nurses shared experiences when one of their patients required all their attention because of changes in their health conditions. Dave talked about such a time and mentioned that even though he did not ask for help, other nurses in the work group saw that he was busy and shared the care of his other patients.

Dave was overwhelmed with his patient load. He explained that the other nurses asked how he was managing and that they were there to help:

> But, uh, you know, everybody really banded together. They- they helped take care of things. Some of them made phone calls, and like talked to people and they said, “You know what Dave, why don’t you like go take a break, go have some coffee, or something, like just- just take it easy for a little bit,” and one of them was back there with me, and just kinda talked and that was like phenomenal, it was such a great moment in nursing, um, and certainly not the unique experience, you know, I’ve- I’ve had people who have had patients who’ve coded, and I’ve said, like, "Oh, you know, are you– you doing okay,” and they’ll be like, “Are you doing okay?”

For Dave, this experience was not unique because the other nurses with whom he worked regularly offered to help without being asked. However, this generous situation was not always the case on other units, as Josie explained:

> Whereas if you have a group where you’re going to say, “I’m drowning,” and nobody comes to help you, it’s going to be a shitty day, it’s going to be a shitty group, and you’re going to distrust the other members of the group. “Well, I can’t rely on these three people to come and help me when I have a bad day, how do I then drop everything to help them when they’re having a bad day?”

For Josie, not receiving help when she needed it also impacted the way that she felt about helping other nurses in the future. Needing help affected the ability of the nurses to care for their patients and impacted their ability to provide care that supported their values and beliefs of nursing. The ability to practice with humility affected the individual nurses, the work environment, and the nurses’ satisfaction with their own work and relationships in practice. Humility had a part to play in each of the transitions, and the nurses were able to move to each transition by giving and receiving support. Humility contributed to their ability to build positive relationships in their work groups.

Emotional Intelligence

Goleman (1994) presented the five traits of emotional intelligence: knowing one’s emotions, managing emotions, motivating oneself, recognizing emotions in others, and handling

relationships. The nurses in the study provided many examples of emotional intelligence in the interviews as they reflected on their experiences of developing the social norms of their practices. The traits of emotional intelligence are supported by relational practice in nursing. Doane (2002) defined them as "a humanely involved process of respectful, compassionate, and authentically interested inquiry into another and one's own experiences" (p. 201).

Kim recognized emotions in the new nurses with whom she worked, and she used this skill to support them during new situations by letting them know that they could acknowledge their emotions and gain experience from them:

> Even now I find myself with younger nurses who maybe, the first time they do a withdrawal (addition withdrawal). You're allowed to not be okay over what happened. Very early before I was a nurse, as a student, an instructor said, it's okay to be very affected by what happened.

Being able to recognize one's own emotions and manage them to be able to carry out work responsibilities is a trait of emotional intelligence that several of the nurses' experiences depicted. Kate gave an example of a time when despite feeling overwhelmed in her practice, she was able to control her emotions because she knew that she had the support of the other nurses in her work group. She explained the change in her emotions as she reminded herself that she was not alone:

> But just even having that subconscious feeling that, if you need something, somebody will be there for you, it definitely brings some ease and calmness to the floor, in a way. Even, like I said, after I had that code and it was nuts for two hours, it was crazy, just knowing that I had this group of people that has my back and is able to take care of people that I can't at that moment, it brought some ease to me. I was like, this is what I need to focus on, and I know that everyone else is doing okay. So even within chaos, it just brings a positive environment.

Emotional intelligence supports the ability of nurses to practice relationally to know their work groups, understand the values of the group members, and support a positive work environment. Sarah spoke about wanting a good work environment. She recognized the need to

support other group members to allow them to express their emotions and for her to acknowledge what others are experiencing and support them:

> Because I want a good work environment for myself, I want people to get along. It's a hard, hard career to be in right now. And so I want to go in as positive as I can and try to create a team environment where people feel comfortable, because I want us to be a well-rounded team and for people not to feel left out or hurt or what can go on personally as well. Because it's just such an interesting job and position to be in, I find, because I can't think of another place where you would go to work and be spat on or sworn at, and it be accepted, and then try to talk another nurse down after experiencing a code situation.

The nurses shared many examples of the five traits of emotional intelligence (Goleman, 1994) that they used in their practices. However, examples of nurses who did not support others and acted in ways that undermined the values and beliefs of their work groups also were shared. Sarah, for example, mentioned an experience when she was belittled and felt that she could not attain the level of practice that others had. She said, "So, I don't know. I felt at times humiliated and belittled by some of the staff that worked there because their expectation was so high that I just, I felt like I could never live up to it."

Sarah's experience affected her self-confidence as a nurse. Other nurses in the study felt the same way as Sarah did when members of their work groups did not support them. The nurses interpreted the actions of their group members as not being supportive by challenging their practices and not offering help.

Relational practice reflects the traits of emotional intelligence and influences the way in which nurses work with each other. Doane and Varcoe (2007) discussed the need for nurses to focus on the intrapersonal (what is happening within us and others), interpersonal (what is happening between individuals), and contextually (what is happening around us).

Emotional intelligence impacts each of the three transitions in the theory of being, becoming and belonging. Nurses who are aware of the feelings of others often step in to support

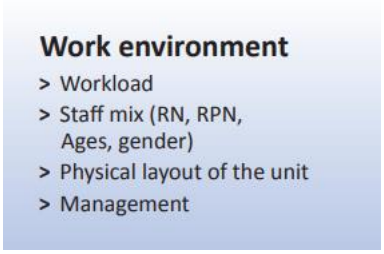
each other. The social norms of nursing practice are affected daily by the interactions of the nurses in the work groups and the meanings that they ascribe to them. The daily interpretations of interactions (Blumer, 1969) facilitate or limit how individuals accept the group social norms and develop relationships within the groups.

Work Environment

The nurses described times when the work environment influenced their ability to follow the group social norms of the group, along with their own values and beliefs. Figure 9 lists the concepts of workload, staff mix, physical layout of a unit, and management within the element of context of work environment as impacting the ways in which the nurses were able to practice.

Figure 9

Work Environment and Concepts



Sarah shared her experience of entering the hospital as a nurse. Her experience touched on the significance of the workplace environment on nurses as they begin to practice:

> When I first started, besides your nerves of course, and everything like that, it's so weird. When you enter the hospital, it's like its own little society almost. You know what I mean? It's like the outside world is no longer and now this is the high school or the building and everybody just kind of cohabitates in it and we figure everything out. And then you go home after 12 hours and you come back and do it again. So it's very much its own little organization I found. And when I first started, I was nerves. And then I started to figure some stuff out. There's lots of time where most, some senior nurses will say something to you and you try not to take it to heart or you would do something differently because you bring something new or different or a different idea.

Nursing shortages were happening before COVID-19, but the pandemic has exacerbated the shortage, impacting the work environment and changing the ability of organizations to hire

and retain nursing staff. The pandemic resulted in nursing shortages that continue to have a direct impact on patient care, according to the nurses in this study.

Victoria mentioned the patient loads were heavier, nurses were unable to meet as a group to discuss concerns, and patients suffered because the nurses could not provide a holistic approach to care:

> Um, not, not that I, not that I know of. Um, I do know, like since I've got there, the patient load is a lot heavier. Um, so I, I, I would say that I find our group meetings are not as often because our we're just extremely busy. So it's kind of hard to find the time to ha- like, to take an hour and actually have a group discussion. Um, so I, I find that maybe just with everything that's going on with the pandemic and just the nursing shortages and things like that, it's, it's put a strain. So I feel like sometimes the patient is probably not getting the holistic care that they really should be because we're kind of rushing through things.

Workload

The nurses shared their frustration not being able to provide care to their patients in ways that the felt they should. Julia spoke about being the only RN on a large unit whose patients required complex and specialized care that she was finding difficult to provide because of the high needs of the patients and staff shortages. At the same time, hospitals had nurses working on units who did not know the patients or had the skills needed to care for them.

Julia's frustration was evident as she spoke about the following experience:

> And I find the pressure of being the only RN on the unit sometimes, or even being short and you're the only RN for night, so you have all the vents (ventilators), and all the PD (peritoneal dialysis), and most of the PDs are commonly cyclers at the moment, you're in for working with no break from... Like it's just, yeah, it's a lot, it's a lot. And I don't know if I mentioned, but we have agency staff, so they have no clue of (name of specific hospital) is, or what the nursing is. We've had lots of people who've only worked in long-term care for their two years of working, and now they're working here on a heavy medical floor, and it's just, you don't have time being the only RN to go teach this person. Never mind, I can teach them how to do a PICC line (peripherally inserted central catheter), dressing change. And it's like, "Okay, but you've been working for four years." "Yeah. I don't really have..." you know?

Increased workloads and the higher acuity of patients also contributed to the manifestation of inappropriate behaviours by some nurses who felt overwhelmed and unable to maintain a calm presence. The nurses were aware of what they felt were their own and the group members' values and beliefs. When they were unable to maintain these values and beliefs, their relationships with each other were affected.

Sarah mentioned the difficulty of communicating when workloads increased. In her interview response, she stated that the oncoming nurse already felt stressed because there were not enough nurses to staff the unit during her shift. Sarah was concerned about one of the patients that this nurse was responsible for, and she tried to tell her, which the oncoming nurses felt was adding to her workload:

> I was talking to a coworker the other day and she was like, yeah, I meant to... I was giving her a verbal report, which we don't normally do, because there were some extra points that I really wanted the oncoming nurse to know. And instead of that oncoming nurse... Because they were also short, and now you've gotten some more notices that you probably didn't want to know. And so, grab the stack of the papers and threw them down on the desk and walked away. And it's like, okay, I understand that you're frustrated and upset, but that nurse isn't purposely doing this to you or trying to get you upset. It's not their fault. 'ut it's hard because you're just faced with all of this, and you're just supposed to take it all and not get frustrated. And it's almost like don't shoot the messenger.

Sarah knew the nurse was already feeling the stress of managing her workload, but Sarah needed to know that her patient would be followed up. The impact of heavier workloads was discussed by many of the nurses and contributed to their emotional responses. Sometimes their responses to stress were viewed as inappropriate and having a negative impact on the work groups. Most of the nurses talked about their workloads contributing to their inability to provide care to patients and work with the others effectively.

Dana explained:

> Um, but lots of the time with short staffing, you just don't have time for that. You get the bare minimum done… it upsets me when I don't have time to give the patients the care that I deem appropriate.

The clinical environment also played a significant role in the ability of the nurses to practice in ways that supported their values and beliefs and the group social norms. Not being able to provide the care that they felt their patients needed was emotionally upsetting to the nurses and affects their willingness to stay the profession because they could not maintain the values and beliefs that they believed were part of nursing. In addition, the nurses sometimes were made to feel that they were not meeting the expectations of their work groups if they did not help.

Adele said:

> It's just this like you can't say "No." Like, there's a phone call for you. Like you're in the middle of a bed bath. Like, it's just this like culture that nurses can't say, "No." And if you do say, "No," then you have bad time management or you're a difficult staff, right?

Many of the nurses shared that if they were unable to complete their care or support others, they believed that they were not following the group norms and felt that they did not belong. Workload added to the perceived stress of the nurses and made it difficult for them to maintain their own values and beliefs as well as those of their work groups, as was evident in Dana's comment, "Yeah, it, it hurts. It, it, it upsets me when I don't have time to give the patients the care that I deem appropriate." If they were not able to provide the care that their patients required, they became upset and felt unable to change the situation.

Staff Mix

Some of the nurses talked about staff mix as contributing to their being able to provide the care that they knew that their patients needed. Staff mix encompasses the professional duties

of the team members, along with age and gender, all of which impact how the group social norms are sustained and developed. Each member of a group brings individual values and beliefs along with those of the chosen profession.

The nurses explained that the duties assigned to staff depended on whether they were RNs, RPNs, or PSWs (personal support workers); interprofessional team members; or other support staff. Josie said that the allocation of duties could result in the nurses being able to be at the bedside more and be more patient focused. If they had enough support, Josie believed that it would allow everyone to practice in their respective roles:

> If we were in a perfect world, and you had more staff, or more support staff, and you could change what your allocation of duties was, I think it would be different. Your main role would be more maybe patient focused. You'd be more at the bedside, maybe doing more of that patient teaching, and doing more that you could enhance patient outcomes with more directly with the individual patient, and that would be your role.

Many of the nurses mentioned the responsibility of ensuring that things were done for patients. To do so, nurses often assumed the responsibilities of other team members because those team members either could not provide care to patients or were not available. Most of the nurses felt that nurses could not say "no" if the result was care not being delivered to patients, even if it increased their own workloads and stress. Hartrick Doane and Varcoe (2021) studied the concept of obligation in nursing and concluded that nurses' ethical values may be difficult for them to follow in complex work environments. These values drove the nurses to take on extra work to support their patients.

As nurses, we recognize that certain behaviours, perceptions, and attitudes that make up prototypical group members are expected of us by the work groups (Hogg et al., 2017). If we do not conform to these prototypical behaviours, we risk not being included in the groups (Hogg et al., 2017). As Julia and Adele explained, when others cannot fulfill their roles, nurses feel that

they cannot say no and take on the work. This extra work can result in nurses feeling unable to uphold their own values and beliefs and at times questioning their ability to stay in nursing.

Julia explained:

> Yeah, even just being like a rehab hospital, I just think there's other areas and disciplines that could step it up a little bit more in the sense that, "Oh, nursing will do that." Like, so many things just fall on nursing, and it's like, "Sure, I'll do your laundry because it's COVID, I'll do this because it's this, and I'll do this." And you know, well, sure. I don't know, but yeah.

Adele said:

> So it's like, if the physiotherapist can't see your patient today, they still have to get out of bed. So, you have to do that. Like there's no "No" in nursing. Like if my manager wants me to do four bed moves after 4:30 and I'm only there till 7:30, I can't say, "No."…So I think that that's another part of why nurses are burning out is because we've created this culture where nurses can't say, "No." They're responsible for... Like it's like this, if this team member can't do it, the nurse will do it. And yeah, you just can't create boundaries, right?

In her statement, Adele referred to the concept of boundaries. In other words, how do nurses maintain boundaries in their practices when they have skills that overlap with other professions? This is an interesting concept that nurses must be able to discuss with each other, interprofessional team members, and management to support them as they follow their own as well as the rules or social norms of their groups to provide the care that patients require.

COVID-19 contributed to the hiring of team members who were not originally members of the work groups. This contributed to confusion regarding the teams' roles and how to assign patients to each of the team members. Cornelius, who noted that the organization had hired PSWs to support patient care on the units, felt that the PSWs and the nurses did not receive enough information to work effectively with the team. The nurses were not sure how to assign the PSWs working on the unit. The PSWs also were unsure of their role on the unit, which resulted in their not wanting to take on more responsibility. This caused conflict between the

nurses and the PSWs because it was difficult to provide care to patients when they did not understand the roles that they were to take on.

Cornelius remarked:

> Yeah, nursing shortage. They increase their load and they put PSWs in there. Not even fair to the PSWs in my opinion, because the PSWs are just thrown in there and there was no leadership for them. And there was... Like, the PSWs on that floor now should be doing what I was doing as an RNA (registered nursing assistant) on (name of unit) back then. They should be doing it exactly the same way, doing scheduled rounds like a round in morning, everyone gets out of bed. Like the way we nursed on (unit name) is like totally day and night to what they're doing now as far as getting people out of bed.

Cornelius brought previous experience and knowledge to the work group that she was now part of, which may have influenced her expectations of the PSWs. The importance of knowing the roles of other professionals is essential to providing the best outcomes of care, but as was evident in the experiences of the nurses in this study, it may result in confusion regarding responsibilities and animosity among group members.

The ages of the nurses also contributed to changes in expectations and the ways that the social norms of the units were followed.

Adele explained:

> Like, I think if I look back now to like when you're a certain age, the most important thing is fitting in, right? Like you're not worried about being... Like professional comes second to fitting in with like the cool kids or the clique, right? And then not that there's like a... Like I don't think our floor is particularly cliquey, but that like feeling of wanting to fit in changes when... Like, there's a few of us now who've gotten married and like have kids. Like that's a different dynamic than the group of people who are either just like getting engaged or they're still single and... Their priorities are just different. So, I think that's what I'm trying to say, maybe the priorities outside of nursing kind of trickle into the behaviors or influence how the behaviors are on the floor.

As Adele said, being able to identify with the experiences of other nurses not only in their practices but also their personal lives contributed to feeling like they fit in with their work

groups. They believed that they had the same attributes of other members of their work groups that aligned with the values and beliefs of the group members.

Staff mix directly also may impact the ability of the nurses to maintain their values and beliefs because it may contribute to increased workloads and confusion about the work that others are responsible for. If nurses feel that others with whom they work are not behaving as a prototypical member of the group, they may not be as willing to support them, leading to unfair workloads and difficulty maintaining good patient care.

Physical Layout of a Unit

Some of the nurses commented on ways that a change in the physical setup of a unit could lead to changes in how the nurses supported each other. Supporting each other was perceived as an important group social norm. Having one particular unit physically split with two separate nursing stations made it more difficult for the nurses to see each other. It also made it difficult to identify other nurses who were struggling to manage their workloads. As a result, nurses on one side of the unit felt that they were no longer supported. Separating the unit put them out of eyesight, which affected communication between and among group members.

Sadie explained:

> The wings have been separated. The (unit) has their own nursing station now, so sometimes people will treat it as different units, whereas I think maybe sometimes people need to be reminded that we're all one unit, and we all help each other out.

Nancy, who worked on another unit, gave an example of needing to walk to the other areas to ask if others needed help:

> There's almost like little groups within the core group, right? Because the department as a whole, we're separated into X, Y, Z, that kind of thing. So for the most part, the teamwork is good, but some people just buy into it more than others and some people feel more, what would the word be? Some people just feel more for their coworkers like that you want to help more, that you want to be a strong team player.

When the areas on the unit were physically separated, it was easier for the nurses not to see how busy some of their colleagues were. Meeting the group social norm of checking in on others to see if they required help was made more challenging because of the physical divisions. Some of the nurses tried to check in on colleagues, but others did not. Inconsistency in offering help to others added to the nurses' stress and the relationships that they had built.

Units do not have to be physically separated to cause issues with nurses trying to support and communicate with each other; however, the size of a unit and patient assignments may make it difficult for nurses to access help from other nurses. Dana explained that although she worked on a smaller unit, staff shortages lead to fewer nurses being present per shift, subsequently increasing the number of patients assigned to each nurse. Their patient population required more nurses to support turning and caring for patients. Because of the staff shortages, it often was difficult to find enough nurses who were not busy with their own patients on the unit to help with the provision of care. This situation resulted in frustration for staff and patients alike, it and impacted the way that the nurses were able to provide the care that their patients expected.

Dana said:

> Um, I used to think when I was, there was a lot more teamwork than there is now, but that's mainly because we're short staffed and this, and like, it's hard to get everyone into one room, especially when we had that one patient who was 500 pounds, 600 pounds, you need to do the teamwork, but sometimes just for daily things, when people are going on their breaks, this and that, it's, it's a lot harder on a smaller unit.

Dana also mentioned the importance of teamwork in providing care and maintaining the values and beliefs of the nurses and their work groups.

Management

Some of the nurses talked about the need for management to support them in their practices and recognize the issues that they encountered when working on the units. When the

nurses felt that management did not see the work that they did and the challenges that they faced, they felt isolated, which impacted their practices.

Adele commented:

> And I think that's sort of maybe the point I'm trying to... Sorry, but that's like kind of the point I'm trying to make is that we have been doing it alone, like we're relying on each other alone, and like we kind of need help from... Like, we need upper management to like, recognize how important the job we do is. Like, we need upper management to support our mental health. We need upper management to like see nurses as like equivalent, right? So, it's like that trench piece, right? Like we're in the trenches together, so we manage, but we really I think a lot of the time feel isolated from upper management and unheard.

When management seemed not to understand either the nurses' practices or their values and beliefs, the nurses felt that they could not discuss their concerns. The nurses assumed that if the management that they directly reported to were not nurses, they would not support them in their practices. Hogg and Rinella (2018) discussed the need for human beings to self-categorize as having the same attributes of the groups that they identity with to raise their sense of belonging through the perception of having a shared identity. If individuals see others as not being prototypical of their groups, they are less likely to trust or be influenced by those individuals.

Victoria echoed this sentiment in her experience of feeling that if the manager was not a nurse, that individual would not understand what the nurses needed in their practices:

> A lot of our managers now just have like a business background or a health science background. So they don't, they just don't get it. Um, so unless they were sick, I don't think that they would really understand what patients actually need. So somebody telling me what I need to do in my job when they have never experienced the job. It just, it's hard. It's hard to take that.

Some of the nurses talked about their expectation that managers would address nurses who were not following the group social norms, such as by manifesting bullying behaviors, and they felt disappointment and a decrease in trust if such issues were not addressed.

Hannah discussed nurses bullying other nurses and not having the situation resolved:

> You know what, one of them was reported so many times to human resources, and they never ever backed us up. They would say, "Oh, well, you know what she's like, we can't really do anything." So we never, and you know how they always have these posters up in the hospital by like, bullying is not a tolerating. Well, you know what, it is tolerated. So nothing was done about that ever. The person who was the worst, who ended up getting fired was reported so many times to human resources that they just, actually, I think the manager at the time said, "Well, you know what she's like. You just deal with it." So, it wasn't dealt with ever., so we weren't backed up.

Hannah's interview response highlighted the need for managers to support the nurses in maintaining the group norms and addressing issues affecting the work environment. Bullying was one of the issues on the units that was not always addressed because it often was more complex than just speaking with the nurses who were bullying other nurses. Norms are rules supported by the nurses working in the group (i.e. descriptive norms) and those supported by the organization, including what ought to be done (i.e., injunctive norms; Kallgren et al., 2000). Even though the injunctive norms of the organization did not support bullying, nurses in work groups may have tolerated it, depending on the descriptive norms of the group. Descriptive norms can be influenced by the context in which they occur, along with the values and beliefs of group members and the groups themselves.

Relationships

The contextual element of relationships was supported by the four concepts of being included in the group professionally and personally, team function, workplace culture, and being taught the social norms of the group (see Figure 10).

Figure 10

Relationships and Concepts

Relationships facilitated the development of group connections and the ability of group members to support each other and work together. All 19 nurses shared examples of their need to develop relationships with each other to learn the group social norms, provide good patient care, support and be supported by others, and develop social relationships. The ability to develop relationships has been related to feeling safe, putting trust in others, learning from others, and developing themselves (Göktepe et al., 2020). The nurses felt that they were able to build trust as they got to know each other not just in their nursing practice but also in parts of their personal lives.

Emily remarked:

> I feel that they (work group of nurses) developed a lot more trust in me and they've gotten to know my personality. So they've just learned to have to deal with me because I work there full time. I feel that since I've been on this unit.

The development of relationships in their nursing practices impacted all three transitions of the theory. Relationships significantly influence the decisions to stay in their work groups and the profession. Nursing is a relating practice in that everything that nurses do impacts the intrapersonal level of their practice as they learn the group social norms and compare them to their own.

Being Included in the Group

Many of the nurses felt that being welcomed by other members of their work groups and having friends on the unit supported their feeling that they belonged to the groups. This sense of belonging also added to their ability to transition onto the unit because they were able to learn the rules of the group and feel comfortable as they started their nursing careers. Sadie added that she had been on the unit with a preceptor, a nurse with experience on the unit assigned to nursing students, and had gotten to know the nurses before she started working. This added to her ability to transition to the unit because others knew her and felt that she was already a part of the unit.

Sadie commented:

> Transition, yes, transition. I did know one or two people prior to working, so they definitely welcomed me with open arms. The friends in the groups that they were in on the unit had also done the same. So I think it was a pretty easy transition, which was really nice, and I definitely think having my placement there helped because then the preceptors that I had, I got to know who they were involved with to on the floor, and it was nice. So I felt okay. I felt welcomed, which was good.

The nurses also talked about relationships as group members as well as friends outside of the work environment. Sadie mentioned the positive aspects of having friends she knew outside of work and now as part of her work group. She felt that it contributed to her learning the rules and behaviours of the unit, making it easier for her to be included in the work group:

> I know that a lot of the close friends that I have on the floor, at least, were very close prior to me being there. I honestly think me knowing a few of those people prior to me going on the floor helped me just kind of get taken in by them. Do you know what I mean? I think it might have been a bit more difficult not having known anybody.

Although friendships such as those that Sadie talked about gave her a sense of being included in the work group, Josie shared the drawbacks of friendship. Josie felt that because they were friends and could easily communicate with each other, there was no downtime from the stress of work:

> And I think that was maybe the hardest part about being X, I don't know if this is applying to this question anymore, or if we're like way off topic now. But it was that the complaints and the issues never ended. They traveled with you. So you would go home and you'd look at your phone and you'd have 50 messages about how bad the shift is because your friends are complaining and you're their source of relief. You couldn't get away from it ever.

Some of the nurses mentioned that other nurses were friends at work, but not outside of work. Josie said that when she changed units, she had friends at work who were not friends outside of work. This allowed her to keep her work and social lives separate. Josie felt that she did not have common interests outside of work contributing to the change in friendships:

> Down on X, I am the senior nurse. I'm the older one out of everybody. So they're in a different place than I am. So we're work friends, but we're not friend friends. Which I actually like better. I found that to be the hardest part about working on XX was that my friendships outside of work were impacting how I felt at work because we don't have the same motivations, I guess.

Being included in their work groups was important to all of the nurses in the study. If they were included, they were able to learn the values, beliefs, and behaviours of the other group members, which allowed them to feel that they had become part of the groups. Being included gave the nurses the opportunity to see firsthand how group members interacted and communicated with each other during the workday. Although being friends with other nurses in the groups outside of work could have been beneficial, it also could have contributed to stress because it might have meant a continuation of discussions about work-related issues.

Team Function

Relationships between and among nurses in the work groups allowed the group members to function well as a team, or not. Some of the nurses mentioned feeling that there would be other nurses to support them in practice and that they would work as a team to support their patients. Gina shared that when she was in school, she took it for granted that the other nurses with whom she worked would automatically be supportive of each other. Once she began to

practice nursing, she found that the nurses had to be committed to supporting each other and that it was not automatically a group norm. Each unit and each work group had different expectations, and it took building relationships with each other to ensure a work environment that was supportive, kind, and caring. Everyone needed to work together to make this happen.

Gina explained:

> Yeah, because initially, we kind of took that for granted in nursing school that we always will be there for each other and that's not a guarantee in groups that we're all going to be there for each other and we're all going to be supportive and kind and caring and advocates. It's not something that's guaranteed. It's something we have to work for to achieve. It doesn't just happen.

The ability of the members of work groups to function well is dependent on the individuals and their emotional states. Rimal and Lapinski (2015) studied the impact on the perception of group norms by the individuals in the groups and found a relationship between the proximity and interdependence of the group. Adele spoke about the effect of emotional state on the ability of the nurses to practice safely as well as how their emotions affected the function of the team. The nurses on the unit worked closely together and were impacted by the positive and negative emotions of other nurses. They often overshared how they were feeling, which had become a group norm that Adele considered not always helpful to the work that the group members had to accomplish.

Adele also felt that she did not know where to go for help:

> Yeah. So yeah, I would say we're really like a strong team. I would say that lately there's been a lot of burn out and anxiety. And so I think that you feed on the really good energy, but you also feed off that bad energy. And like there's been a lot of struggling with mental health. And I would say that I sometimes wonder if it's overshare with each other, just how much we're struggling without knowing like sort of where to go to get help.

Knowing how others in their work groups were feeling or coping with their patient workloads affected the ability of the other group members to maintain group norms, such as meeting the needs of patients, working together effectively, and supporting one another.

Kim talked about being aware of the individuals in the work groups to find out how they were managing their work. She explained that having unit awareness was important to the success of the groups. Kim suggested that getting to know each other's strengths and weaknesses was the result of spending a great deal of time together:

> Unit awareness was big having an idea of who was struggling, who was not struggling. And it's like nursing's so interesting. You spend like half your life with these people. And just kind of having even a basic understanding of who each other's were and the strengths and weaknesses oh, made the team successful.

Group functioning was discussed by many of the nurses because it impacted their ability to work well and safely. The relationships that they developed with each other allowed them to follow the norms of the group and the nursing profession, such as being supportive of each other, providing safe patient care, and feeling that they belonged in their work groups. There were upsides to close relationships that extended beyond the workplace. These could be supportive in that they understood the stress of nursing and the challenges that nurses faced at work. They had an intimate understanding of nursing that others did not have. The downside of close relationships was that they were never away from work because this was often what they talked about in their social spaces. As Adele mentioned earlier, she did not know where to go to deal with the stress of work, which highlighted an area where management could develop strategies to support the nurses in dealing with the stress encountered on and outside of the unit.

Team functioning was related to the ability of the nurses to communicate well with each other to share their knowledge and experiences with patient care and the expectations of other group members. Sarah explained that even though they did not have a formal verbal report, they

did check in with the next nurse if they were concerned about the patients or wanted to make sure nothing got missed:

> So I just always tell people make sure that you're communicating well with each other because you don't want anything to get missed. Because if you're just reading a paper in front of you, it's not seeing the patient or going over everything that it can leave a bit of room for error. So communicate, communicate, communicate. And a lot of the nurses are senior on our floor as well, and have been doing this for years. So they have such vast knowledge about everything. I think we're a really good team when it comes to communicating.

This statement contrasted with Patricia's experience with nurses who did not share their knowledge. She was not sure why this happened, but she began to think that it may have been that they did not want others to do well. She saw this happen with new graduate nurses as well as coworkers. Not sharing information can contribute to mistrust between and among group members, and negatively impact team function. Several of the nurses identified communication and teamwork as a norm of nursing and part of their values and beliefs.

Patricia explained why she thought that nurses did not share information:

> You know what? I think it works down to teamwork. Eh, I guess if you're... What I've found, mostly that I've found really hard. I think people don't share their knowledge anymore because... I don't know why that is. If they want to be more superior or I don't know. You see, when you work as a team, you got to share, whereas when you work individually, you shine more I guess if you know more. I don't know what the... There is a problem though, with the nurses coming out of school right now. And I'm not sure what it is.

Teamwork is essential to the practice of nursing; without it, nurses cannot provide optimal care to patients. Communication is required for good teamwork, as the nurses in this study indicated. They understood the group norms and behaviours that contributed to good team functioning by working and discussing the challenges and successes that they achieved working within the groups.

Workplace Culture

The workplace culture are the norms shared by the individuals working in their groups (Sutton, 2018). All of the nurses talked about differences in the work environments of the units on which they worked.

As Sadie explained, she knew some of the nurses the unit and felt more comfortable starting on the unit. She had heard that the nurses on the unit were a "close-knit group," so it may have been more difficult for her to transition to the unit if she had not already known some of the nurses. Having previous knowledge of how the nurses on the unit worked together highlighted the importance of knowing the group norms beforehand.

Sadie had already learned some of the group norms from nurses already working on the unit, which made the transition to the unit easier for her:

> So if I would have maybe come from out of town, then it would have been harder for me to build those relationships, but I think because I had already a little bit of a relationship with some of those people prior to working, it definitely helped me transition better. But I do know that they ... I had been told even prior to me working on the floor that they were a close-knit group. XX was one of those floors that was close. So I believe it was a thing before me, but actually having experienced now.

Sarah also described her work group as "tight knit" and acknowledged that it was sometimes difficult for new nurses to break into the group. She explained that members of the group got together outside of work, which strengthened their identifying as members of the group. They could learn the norms of the group, acceptable group behaviours, and understand how they fit into the group. Developing these relationships with other nurses on the unit built trust because they could predict the behaviours and norms of the group while also making it challenging for nurses new to the group to fit in.

Sarah commented:

> And that's not to say everybody wants to hang out with their coworkers outside of work or, or whatnot. But I find that a lot of trust goes into working with these people. And then if you enjoy hanging out with them as well, then that's really beneficial. I would say it's a really positive unit. I've had a few physicians say to us too, that they really like working with us as a well-rounded staff. And they know us by name a lot of the nurses and a lot of the physicians. It's a really, really tight knit group for sure. Which is sometimes hard to break into, right? I'm lucky that I've made my way into it. So very tight knit and very team focused.

The ability to build friendships with the nurses on the unit supported their learning the group norms and made it easier for them to become part of the work group. Emily explained that there was a routine to the unit: They acknowledged each other when they started their shifts and then took part in handover reports that allowed the nurses to ask questions of the nurses leaving and gain a better understanding of the patients and their health concerns. The handover also was a space for learning what was expected of patient care and became an opportunity to learn the expectations and behaviours of the nurses working on the unit. The relationships between the nurses' communication and relationships with each other were important for them to learn the group norms and made them feel that they belonged to the group.

Emily said:

> So every day, when I come on, there's obviously a friendly greeting. There's a good handover report given. Well, I've talked to them a lot, even outside of the workplace. So we have an idea of what's going on with our personal life. There's some good banter between us.

Relationships on a unit can contribute to additional stress for nurses. The norms of nursing are shared and built between and among nurses in the various work groups, the manager, and the organization, and they are often seen by nurses as an obligation that they cannot say "no" to. This expectation of not saying "no" contributes to the culture on the unit, with the expectation

being that nurses will take on more work, even if it means not meeting the values and beliefs important to one's own nursing practices.

Adele discussed this obligation to do whatever was asked of her because it impacted her patients:

> Yeah. So that's sort of the first part is the trauma piece. The second part is, I've thought lots about this, because I myself felt burnt out last fall and took a couple months off for like not just work-related, like I had some personal issues, but it's a job that doesn't give you the capacity to say, "No." So like, you can't have any boundaries. So it's like, if the physiotherapist can't see your patient today, they still have to get out of bed. So, you have to do that. Like there's no "No" in nursing. Like if my manager wants me to do four bed moves after 4:30 and I'm only there till 7:30, I can't say, "No."

Nurses feel a direct responsibility for and obligation to their patients that is reinforced by other nurses, managers, interprofessional teams, the organization, the CNO, and schools of nursing. Often, nurses like Adele will feel that they cannot say "no" if requests have a possible impact on care. Trying to do it all affects the culture on the unit by adding to nurses' stress and their feeling that they have no other recourse. This increase in their workloads contributes to nurses feeling that they cannot get away from the stress of work.

Josie said that her friends on the unit carried problems at work into their private lives:

> But it was that the complaints and the issues never ended. They traveled with you. So you would go home and you'd look at your phone and you'd have 50 messages about how bad the shift is because your friends are complaining and you're their source of relief. You couldn't get away from it ever.

The workplace culture of the nurses in my study was influenced by the relationships that they had built with other nurses on the unit, the norms of their work groups, and their ability to maintain their responsibilities and obligations to the patients on the unit. From their stories, others such as managers, the organization, the regulating bodies, and other members of the health care team influenced the norms of the nursing groups.

Being Taught the Social Norms of the Group. Relationships played a significant role in nurses learning the group norms, as this study demonstrated. As evidenced throughout the contextual element of relationships in my theory, having work and outside-of-work friendships contributed to the ability of the nurses to discuss their work, their expectations of each other, and how they worked as nurses in their work groups. These formal and informal conversations allowed the nurses to share the expectations of the group and build the social norms of the group.

When the nurses initially started working on the unit, they often observed the actions of other nurses and listened to what they were discussing.

Julia explained:

> Yeah, I would keep my answer the same honestly, it's through observing, and you know I shouldn't say that. And listening, listening to lots of break room chatter. You hear a lot of things so some of the expectations and things that, how the unit is run, is definitely learnt by who you're around, who's orientating you, so, yeah, I think it's a combination.

Sarah mentioned that there was no handbook on how to work once she was in her nursing practice. She stated that it was about watching what others did, trying to understand why they were doing things in a certain way, and learning from other nurses:

> There's definitely no handbook or anything like that. I wish there was that tells you this is how we do it. There's so much when it comes to nursing outside of school, this is how you do nursing. This is how you provide your care. And this is how you give this antibiotic. It's a lot of emotion and behaviors and a lot of that stuff that goes on as well. It's being able to watch it, understand it and then learn it from them as well.

Kim spoke being inquisitive and asking questions when unsure why things were done in a certain way. She said that she needed to learn the culture on the unit. She had seen times when nurses did not seem to be able to learn the routine of a unit and left. One norm on the unit involved turnarounds, times when the nurses worked together to provide care as a team. During these times, the nurses talked about how patients were doing, and they had an opportunity to get other nurses' ideas and feedback about the status of their patients.

Kim described the culture on her unit:

> Or if you're not, if you haven't picked up on the fact that everyone seems to be inquisitive, ask the questions, we don't want anyone trying to do this on their own, you probably won't do well in the X unit. All of these things. And it kind of really does sort of all happen on turnarounds. But the culture that has been laid out, if the nurse can't really adapt to it, then I don't know, they usually don't end up doing very well. But yeah. Does that answer the question, like the culture that's laid out affects.

Julia, Sarah, and Kim discussed the idea of observing other nurses on the unit and listening to how they spoke about their work. This was one of the most common ways that they felt that they learned the norms of the unit.

Sadie said that she may have learned some of the group norms from the preceptor (primary nurses who work directly with student nurses in their 4th year). Overall, she felt it was by observing the nurses and incorporating these norms into her own practice. Then she developed her own routine, which was similar to the nurses that she had observed:

> I guess, just seeing other people do it too. I'm trying to think of ... I mean, with a preceptor, they tell you kind of ... I don't know. Honestly, nobody really told me. It was more of just a visual learned behavior, in a way. Each shift, I would just see how people do things, and kind of just make my own routine. Then aside from that ... It was more just like a visual learned behavior, I guess, in a way. Like I said, it wasn't really verbal. Nobody really told me, "This is what you need to do." It was just like I kind of just saw what was being done and kind of did it my own way or helped out in the way I thought that was maybe being missed or needed, I think.

One of the ways in which the nurses learned group norms was when they were corrected by other nurses. Josie would tell new nurses what they needed to do to feel confident in their work. Josie gave an example of a new nurse who offered to help put a new patient's chart together. The nurse whom she completed it for complained that it had not been done correctly. Josie asked if she had explained it to the new nurse. She had not.

Josie took time to tell the new nurse how to do it correctly while also supporting other nurses in sharing the group norms:

> You go and tell her. Like, "Hey, you know what's super helpful when we do a chart is that we do it all. And we do it the same way the ward clerk will do it. You go through and you process the meds, and you make sure the orders are in. So that when I come back from doing my assessment, all I have to do is check it." And she went and did that…And she was like, "Oh, my God, I never knew that. I'll do it right now." How easy. Because you communicated. And no one was offended.

Being taught and learning the group norms is a complex skill for nurses new to any work groups and requires them to feel confident enough to ask about rules and expectations. Learning these norms was the result of watching, listening to, asking, and being corrected by other nurses in their day-to-day practices. Relationships contributed to the ease or difficulty learning the norms to become a part of the work groups. Building trusting and supportive relationships with the nurses on the unit contributed to the nurses new to the unit learning the group social norms and feeling that they belonged. The ability of the nurses to reflect on and identify what they valued and believed in as nurses and as part of the groups was relational.

Navigating Conflict. Some of the nurses talked about relationships sometimes resulting in conflict that arose when some nurses were unable or did not want to follow the group norms. Cindy worked in a small group whose members relied on each other for support because they worked closely with patients who had multiple health needs. Each nurse in the group brought expertise, so it was norm to share knowledge and expertise to provide the best care to patients. If one member of the group was not sharing information, the results were distrust and tension in the group.

Cindy explained:

> Um, yeah. It just makes it really, really challenging, 'cause then it kind of snowballs into this whole thing of, this person's always doing this, and we can't trust them, and it's really hard to work with a small group when there's tension in the small group.

Cindy had brought this dilemma to the attention of the manager and had spoken with the nurse. Things changed for a short time, but then went back to this nurse not sharing information. This situation was challenging for the other nurses in the group and lead to conflict in the team and difficulty providing patient care.

Cindy said that they had team meetings to address being open with each other and sharing knowledge:

> Um, well, I mean for any group, the biggest thing is openness. Um, 'cause if you're, if you're not going to listen to other people, what's the point of even having discussions with you, if we're just gonna be forced to do what you wanna do, what's the point of even having, what's the point of wasting an hour and having a group meeting when we're not really working as a group? Um, so the biggest thing is openness and like having, uh, uh, in our group the nice thing is that, um, everyone has to ha- be part of the discussion. You're not just, you know, a lot of like our staff meetings, most of us didn't even apply to half of the people there (laughs).

Dana spoke about nurses in the work group initially not sharing information with her; however, once she developed a relationship with the nurses, they began to be supportive, share knowledge, and help her to provide good patient care:

> There's lots of people who they seem like they know it all. So they're, you kind of feel like they'd be too busy or too good to answer your questions, but then after you break down that barrier, uh, you realize that they're willing to help you and they want you to be doing the best care.

Navigating conflict was part of being a group member. Many of the nurses talked about conflict, such as having disagreements about patient assignments, not wanting to help others, and not sharing knowledge, as Cindy and Dana mentioned. Nurses who did not follow what the other nurses felt were the group norms came into conflict with each other as they tried to work together to support patient outcomes and manage their workloads. They often worked out these conflicts because they relied on each other to manage the needs of their patients and support each other by sharing knowledge and physical help.

Communication

The element of context, communication, was supported by the concepts of open communication within the group, charting and verbal reports, timing of communication, group support and where communication takes place impacted all the transitions in the theory (see Figure 11). Each concept was explained by the nurses.

Figure 11

Communication and Concepts

Communicating social norms is necessary for individuals to learn the values, beliefs, and behaviours of other group members so that they can feel that they belong (Hogg, 2018). Individuals in groups look to others in the groups whom they perceive as prototypical, that is, having the attributes expected by the group members to gain dependable information about the social identities of the groups (Hogg, 2018). Communication in nursing groups occurs in many ways: informally through gossip and hallway conversations, formally from managers and the employing organizations, charting and reports, verbally from others in the groups, and nonverbally through the behaviours of others towards them (Bulduk et al., 2016).

Open Communication Within the Group

Open communication is important for nurses to provide the best care possible to their patients, feel that they belong to their work groups, and identify as having the same values and beliefs as other members of their work groups. Kim recalled a time when she was caring for a

patient whose condition deteriorated, so she called for support. No one seemed as concerned as she was. She became upset because no one was supporting her. The other nurses finally explained what the plan was for the patient, which was that he was very sick and they could do nothing to improve the outcome.

Kim explained the situation:

> Absolutely. And for that particular case, I needed to know what he was thinking because I'm sitting there being like, what are we doing? This person is not going to survive. This is not what he... He was so sick and it turns out the physician the whole time knew he probably wouldn't survive the night, but didn't tell me that. So as far as I'm thinking, do you think we're saving this? What are you doing? Why aren't doing like this, that, and the other thing being like, he needs to go to OR he needs to do all these things. The physicians already knows the surgery's not going to... We're too far gone. He's been denied by surgery. Do you know what I mean? Surgery won't even take him, but I didn't know that. So I'm sitting there being like I so confused. Why aren't we doing anything? And so at the end we were just like, okay, we obviously needed to tell each other what we felt. So then had I known that I would've been like, okay, this is a man who's we can try and we will, but he probably won't survive the shift.

Once Kim realized the plan, she was able to change her plan of care, but this incident affected her trust in the other group members to relay information. She also felt left out. Her example of missed communication highlighted the impact that it could have on individual nurses, their sense of belonging to the profession, and their questioning of the group members' values and beliefs.

Some work groups had open communication, and they had strategies i to improve communication. Eden stated, "We all tell everyone about our patients. We do it like a huddle. And that I feel has really increased our communication because we have teams, we have a medical emergency team that I was part of." Having the ability to take the time to report on the patients in their care to other nurses in their work groups allowed the nurses to feel more like part of the teams and gave them the opportunity to learn the group social norms and how other nurses managed their patients' care.

Nurses who had used verbal reports as part of their practices found it to be a great loss when the organization changed from verbal reports to written reports. This change was a loss of verbal and nonverbal communication and the nuances of communication between and among group members. During verbal reports, the nurses could see the behaviours of other nurses, their knowledge, how they problem solved and what was expected of them sharing group social norms.

Nancy shared her experience:

> I'm one of those people that I think, man, we had some amazing group dynamics back at the XX. And one of the things that I honestly believe that has changed the dynamics about nurses as a group when you're working together. One of the things that I think is hugely contributory to that is they took away group reports. Everybody used to sit together and we all heard report together on the whole unit. So I knew if Cathy X's set of rooms were crappy, we all knew it. Every one of us knew that Cathy was going to have a crappy day that day because you who had the sickest and the heaviest patients. And we therefore all pitched in because everybody knew it. So nobody let Cathy flounder like nobody went for coffee without Cathy. And nobody went for lunch without Cathy because we all knew.

There was an expectation among the nurses in my study that the group members would support each other. Verbal reporting allowed everyone to understand the complexity of the patients on the unit and the workloads of other nurses. The ability to communicate with other members of their work groups during verbal reports facilitated the sharing of knowledge about patients and supported nurses new to the unit in understanding the expectations of the work groups and the group members' values and beliefs.

This contrasted with units that used computer-written shift summaries for patients that only the primary nurse would read. This resulted in the nurses only knowing their own patient assignments and how other patients on the unit were doing. Nurses on the unit began to recognize the workloads of other nurses throughout their shifts as they discussed patients and delivered good care, but these tasks took time and constant communication.

Sarah stated:

> Me, myself, I'm always telling that, but there's sometimes where communication breaks down and on our floor, we don't do verbal report. We have everything written down and printed. So we just leave that. And then if people have questions or just extra little points that you need to mention, you can chat about it. So I just always tell people make sure that you're communicating well with each other because you don't want anything to get missed. Because if you're just reading a paper in front of you, it's not seeing the patient or going over everything that it can leave a bit of room for error. So communicate, communicate, communicate. And a lot of the nurses are senior on our floor as well, and have been doing this for years. So they have such vast knowledge about everything. I think we're a really good team when it comes to communicating.

The ability of nurses in work groups to communicate about their patients is complex. It occurs formally during reports and informally throughout the day. Communication allows nurses to learn the group social norms through the ways that they communicate and where they communicate, which may influence the group norms and nurses' identity as part of the group, all of which are essential to the development and sharing of the group norms.

Charting and Verbal Reports

The way in which nurses formally communicate about the care that they deliver often is controlled by organizational policies. Most of the nurses in this study agreed that they were expected to document all of their care in the form of computer charting. Nancy spoke about documenting informally and formally throughout a shift so that she had the information that she needed to communicate to others in case a patient's condition changed. This was important to her practice because she could see how the patient changed throughout the shift. Nancy also stated that charting was a "good behaviour" that was an expected norm of practice:

> And I think it's also important and that it's funny, is documenting, taking good notes, because in a 12-hour shift a lot can happen. But I find if you're documenting throughout your day and you're writing things down or on your worksheet and whatnot, that you're able to then refer back to it, especially in a code situation or anything like that. So definitely, and that's almost communication as well, that you're documenting and charting. So those are good behaviors to learn for sure.

Gina explained that although the nurses on her unit used paper charting, they either did not always have the information that they needed or they had more than they needed to see. She stated that the nurses worked together to adjust the charting form to make it more useful for them. Working together to adjust the charting form contributed to the identification of behaviours required by the nurses in the same work group as Gina to provide patient care.

Gina shared an example of the communication between and among group members using the daily task sheet:

> Sometimes. Sometimes they work. If we can, especially with saving time on, I don't know, for example, charting, because we use paper charting, collaborating with ideas how to condense sheets and stuff like that, those work, or even with daily tasks, we made a daily task sheet and worked on it together. We are able to make changes together, yes.

Although computer charting was the norm on most units, some units would allow the nurses to give verbal reports about patients to the oncoming nurses. Nurses who had been able to give verbal reports but had moved to computer charting felt that there had been a loss of teaching opportunities for new and experienced nurses to learn the norms and expectations of other nurses regarding patient care and behaviours on the unit.

Julia and Adele discussed the positives of verbal reporting, such as nurses being able to ask questions and learn from each other.

Julia explained:

> But no, the communication was great, that's the one thing I really liked about XX, they still did verbal reports, so that was great. And they were always really kind to one another, like, just the report was very, "Oh, I did this for you, Sue." I don't know, they always helped the next shift, which was really nice, yeah. Yeah. Julia

Adele said, "So, yeah, like I think like to each other, we communicate well. I think we're like really good. We like do verbal reports, so we make sure that we're communicating like key information about patients back and forth."

Formal communication on the units occurred through charting and reporting to other nurses and members of the interprofessional team. For charting and reporting to be effective, the other nurses needed to understand what information was being relayed. They needed to know the language of the unit and how it was used to convey information. When the nurses first joined the work groups, they had to learn the group social norms regarding communication.

Timing of Communication

Communication between and among nurses in the work groups continued throughout their shifts, but there were times when formal reports on patients were expected. These formal reports usually occurred at the beginning and end of each shift, when information about patients was shared with the oncoming nurses. The way in which information was communicated varied on the units, with some units using face-to-face reports so that nurses could speak directly with each other and other units using written or computer reports prepared by the previous nurses to the new nurses coming on shift. Formal reports were expected by the organization at the beginning and end of all shifts, as well as when patient care was being transferred to another member of the work group. Informal reports between and among nurses occurred throughout their shifts and were in response to changes in the nurses caring for patients, such as during breaks.

Not all the nurses communicated well with each other. Cindy explained that in their small work group, she likes to be able to let other members of the group know what was happening with her patients so that care was continued appropriately. She attempted to give verbal reports, even though the other nurses might not have considered them important. It was important to Cindy to convey to other nurses what was happening with her patients:

> Or report. We don't really, we don't do that. But, like, I like to do a mini report. Like I mentioned, like, I'll tell the other nurse, like, "So-and-so's coming in. I did this, this,

> this," whatever. Um, and I get a cold shoulder from that, but whatever, I'm gonna keep doing it. [laughs] So great communication is a must.

Most of the nurses identified communication on the units as good. They communicated with each other throughout their shifts to let each other know how patients were doing and if they needed help.

Dave spoke about his experiences working with the other nurses in his work group:

> Um, hmm, almost impeccable. Um, I think that because we are a smaller unit, and we have a narrower focus, um, there have not been many shifts where I've been unaware of a patient deteriorating, or an issue on the unit. Um, you know, everybody's kind of on the same page, and if we're not, it's very easy to correct that. Um, so between, uh, my nursing colleagues, we have very, very good communication.

The ability to communicate openly with the other nurses throughout their shifts facilitated the transfer of knowledge about patient conditions and interventions, as well as expectations about the provision of care. This communication helped to establish and reinforce the values, beliefs, and behaviours of the nurses working on the units and the connections that they had to each other.

The ability of the nurses to begin their shifts by sharing with each other how they wanted to work with their patients made it easier for all members of the work groups. In this way, the group members knew who wanted to work together and who preferred to care for their own patients alone. Knowing what the values and beliefs of the other nurses in the work groups contributed to ensuring a positive work environment. Then the nurses could plan the workday knowing who to ask for support.

Jody explained:

> Or if we're working, say, in neurology and there's an in nurse and an out nurse (nurses not usually assigned to the floor) or two out nurses, same thing, "This is my patient. This is your patient. We follow them the whole way." Or sometimes it's, "No, no, no. We'll work together. We communicate. I'll help you do this and I'll do this kind of thing." So, they communicate together or they communicate that they want it to be separate. So, you

> learn over time who wants to do what, and you just work with your shift around that. That's what I do.

Timing of communication played an important role in the nurses' work groups. Formal and informal communication happened throughout the shifts. Missed communication would impact the ability of the members of the work groups to work well together and threaten the group norms and trust. Hogg (2018) explained that group members looked to each other to learn the group norms and that when they were uncertain of the norms, they would question their social identity as a group member.

Group Support

Communication among nurses in the work groups also functioned as a way to support each other not only when they were struggling but also when they were doing well. Communication may be verbal or nonverbal, but it is still the way in which individuals in groups understand what is expected of them (Hogg, 2018).

Supporting each other during times when they felt challenged or did not feel that they were doing what they needed to do was explained by Kate:

> Anyway, so I just know that one patient wasn't speaking to her, and she took it to heart. She started documenting and started to cry, so I comforted her. I rubbed her back. I was like, "You know what, it's okay." I was like, "You're a great nurse. You cannot take what he's saying to heart. Do not think that what he's saying is the truth." I mean, with COVID we're technically not supposed to give each other hugs. I did give her a hug because she needed that at that time. I think it turned around the behavior a little bit of her maybe ... Sometimes you need to let that emotion out. I feel like as nurses we tend to hold that in because we don't want to show it. So I supported her in letting that out, and then I reassured her that she is a really great nurse. I think it did turn around her behavior, and she was a bit more positive after. I don't know if that's maybe what you're looking for.

The statement by Kate pointed to the need to support one another in working through conflicts in practice. Recognizing the emotional states of others was a skill that some of the nurses, including Kate, discussed. She found that her own experience allowed her to

communicate her support to the other nurses in her work group and improve the outlook of the other nurses about her patients and the care that she was providing.

Group support is based on the ability to communicate needs and what can be done to support others. Nurses are able recognize other nurses in their groups with whom they want to work because these nurses communicate the calmness and support that others may not.

Kim spoke about the feeling that she had when she knew that the other nurses in her work group would help. It was not only the verbal behaviours but also the nonverbal behaviours of the nurses that supported each other. The presence of some nurses brought calmness, as Kim noted:

> Absolutely. You think if you up, a patient rolls in that's like been knocking on heaven's door for however long, and you've got all the right people in there. You feel safe. You feel that your own competence can... Is there because you're calm. You know that if you've missed something, someone else is right behind you. They got you. And someone throws a joke in there at some point is even better. You can handle that. And that's so different than when the wrong crew is in there.

Where Communication Takes Place

Communication between and among the nurses happened throughout their shifts. There were times when communication was formal, such as in charting and reporting to other nurses when going for breaks or to physicians and the interprofessional teams. Informal communication between and among the nurses in the work groups occur throughout the shifts and in the nurses' time off.

Dave mentioned the legal aspects of communication. He stated that he was careful to formally write down the conversations and orders that he received from attending physicians. The conversations with physicians were sometimes informal, but Dave documented them, too. For the nurses, writing the information on patients' chart protected them and the physicians from miscommunication and ensured clear instructions regarding patient care. Communication between nurses and physicians could be influenced by the norms on the unit and organization

regarding how and where communication was to occur. Through communication, others learned the group norms and how they were expected to communicate with each other and how their role impacted communication (Hogg, 2018).

Dave said:

> Yeah, so because of a lot of, because all of it's legality (laughs) stuff, um, I, for me, I will write like every time that I'm discussing with the, like, if I'm actually having a verbal or telephone conversation with that physician, I always write it up in a note for them to sign. So hi, Dr. So-and-so, um, just following up regarding this patient, um, this is what we discussed. This is what we agreed upon. I will follow up in two weeks with this client if there's any updates, I'll follow up with you again. Um, so there's always, sometimes I shouldn't say there's always, a lot of the times there's informal conversations like over the phone, um, that I, I have to document as well.

Much of the communication between and among the nurses was informal. Adele said, "Oh, I would say it's often informal. Like I think probably even to the extreme of informal sometimes like at the nursing station or in the hallways, I think there's probably like too much informality." Being able to communicate throughout the day with other nurses about patient concerns, skills, policies, and knowledge were very important to the nurses.

Sarah explained:

> So I just always tell people make sure that you're communicating well with each other because you don't want anything to get missed. Because if you're just reading a paper in front of you, it's not seeing the patient or going over everything that it can leave a bit of room for error. So communicate, communicate, communicate. And a lot of the nurses are senior on our floor as well and have been doing this for years. So they have such vast knowledge about everything. I think we're a really good team when it comes to communicating.

Formal communication on a unit was imperative for the nurses to know how their patients were progressing, know how other nurses were managing their patients, and know about upcoming admissions and discharges of patients.

Eden described bullet rounds, which involved the nurses meeting with the unit manager to plan the shifts:

> I think it's pretty good because you set up for the day, you say, "Okay, we're going to get an admission. You're going to have this." We have bullet rounds. So bullet rounds every day, so that we all meet at 8:15 with the manager, all that.

The rounds allowed members of the work groups to plan their days, gain knowledge of patient conditions, and share information about caring for patients with complex conditions.

Summary: Elements of Context Influencing Being, Becoming, and Belonging: The Process of Social Norm Formation of Nurses Working in Groups

As the nurses in the study described their experiences of the development of social norms in their work groups, it became apparent that there were elements of the context in which they practiced that affected the process of this formation. Contextual elements affected all aspects of how they understood and adhered to not only their own values and beliefs but also those of the other members of their work groups. The elements of context apparent in the experiences of the nurses were personal attributes, work environment, relationships, and communication.

The nurses identified what they felt were the social norms of nursing practice (i.e., compassion, empathy, knowledge, trust, support, patient care) and that for them to belong to the profession, the group social norms also had to align with their own norms. The context played a major role in facilitating or limiting the process involved in the development of the group social norms that enabled the nurses to move through the transitions of being a nurse, becoming part of a group, and belonging to the profession.

All the participating nurses identified the personal attributes of trust, self-confidence and knowledge, alignment of their values and beliefs with those of the group, ability to ask for and offer help (humility), and emotional intelligence as contributing to the formation of relationships

in their practices. Relating was central to their nursing practices and was impacted by the nurses' attributes and how they chose to build relationships in their practices (Hartrick Doane & Varcoe, 2021). The nurses gave examples of the ways that trust supported or harmed their ability to care for patients. Their ability to trust that other nurses would support them and step in to look after their patients when they were busy established a positive work environment and contributed to group cohesiveness. However, when the nurses felt that they could not trust others to help them when they needed it, they felt overwhelmed and believed that they could not provide care to their patients.

In their experiences, the nurses frequently decided how good the workday would be depending on the nurses with whom they would be working. The nurses often did not have a choice about their workmates because scheduling was the responsibility of the unit manager. Nurses work within social structures defined by the organization and society. Social structures create boundaries in which individuals must interact, develop similar attributes, and have access to similar resources (Burke & Stets, 2009).

In situations where the nurses felt that other nurses had the same attributes as themselves and the profession, they were able to follow the social norms that contributed to positive outcomes for patients. Nurses who could recognize emotions in other nurses and respond to their concerns were able to build and maintain relationships. Throughout the experiences of the nurses, the ability to ask for help as well as support others increased group trust and contributed to a positive work environment.

Humility is the ability of individuals to understand their contributions to others in context (B. Brown, 2021). Work groups, units, and patients were all different, depending on where the nurses were working. Being able to recognize the needs of others and offer support was impacted

by the demands of the context in which the nurses worked. When a unit was understaffed, the nurses were required to increase their patient workloads, which often increased their stress and reduced their ability to provide good care to their patients. Unit managers were viewed as supporting the practices of the nurses on the units by offering help and providing suggestions to decrease workloads.

Building relationships with other nurses in their work groups was seen as essential by the nurses in the study. Relationships allowed them to learn the group social norms by asking questions, observing peers, and receiving feedback from other nurses about their practices. Relationships contributed to their identifying as a nurse when other nurses would approach them for advice and support. The nurses talked about feeling that they were part of their work groups as they built professional and social relationships. Feeling that they were part of their work groups meant that the other nurses would include them in conversations and ask if they needed help. On units where their nurses felt that the workplace environment was supportive, they commented that other nurses would check in on them and take over their patients if necessary. Showing concern for one another and offering help were identified by all of the nurses in the study as a norm central to their practices.

To be a nurse means always relating to and understanding one's own values and beliefs and those of others and how these values and beliefs contribute to the ability to support patient care and build relationships in practice (Hartrick Doane & Varcoe, 2021). Strong relationships helped the nurses in my study to learn the group social norms and made them feel that they belonged to their work groups as well as the profession. Communication played a central role in the ability of the nurses to learn the group social norms. Learning the language used on a unit and how to communicate with each other took time.

Holmes and Woodhams (2013) examined the literature focusing on communities of practice, which identified similar outcomes associated with communication in the practices of the nurses in this study. The researchers connected the use of jargon and humor in communicating the expectations of members of a community of practice. The nurses in my study needed to learn how the group members communicated and what the communication meant. Communication was possible because the nurses shared a common social identity that brought with it a common understanding and language (Postmes, 2014). Once the nurses understood what was expected of them, the group social norms made them feel that they were becoming part of their work groups.

Communication in the nurses' work groups occurred formally and informally, giving the nurses information about the values and beliefs of the other nurses in the work groups. The nurses found it difficult to learn these values and beliefs until they had built relationships with the other nurses in their work groups. At first, they observed the other nurses and asked questions. As they became more comfortable in the work groups, they felt more confident that their nursing practices would align with the values and beliefs of the other members of their work groups. Communication with other nurses often occurred informally in the hallways, at the nursing stations, and in patients' rooms. Being able to ask questions when they needed help from other nurses in their work groups contributed to strengthening the relationships and developing the group social norms. Formal communication occurred during shift reports, huddles, and patient rounds, giving the nurses the opportunity to consult with one another, ask questions, and develop knowledge of the group social norms.

The context in which the nurses learned the group social norms could affect their identity as a nurse. I heard from the nurses that if their values and beliefs did not align with those of the

other members of their work groups, they felt that they did not belong. A major factor of context that limited the ability of the nurses to follow their values and beliefs, along with the group social norms, was workload. Heavy workloads impacted the ability of the nurses to provide the level of patient care that they valued, and they contributed to the nurses' stress and affected their ability to support other nurses. The emotional toll that the nurses talked about when they had to choose to provide some, but not all, elements of care lead to moral distress influencing their decision to remain in the profession. Throughout the process of social norm formation, the nurses' experiences, interactions with others, and the meanings that the nurses constructed impacted their being a nurse, becoming a part of the group, and belonging to the profession.

Part 4: Interaction of the Three Transitions of the Theory and the Four Categories of the Elements of Context

The complex substantive theory of being, becoming, and belonging, the process of social norm formation of nurses' groups, was influenced by the values and beliefs that the nurses identified as bringing into the profession. The ability of the nurses to share the same values and beliefs of the members of their work groups was either facilitated or limited by the elements of context. This interaction of the context with the three transitions was evident throughout the experiences of all 19 nurses in the study. For example, if communication between and among the nurses in their work groups was not supportive or effective, the nurses began to feel that no one would help or support them. They could not build relationships, learn the group norms, resolve conflicts, or develop expertise in their practices if they did not communicate well with each other.

Another example of the effect of context that was explicated throughout this chapter was the impact of workload. If the nurses' patient workloads increased, they often were left to decide

what they could or could not do for patients based on the time available to them. This situation left some of the nurses feeling uncomfortable in their practice. They felt an obligation to deliver good patient care, and when they could not provide the care, they felt that it did not reflect their values and beliefs.

The elements of context are fluid because of external and internal influences. The work environment is impacted by factors outside of the control of nurses: workload; staff mix (such as RNs, RPNs, PSWs, ages, genders); physical layout of a unit; and management. The nurses in my study mentioned having to adapt to changes in the work environment. Sometimes the changes supported their ability to provide patient care and follow the social norms that they felt identified them as a nurse. As one nurse explained, her unit manager was aware of the stress that the nurses were under and was available to offer support and knowledge to staff.

Driving the process of social norm formation throughout the three transitions were the nurses' connections to and development of relationships with other nurses in their work groups. If the context supported the development and maintenance of relationships, the nurses often were able to maintain the values and beliefs that they associated with themselves and their identity as a nurse. However, context also limited their ability to support each other and maintain the group norms.

The complex process of social norm formation of nurses working in groups was influenced by the nurses themselves, their self-concepts, their ability to self-identify as having the same attributes as other members of their work groups, and their feeling that they were prototypical members of the groups. Their identity as a nurse and part of their work groups was impacted by how society and the organization viewed them as nurses, how patients and families

viewed nursing, and how the context in which they worked facilitated or limited their learning and execution of the social norms not only of their work groups but also the profession.

Chapter Summary and Conclusion

Chapter 4 presented the findings from the 19 nurses' experiences relevant to the process of social norm formation in their practices working in groups in the health care setting. The theory of being, becoming, and belonging was grounded in the data and constructed based on the interactions between myself as the researcher and the participants, who provided responses to the interview questions about past and present experiences and research practices (Charmaz, 2014). The three transitions and their supporting concepts were explained in detail in this chapter. In addition, the four elements of context (i.e., personal attributes, work environment, relationships, and communication) and their concepts were discussed in relation to their impact on the nurses' progression through the transitions.

The results highlighted the temporality of social norm development as the nurses identified the norms that they brought to their nursing practices as well as the norms of the other nurses in their work groups. It took the nurses time to learn the group norms. The nurses sometimes felt comfortable or uncomfortable in their identity as a nurse, in becoming part of work groups, and in belonging to the groups and the profession. As the nurses in the study moved through the three transitions of the theory, they had to identify as a nurse based on their values and beliefs about nursing. Then they had to become part of their work groups by learning the values and beliefs that were prototypical of the group members that formed the group social norms. This process took time because the nurses needed to self-identify as having the attributes of prototypical members of the groups. Finally, to remain in the profession, the nurses' values and beliefs had to align with those of the other nurses in their work groups.

During the interviews, the nurses spoke about the importance of relationships to the process of social norm formation. Understanding and operationalizing the group social norms helped the nurses know how to nurse, work with other nurses in groups, and identify when they felt that they belonged and did not belong to their work groups or the profession.

CHAPTER 5: DISCUSSION OF FINDINGS

Introduction

In my final chapter, I focus on the theoretical worth of the findings of the substantive theory of being, becoming and belonging. The theory was grounded in the data provided by interviews with 19 nurses working in northwestern Ontario in the health care setting. The purpose of the study was to explain the process of social norm formation and the factors facilitating or limiting social norm development in the health care setting. The discussion of the findings is presented as follows: (a) reflection on the significance of the study; (b) integration of the theory and literature to the three transitions, and the elements of context that facilitate or limit the development of social norm formation; (c) integration of the RQ and subquestions into the findings; (d) presentation of the implications of the study to the community of nursing, education, nursing practice, and organizations; (e) limitations and challenges; (f) presentation of the future directions; and (g) a conclusion.

Reflection on the Significance of the Study

Nancy, one of the nurses in the study, shared these thoughts:

> I'm at the point in my life where I could retire. I have enough years in the pension to retire. I tell people if I ever seem cranky or I'm not nice to a patient, tell me to go, but when I see people who have the same values as me and you've found your people who think like you, and I think I can still be a nurse, then I can still do that because I still love it. So as long as other people... Because I think that people have the ability to make you feel like, oh, this is a lot of crap. I just don't know that this is worth it anymore. So I'm not there yet. I found my people at work who make me still think I want to be this [because] this is still who I am.

Throughout the interviews with the 19 nurses, the feelings that Nancy described resonated with the other nurses regarding the importance of finding your "people," that is, the nurses and groups identified as having the same values and beliefs as they held about what it was to be a nurse. Researchers have found that nursing students as well as experienced nurses need to

be connected to other nurses through socialization to the unit (i.e., peer mentor programs); a positive work environment; a feeling of safety that others will support them; the feeling that they fit in with the group; and recognition that they are learning their role in the group (Levett-Jones et al., 2009; Reinhardt et al., 2020; van Rooyen et al., 2018). Shared patterns of thought, feeling, and behaviour of the group contribute to shaping the social norms of the group (Hogg & Reid, 2007). The notion that others in the group hold the same values and beliefs that we hold strengthens the salience of the identity of a nurse as a member of a group. Self-categorization is the ability of individuals to identify similar attributes in themselves that are present in other group members. The nurses explained that being, becoming, and belonging involved recognizing that other nurses held the same values and beliefs that they identified as being a nurse, becoming a part of the group, and belonging to the profession. The ability of the nurses in the study to feel that they belonged to their work groups had a profound impact on their decision to remain in the profession.

Kox et al. (2020) found that nurses left the profession within 2 years of entering practice because of the lack of challenge in the job, lack of passion, lack of perceived competence, lack of satisfaction because of heavy workloads, lack of work capacity, and lack of feeling of belonging. The use of SIT and social norms in my study provided a different perspective to Kox et al.'s work by explicating the complexity of nurses' work and the impact of others on nurses' feeling of belonging and decision to remain in the profession. Some researchers (e.g., Levett-Jones et al., 2009) have examined nursing students' sense of belonging in clinical practice that was the result of their collegial relationships with nurses who supported connectedness and their ability to learn and gain confidence. Other researchers (e.g., Ching et al., 2022) have examined the experiences of new nurses and the ways that they explained belonging by adjusting to blending in, not being

ignored, becoming an ally, achieving goals through concerted effort, and sharing emotions and becoming family. These experiences were reflected in this study as connecting with others, identifying as a nurse, having others come to them for advice, supporting each other emotionally and physically with patient care, and feeling that they were with "their people." The values and beliefs of the nurses in my study highlighted the fact that their social experiences with families and friends, patients whom they cared for, society, media, organizations, and governing bodies impacted their interpretation of the social norms of nursing practice.

There has been a paucity of qualitative research on the process of social norm formation of nurses working in groups in the health care setting. SIT has been used as a lens to examine nurses' identification with their work groups and their interpersonal communication, such as willingness to confront conflict, feelings of learned helplessness, and employment turnover (J. J. Moreland et al., 2015), as well as how nurses in in-groups (i.e., their own groups) and outgroups (i.e., other groups) negotiate complaints with colleagues (Lazzaro-Salazar, 2017) and share influence and responsibility of groups through communication (Hewitt et al., 2015). Many researchers have argued in favour of using SIT to examine issues and problems that arise in the workplace, including communication of group norms, development of a nursing identity and an organizational identity, the influence of perceived norms on behaviours, and the role of self in group processes (Brickson & Brewer, 2012; Ellemers et al., 2003; Haslam, 2014; Hogg et al., 2017; Hogg & Rinella, 2018; Hogg & Terry, 2012; Rimal & Real, 2005; Willetts & Clarke, 2014; Willetts & Garvey, 2020).

To my knowledge, no previous researchers have examined the process of social norm formation of nurses working in groups in the health care setting that also included the perspectives of relational inquiry (Hartrick Doane & Varcoe, 2021); SIT (Tajfel, 1982); and

communication of social norms (Ellemers et al., 2003; Hogg & Rinella, 2018; Holmes & Woodhams, 2013). Knowledge gleaned from this constructivist grounded theory study will provide insight based on the experiences of the 19 nurses into the ways that nurses develop social norms leading them to feel that they can begin to identify as a nurse, become part of a group, and belong to the profession. Identifying facilitators of and barriers to the process of social norm formation will contribute to providing interventions that lead to nursing retention in a time of crisis in the provision of health care resulting from the loss of nurses from the profession.

Doris Grinspun, chief executive officer of the RNAO, released this statement in a report in 2022:

> About 69[%] of nurses plan to leave their positions in the next five years. And of those, 42[%] plan to leave the nursing profession altogether, whether by retiring or seeking employment in a field other than nursing.

Before the COVID-19 pandemic began in 2020, Canada and other countries were already facing nursing shortages, but now, an unprecedented number of nurses either have left or are considering leaving the profession. The CFNU (2022) reported that nursing vacancies in Canada have tripled in the last 5 years. The report targeted solutions to the nursing shortage directed at retention and support, recruitment, mentorship, and return and integration (Ahmed & Bourgeault, 2022). Although there is no simple solution to address the exodus of nurses from the profession, the results of this study shed light on approaches that could repair some of the issues surrounding the retention of nurses in the profession.

My theory offers insight and contributes knowledge that will allow nurses and the employing organizations to become more aware of how nurses develop, learn, and apply the explicit and implicit social norms of their work groups, as well as understand the ways that the context in which they work impacts the process of social norm development. Nurses who can

maintain the values and beliefs that they see as part of the profession of nursing are more likely to remain in the profession (Kristoffersen, 2020). The social norms of the group impact the ability of individuals to identify themselves as being a nurse (possessing the attributes of a nurse), becoming a part of a work group (self-categorizing as prototypical of the group) and belonging to the group and the profession. This constructivist grounded theory study will contribute to further research focusing on the development of strategies to create a work environment that enhances the ability of nurses to adopt group norms based on their values and beliefs. As seen in the theory, the context in which nurses are situated greatly impacts the way in which nurses enact their own scopes of practice and work together in groups to provide excellent patient care, which was the central belief of all of the nurses in this study.

Integrating the Theory and the Literature

The substantive theory that I developed has three transitions: (a) being, identifying as a nurse; (b) becoming a part of the group; and (c) belonging to the group and the profession. The theory also holds 13 concepts that support the three transitions. These transitions, which occur over time, reflected the temporality of the transitions that the 19 nurses experienced. Although there was progression in the transitions, there also was flux in the transitions because the participants stated that there were times when they felt like nurses, were a part of their work groups, and belonged to the profession, and other times when they questioned themselves as being a nurse, becoming part of a group, and belonging to the profession. This flux was influenced by the contextual elements of personal attributes, work environment, relationships, and communication present in the nurses' practices impacting the formation of social norms and influencing their ability to move to the next transition as well as the decision to remain in their groups and the profession. Following is an explanation of each transition of the theory.

Transition 1: Being: Identifying as a Nurse

For individuals to self-identify as a nurse, they must self-categorize as possessing the attributes that they identify nurses as having. This first transition combines the concepts of being a good nurse; feeling like a nurse by developing confidence and expertise; being recognized as a nurse by others; feeling comfortable and uncomfortable; and identifying unacceptable behaviours, values, and beliefs of nurses. This transition involves individuals knowing their own values and beliefs and being able to identify social norms that support or undermine them. Social norms are the socially negotiated implicit and explicit rules of work groups (Rimal & Lapinski, 2015).

The nurses in the study were able to articulate the values and beliefs that they felt a good nurse should possess: caring, compassion, empathy, knowledge, trust, humility, and emotional intelligence. These values and beliefs have been promoted by schools of nursing, the CNO (2023) the CNA (2015), and nursing scholars such as Benner (1984) and Hartrick Doane and Varcoe (2021). The nurses perceived that these explicit values and beliefs were evident in themselves and the behaviours of the nurses with whom they worked. Implicit norms were not readily evident to the nurses, but they were apparent in their experiences. For example, the way in which the charts were put together when patients were admitted varied from one unit to another. If a chart was put together incorrectly by a nurse, other nurses might assume that the nurse was lazy. Instead of ostracizing the nurse, the other nurses should have asked if the nurse knew how to prepare the chart correctly. Implicit norms were not easy for the nurses to identify until they reflected on how others responded to their behaviours. Kim explained an implicit norm of her group:

> Even if you're not a tea drinker, if you're first in the back room, you put the kettle on. Even just little things like that. I don't ever know if I picked up as much as I was just told, "This is how the unit worked."

Implicit rules were difficult to learn, as the nurses stated, and it was only when they did something not considered normative of the group and were ostracized for it that they realized that they had broken a rule of the group. The social norms that the nurses identified were shaped at the microlevel of the nurses themselves in their own identification of their concepts and the values and beliefs that they brought to their practices. Rimal and Lapinski (2015) identified perceived norms to be at the microlevel depicting the social norms of the group and injunctive norms at the macrolevel (i.e., behaviours expected of all individuals in the organization and community). Rimal and Real (2005) asserted that descriptive and injunctive norms may vary depending on the context in which the group is situated and that descriptive norms become stronger as the group identity becomes more salient. The nurses in the study did not have any difficulty identifying the values and beliefs that lead to what they felt were the behaviours and social norms of nurses, but not all of them recognized the impact of their employing organizations and society in shaping their beliefs about what it meant to be a good nurse.

Relationships had a significant impact on the ability of the nurses to feel like a nurse. The other nurses with whom they worked with needed to recognize them as nurses who had knowledge and expertise. The nurses talked about feeling like a nurse when others came to them and asked for advice. The ability to implement interventions based on knowledge that improved patient outcomes also contributed to the salience of their identity as a nurse. The interactions that the nurses had with each other could have contributed to their feeling or not feeling like a nurse. Some of the nurses described being bullied by other nurses, a problem that impacted their confidence as a nurse and their intent to remain in the group. Bullying has been identified in the

literature as impacting the mental health of nurses, decreasing their self-confidence, self-esteem, and intention to remain in the profession (Goddard & Mason, 2023; Hsieh et al., 2019). In my study, if others questioned their practices or behaviours, they often questioned their nursing identity. In contrast, when others recognized their contributions to patient care and support of other members of their work groups, this made their identity more salient.

The meanings constructed about their identity as a nurse reinforced the premise of symbolic interactionism that our interactions with others and the meanings that they have for us contribute to our own actions and interpretations of how to deal with them (Blumer, 1969). It also brings to the forefront the temporality of the identity as a nurse and the impact of social norms of work groups on one's identity as a nurse.

Nurses working in the health care setting are influenced by the policies and procedures that they must follow in providing care, which becomes a difficult task when also dealing with increased patient workloads. During the COVID-19 pandemic, policies changed several times based on new knowledge about the virus, its transmission and course. Nurses found it difficult to follow the constantly changing policies around PPE, and there was unclear communication about changes and nursing expectations, as well as the need to stay safe and protect their families (Crowe et al., 2021). Engaging in open communication with the employing organizations, management, nurses, and all others involved in patient care was important to the nurses in this study and helped to prevent or resolve conflict. J. J. Moreland and Apker (2016) as well as J. J. Moreland et al. (2015) identified respect and communication as prosocial attributes that facilitated improved conflict management among the nurses. Improvements in communication between each other and management may contribute to the capability of nurses to voice their concerns regarding increased workloads.

The 19 nurses agreed that putting the needs of patients first was an essential social norm for them that they had been taught in their education and reinforced by their regulating bodies, family, friends, and society. This often meant that they felt that they could not say "no" to taking on extra work, especially if refusing had a negative impact on the care of their patients. They felt obliged to take on more if it was asked of them. The obligation that nurses feel toward providing care that reflects their values, beliefs, and ethics of practice often underlies their inability to say "no" to requests that may impact patients negatively (Hartrick Doane & Varcoe, 2021; Jones-Bonofiglio, 2020). As nurses, we often recognize that in taking on extra work, we cannot provide the holistic care that we want to and must make decisions about what we can and cannot do, resulting in sometimes feeling moral distress (Jones-Bonofiglio, 2020).

Unacceptable values and beliefs identified by the nurses in the study reflected behaviours that negatively impacted patient care and group cohesiveness. Unacceptable behaviours directly and negatively impacted the nurses' work environments. Nurses who exhibited unacceptable values and beliefs often were influenced by the context and personalities of the other nurses working in their groups, as observed by the participants in my study. Workloads and personalities often contributed to the nurses feeling overwhelmed, burnt out, and unable to maintain good patient care (Aiken et al., 2011; Farid et al., 2020; Kutney-Lee et al., 2016).

This first transition of the theory was grounded in the experiences of the nurses, whom I asked why and how they came to feel like they were a nurse. They were able to identify as a nurse as they came to self-categorize as having the same values and beliefs that they felt all nurses should possess, build their self-confidence and knowledge, and be recognized by others as a nurse. Once this happened, their identity as a nurse became more salient. The context of the environment in which they practiced facilitated and limited their ability to identify as a nurse.

Once they felt that they could identify as a nurse, then they felt comfortable becoming a part of the group.

Transition 2: Becoming a Part of the Group

Becoming a part of a group was essential for the nurses to be able to provide patient care. This transition holds five concepts: learning the group's values and beliefs from what other nurses say and do, building relationships, working as a team building trust, reflecting on how the group's values and beliefs developed, and influencing the group's values and beliefs. The ability of the nurses to enact the concepts allowed them to move through this second transition. The nurses provided examples of how they became a part of their work groups: They needed other nurses to share their knowledge, they needed to support each other emotionally, they required mentorship when joining new work groups, they needed help with the physical and emotional care of their patients, and they needed to know that other nurses would support them when such situations might arise. When the nurses felt that other nurses did not support them, they struggled to become a part of their work groups. All 19 nurses discussed the positive and negative differences that other nurses made to their practices, depending on what their values and beliefs were and how they aligned with their own.

Social norms are the socially negotiated implicit and explicit rules of work groups (Rimal & Lapinski, 2015). As the nurses learned the values, beliefs, and behaviours of other group members and felt that they aligned with their own, they were able to build relationships with each other, work as a team, develop an understanding of how the norms of the group developed, and felt that they could influence the group values and beliefs. This was not an easy transition for the nurses in the study, as they explained. When group members showed concern for the nurses as individuals and colleagues, the nurses felt that they were becoming a part of their work groups. These interactions with group members gave the nurses insight into the group values and

beliefs that underpinned the group social norms. If the nurses felt that their own values and beliefs did not align with those of their work groups, they had difficulty feeling as if they were part of the groups.

The nurses were able to identify how some group norms may have developed as they worked in their nursing groups. Some participants felt that it may have been the senior nurses on the units who directed how care was provided and the behaviours that they felt represented a good nurse. Others felt that the behaviours were the result of the nurses bringing their own values and beliefs to the units that supported behaviours already present in the work groups. Some of the nurses felt that the strong personalities of other members of the work groups set the norms.

The nurses' experiences supported the notion that social norms can be fluid (Rimal & Lapinski, 2015). For the nurses to become a part of their work groups, they had to learn the social norms by watching what others did, asking questions of other nurses, and interpreting the actions of others. The nurses found it easier to learn their groups' social norms if they already knew individuals in the groups. Zong et al.'s (2021) examination of informational and friendship ties and positive gossip in the workplace found that friendship ties contributed to positive workplace gossip and socialization. The nurses in my study supported this contention, explaining that having friends in the work groups facilitated their learning the group norms and fitting in more easily.

While in this transition, the nurses mentioned having to determine how they needed to behave to fit in with the groups and that as their identity as a nurse became more salient (i.e., they became more confident in their own abilities and knowledge), they felt more comfortable in the groups. Once they focused their energy on fulfilling their role and providing good care to

patients, they began to develop relationships with the other nurses and influence their behaviours. These changes in the nurses themselves allowed them to feel that they were becoming a part of their work groups. The next transition illustrates the progression of the nurses from feeling that they were part of their work groups to feeling that they belonged to the groups and the profession of nursing.

Transition 3: Belonging to the Group and the Profession

Jody said:

> Oh, well, the fact that we're carrying out all those nursing skills together and we're all working with those patients together, I think that that's a huge thing because we're carrying out nursing practice. We're talking to our patients together. We're caring for them. We're informing them. We're doing skills that are all within nurses' scopes of practice. You know what I mean? Like per clinic or per shift or per unit, I think doing all those classic nursing skills and communications with our patients together, I think that's what makes me feel like I'm belonging in nursing practice.

This statement reflected Jody's feelings about belonging to her specific work group because she recognized her own role as a nurse and was in a group that reflected behaviours that she considered important. She commented, "We're carrying out nursing practice." In the third transition of belonging to the group and the profession, the nurses felt a real sense of belonging to their work groups and the profession when the behaviours of other nurses in the groups reflected their own values and beliefs about caring for patients. If the values and beliefs of the nurses participating in this study did not align with those of other group members, they did not feel that they belonged, so they often tried to adapt their practices to remain in their work groups and the profession. Adapting and trying to change their behaviours or values worked in the short term, but if the nurses felt that they were always adapting, they would choose to leave the groups and perhaps even the profession. The nurses' experiences supported the notions of accessibility and fit. If the nurses felt that the group norms aligned with their self-concept, they felt that they

fit into the groups that they worked with, which correlated with normative fit (Hogg & Reid, 2006; Oakes et al., 1991).

In this third transition, the nurses' experiences highlighted the four concepts of remaining in the profession by developing and maintaining relationships, being unable to be the nurse that they wanted to be, remaining in the profession by adapting or changing, and making a difference or being proud to be a nurse. These concepts contributed to how strongly the individual nurses felt about themselves as a nurse and how prototypical they were of their work groups and the profession. Their relationships with other members of the groups; their ability to be themselves (i.e., their values and beliefs aligned with those of the groups); and their belief that they made a difference in their practices all contributed to their social identity as a nurse. Elements of context, such as increased workloads, poor relationships with other nurses, changes in their self-confidence, and poor communication with group members, affected their ability to support patients. If the nurses were not able to practice nursing in a way that aligned with their values and beliefs, they felt that they did not belong, so they tried to adapt or change to continue to belong.

Victoria explained:

> Um, to be honest, since the pandemic I've, I've been looking at leaving nursing, um, I just, I realize how little, I don't know how to word this, (laughs) so it's not terrible. I, I just, I realized how little society really cares about nurses since the pandemic. Um, and even just like workplace in general, I find a lot of our management, um, they just, it doesn't matter how much you're doing. You're just not doing enough. Um, I, I just, yeah, I, I feel, I feel now just with everything that's been going on that, especially with the work so- shortages and things like that, people are doing too much than they can handle. And I don't know.

Victoria tried to adapt and change by taking on a larger workload, but she found that she could not handle the added responsibilities. She also felt that she was not appreciated as a nurse either by society or management. These experiences resulted in Victoria considering leaving the

profession, not just her current position. She questioned her choice to be a nurse because she felt that others, including management and patients, did not recognize her contributions and continued to ask her to do more. She did not feel supported.

Elements of the Context Influencing the Process of Social Norm Formation

The three transitions of the theory of being, becoming, and belonging were impacted directly by the contextual elements of the personal attributes of the nurses, the work environment, relationships, and communication. Throughout the nurses' experiences, context influenced their ability to learn the social norms of their work groups. Each contextual element was intertwined with each transition in the theory and affected the nurses' feelings about their social identity as a nurse and their sense of belonging to their work groups and the profession. Their personal attributes and other nurses' personal attributes contributed to their feeling either comfortable or uncomfortable in their nursing role and impacted the relationships that they were able to build into their practices. Their relationships with other nurses in the work groups initially supported their learning the social norms of the groups and their ability to influence the norms.

The work environment may be influenced by the relationships among nurses that can positively or negatively affect the way in which they support each other and provide patient care (Reinhardt et al, 2020; Wei et al., 2018). The nurses talked about the physical layouts of their hospital units as either supporting or hindering accessibility to other nurses. All of the nurses spoke about the impact of workload on their ability to follow the social norms of their work groups that supported their values and beliefs. If they could not provide care or work with others in ways that supported their values and beliefs, they did not feel that they belonged in the profession. The context of the environment had a significant bearing on the nurses' ability to follow the group social norms.

Organizational researchers have recognized communication as paramount to the development and maintenance of social identity and the establishment of a social reality (Postmes, 2014). Nurses have a specific language and way of communicating within and outside of their work groups. Holmes and Woodhams (2013) presented evidence of the role of talk in joining a community of practice and asserted that individuals learn how to fit in by conversing with other group members, learning the jargon, and participating in small talk. Individuals also must develop an understanding of the expectations of the organization (Holmes & Woodhams, 2013). Willetts and Garvey (2020) stressed the significance of nurses' ability to communicate with each other regarding patient handovers and how this ability contributed to building their social identity as a nurse.

Based on the interview responses of the nurses in this study, having the ability to communicate with each other professionally and personally was necessary for them to feel that they belonged to the profession. The nurses mentioned feeling that some groups' social norms were different from those of their own work groups, supporting Postmes's (2014) comment that communication is both a part of the social reality of a group and the social identity of its members. Communication between nurses improves as their level of emotional intelligence increases (Raeissi et al., 2022). Emotional intelligence supports communication: Individuals with higher emotional intelligence have an increased self-awareness and self-efficacy reflected in their ability to communicate (Raeissi et al., 2022).

It was clear that the elements of context (i.e., personal attributes, work environment, relationships, and communication) impacted each transition. For example, the relationships that the nurses had with each other influenced their ability to identify as a nurse, which developed as others, such as nurses, interprofessional teams, patients, and families, recognized them as having

the knowledge, expertise, and skills expected of a nurse. They shared this knowledge with coworkers and used it to improve patient outcomes. Relationships were necessary for the nurses to become a part of their work groups, and others shared the norms of their work groups with them that allowed them to fit into the groups. Feeling that they belonged to the profession was connected to their relationships with other members of their work groups. If they were able to build professional and personal relationships with other nurses in the groups, they felt that they belonged to the groups. The meanings that the nurses gave to their interactions with each other were significantly influenced by all of the elements of context that they identified in their day-to-day experiences.

Integration of the RQ to the Theory

The theory answered the central RQ and subquestions. The transitions of being, belonging, and becoming were linked to temporal changes in the nurses' experiences of developing social norms throughout their work in groups. The nurses initially self-categorized as having the same values, beliefs, and attributes of what they perceived other nurses as possessing. They then began to see themselves as nurses incorporating the social norms of the profession and groups in which they worked into their identity as a nurse because of their social interactions with other members of the groups. The nurses' ability to recognize which values, beliefs, and attributes were prototypical of members of the groups supported their either becoming part of or leaving their work groups. Finally, for the nurses in this study to feel that they belonged to their work groups and the profession, they had to feel that the values and beliefs of the social norms of the group aligned with their own values and beliefs.

One RQ guided this study: What theory explains the process of social norm formation and the factors facilitating or limiting social norm development in nursing groups working in

health care settings? Nursing groups referred to nurses working in groups on units in the health care setting.

The following sections provide answers to the RQ and three subquestions.

Evidence for Subquestions 1 and 2

1. What are the components, or the systems of the rules and observations, that comprise the social norms of a group of nurses?
2. How do the social norms of a group of nurses develop?
    a. What factors contribute to or constrain the development of social norms?
    b. What is the role of informal and formal communication in the development of group norms?

The nurses described the values, beliefs, and behaviours of their own and other nurses that indicated both implicit and explicit, descriptive, and injunctive norms spanning the personal level (their own norms) and the group level to the level of the profession as a whole. Nurses' social norms are influenced by the system in which they are educated, work, and live. The nurses in my study talked about the ways that their own values and beliefs aligned with what they perceived nurses to have, even before they entered the profession. They learned the norms through a process of interactions with the health care system, family members who were nurses, the media, and their own perceptions of the profession of nursing. The nurses identified several social norms: Nurses should be kind, caring, compassionate, empathetic, knowledgeable, trustworthy, and respectful; they should demonstrate ethical behaviours; and they should be able to work collaboratively to support patients in seeking positive health outcomes. The behaviours that they associated with these values involved being on time for work, supporting colleagues when they were overwhelmed, caring for patients and advocating for them, sharing knowledge,

and supporting colleagues and patients emotionally and physically. Some of the implicit norms of the groups included putting the kettle on when being the first one to take a break, putting patient charts together for each other, or replacing linens on a stretcher. They did not always think to tell nurses new to the work groups to do these things because they took these implicit norms for granted. The result of not knowing the implicit norms of the work groups would sometimes result in nurses being ostracized for not following the rules. This situation was difficult for nurses new to the groups because they wanted to be seen as a part of the groups.

The expectations or rules of the employing organizations regarding how nurses should practice, along with expectations from patients and families, impacted the nurses' practices and process of social norm development. As mentioned earlier, the nurses felt that they could not refuse requests from the organizations, other nurses, patients, and management, even when they felt that they could not meet the expectations. These expectations, such as taking on increased patient workloads or providing care normally given by other professionals such as physiotherapy, dietary, and housekeeping when those professionals were not available, lead to their feeling that they were not providing care or supporting colleagues in ways that reflected their values and beliefs. This led the nurses to believe that they did not belong in the nursing profession.

The theory that emerged from this study directly addressed Subquestion 2, which described the process of group social norm formation through the three transitions of the theory. The process of social norm formation was discussed by the nurses as being ongoing: It contributed to their self-categorizing as a nurse having the same attributes as they perceived other nurses to have and identifying the norms that they saw nursing as possessing. Workload and communication, along with personal attributes and communication, were identified by all 19

nurses as facilitating or restraining the development of social norms as they impacted their ability to build relationships in practice. They saw fluidity in group social norms that were impacted by themselves, other group members, and the context in which they worked and lived.

The elements of context influenced the process of social norm formation of nurses working in groups and were identified in this study as their own attributes and those of other nurses (i.e., self-confidence, knowledge, alignment of the group values and beliefs with their own, humility, emotional intelligence); work environment (i.e., workload, staff mix, physical layout of the unit, management); relationships (i.e., being included personally and professionally, team function, workplace culture, being taught the social norms of the group); and communication (i.e., open communication, charting and verbal reports, timing of communication, group support, where communication took place). The context was always changing because of factors that often were outside the control of the nurses: patient acuity, workload, nurses leaving or joining the work groups, staff mix, personalities of coworkers, and changes in organizational policies and procedures directing their ability to care for patients.

The contextual elements contributed to positive and negative influences on the social norms of the groups of nurses. Workplace environments that the nurses perceived as being supportive allowed them to care for patients in ways that followed the rules or social norms of their work groups. Open communication, strong personal and professional relationships, and the willingness of other nurses to help contributed to environments in which the nurses felt that they belonged and could use their knowledge, values, and beliefs to support patient care.

These behaviours were formally and informally communicated to nurses through the policies and procedures expected of nurses by the registering body (i.e., the CNO) and their employing organizations. The hours that they worked, how they should behave toward patients,

the skills and knowledge that they needed to maintain, and how they should work with colleagues were all communicated formally by the health care setting. These formal rules were the injunctive norms of the organization in which they worked. Similar values and beliefs were communicated informally through the groups in which they worked and were referred to as descriptive norms. Although the work of the nurses in the study reflected injunctive norms, they also followed the descriptive norms of their groups. When workloads were high, the nurses could not maintain the level of patient care expected by the employing organizations and themselves. The work groups would then decide what was essential to care and would work to provide it. This often meant that the nurses did not have the time to support patients emotionally or develop trusting relationships with patients and families. This lack of time made the nurses feel that they were not providing the level of care that they wanted to and resulted in a disconnection between their obligation to patient care and their physical and emotional ability to provide it.

Identifying as a nurse is complex for nurses and is related to their own self-identity and ability to identify as a nurse. It is related not only to the many interactions that they have directly with others but also to the unseen influence of the health care setting and its policies, procedures, and expectations of nurses, as well as those of the society in which they practice, as demonstrated by the responses of patients, friends, and families of nurses to these nurses in the study. Burbank and Martins (2009) discussed use of the theoretical perspectives of symbolic interactionism and critical theory to understand nursing practice. Symbolic interactionism can be used at the individual level, that is, the microlevel, to examine the process of social norm formation in nursing (Burbank & Martins, 2009). Individuals' interpretations of their interactions with others and reflection on their practices form their knowledge of what the norms of nursing are for them that influence their identifying as a nurse. At the macro-, or societal, level, critical

theory can be used to address the effect of the context in which nurses work, within the organization and outside within society, and how government decisions not always visible to nurses at the bedside impact what nurses do in practice (Burbank & Martins, 2009).

The nurses in the study shared how they learned the social norms of work groups and the profession, but they did not always directly link the norms to the employing organizations or the larger societal and political influences on their practices in their groups. Their professional and social relationships contributed to their learning the social norms of their work groups. Recognizing the influence of social groups and context on nurses' development of the social norms of nursing practice is essential in retaining nurses and providing patient care that improves health outcomes. Researchers have found that work groups have more influence than the organizations on individuals and that the socialization of group members to develop the social norms of the group influence the salience of each member's social identity and sense of belonging (Brunetto et al., 2013; R. L. Moreland et al., 2012; Reicher et al., 2010; Woodhams, 2014).

Evidence for Subquestion 3

3. What are the impacts of the group's social norms at various levels?
    a. How do the group's social norms shape nurses' identity?
    b. How do the group's social norms impact the work environment?
    c. How do social norms affect how nurses perceive the profession as a whole and their decision to remain in the profession?

This section addresses the ways that group social norms impact the social identities of nurses, the work environment, and nurses' perceptions of the profession and their decision to either remain in or leave the profession. To identify as a nurse, the 19 nurses in my study

recognized that their own values and beliefs reflected what they felt good nurses should possess. These values and beliefs contributed to the social norms that they associated with the profession of nursing. Their understanding of the values and beliefs of nursing were the result of how social norms were communicated and represented in their education, the media, their interactions with other nurses, and the meanings of the norms in their own practices. Having others recognize them as a nurse and having family and friends ask them for information because they also recognized them as a nurse contributed to their identity as a nurse. They all recognized that their knowledge contributed to positive patient outcomes.

Units on which other nurses shared their knowledge and supported nurses in becoming part of the work groups also contributed to the nurses building their identity as a nurse. Learning group norms was difficult for all of the nurses. Joining groups whose norm was to support new members by explaining the rules of the work groups also helped the new members to feel more confident about their knowledge, skills, and ability to provide good patient care. The nurses provided examples that when they first started with their work groups, nurses already in the groups would explain routines on the units and what they were expected to accomplish during their shifts. This information made them feel more comfortable working with other group members.

The nurses in the study discussed the ways that social norms varied from group to group and that they needed to learn the norms to fit into the groups. The group social norms were not fixed, so the nurses could be influenced by the strong personalities of other nurses or could change over time as other nurses joined and left the groups or by the management on the unit. They also could change depending on the context of the environment. The nurses identified the fluidity of social norms and the need to learn them to be part of the work groups.

Feeling that they belonged to the work groups, not simply becoming a part of the groups, was influenced by their relationships with the other nurses in the groups. They had to feel that others were concerned about them in their work and home lives. They needed to continue to build and support relationships in practice by supporting colleagues and collaborating to care for patients. Most importantly, the nurses had to feel that the social norms of their work groups reflected their own values and beliefs. If the nurses felt that they needed to continually adapt their behaviours, values, and beliefs to be a part of the groups, they would decide to switch groups or consider leaving the profession.

Groups whose norms were to check in on each other and offer help were able to better cope with increased workloads and patients' health crises. The nurses gave many examples of knowing that other nurses would support them and that the day would go well because of the other nurses in their groups. Negative work environments were related to the nurses not being able to receive help when struggling to manage their workloads. On these units, nurses took responsibility for their own patients, and they did not always ask others if they required help.

Group norms directly impacted the work environment, which affected the nurses' perception of the profession as a whole and their decision to stay in the nursing profession. Groups in which the norms of the group aligned with the nurses' values and beliefs contributed to the nurses feeling that they belonged. One strong norm of all of the nurses in the study was that they worked to provide the best care possible to the patients. If the norms of other nurses in the group negatively impacted the way in which patients were cared for, or if they did not support each other, the nurses felt that they did not belong in the group and considered leaving the group and the profession. One nurse stated that she was being asked to take on other roles that were not part of her job and that she felt took away from the care that she was providing to

her patients. She felt that others were not listening to her concerns and expected her to take on the other roles, despite her worries about the impact on the care of her patients.

Implications of the Study to the Community of Nursing

Education

Developing or integrating SIT into the nursing curriculum would help nursing students to examine the process of social norm formation and how they learn and integrate social norms into their practices working in groups. Providing faculty with knowledge of social identity formation would help them to be aware of the ways that they demonstrate the values and beliefs of nursing and inform students of group social norms that may impact the nursing areas that they are teaching. Students would need to be able to self-reflect on what they consider the social norms of nursing and how these may impact their intention to remain the profession. Knowing that group norms are both implicit and explicit would support nursing students in reflecting on the behaviours of work groups to learn the norms of the groups. This knowledge would support nursing students in identifying group social norms and would allow them to become members of the work groups and build relationships with the nurses with whom they are learning. Knowing the social norms of nursing would contribute to students understanding how their behaviours contribute to their ability to work with others and support patient outcomes. Educating nurses about the need to connect with individuals and build relationships in groups is essential for them to learn the group norms to support their self-identifying as a nurse, becoming part of their work groups, and belonging to the profession. Knowing and feeling comfortable with the social norms of the work groups will influence nurses' decision to remain in the profession.

The nurses in the study viewed self-categorizing as having values and beliefs similar to those of other nurses learned through experience, family members, education, society, and the

media for example. Explicitly addressing the social norms of the profession of nursing would better situate nurses to influence the norms that they see as common to nursing practice. Revealing and questioning the social norms of nursing faculty were topics examined by Tengelin and Dahlborg-Lyckkage (2016), who reported on the ways that faculty spoke about the norms of nursing by analyzing their responses through a norm-critical lens. The researchers found that the ways that individuals can reveal underlying discourse, and by being self-reflective, individuals can identify norms that reflect power structures and unequal relationships. Nursing students and new graduates would be better prepared to examine the social norms of groups and the profession critically and how they might impact their future practice. They also would be able to identify how they, their social groups, society, and government policies impact the social norms of nursing.

The populations of students entering nursing have changed over my career in the profession. There are younger students; those who identify as LGBTQ2S+; and students from a wider cultural representation, including students with young families and extended family responsibilities, and more students who identity as male than in the past. Making space for all of these students requires an understanding of what the social identity of nursing is and how the social norms of the profession are developed. We all come to nursing with different life experiences and our own social norms. The nurses in this study identified the importance of their own values and beliefs aligning with the profession to feel that they belonged. Belongingness has been linked in the literature to the retention of nurses (Reinhardt et al., 2020) and the ability of nursing students to be nurses (Teskereci & Boz, 2019).

Developing curriculum content that explicitly states the social norms of nursing and supports nursing students in learning them may help them to identify as a nurse. Clinical practice

experiences contribute to students learning the norms of nursing because they are exposed to the practice environment (Teskereci & Boz, 2019). Students' experiences in clinical practice have implications for training clinical instructors to support students in learning the social norms of nursing and listening to students who are experiencing challenges in the ways that they perceive their own social norms fitting with those of the nurses with whom they are working.

Understanding how social norms are influenced will better position students to reflect on the practice of nursing. Nursing students should have the opportunity to critically consider how the social norms of nursing impact themselves, coworkers, and patients. Willetts and Clarke (2014) spoke to the importance of using SIT to highlight the situational and multifaceted nature of nurses' practices. Hartrick Doane and Varcoe (2021) discussed the need to examine the knowledge, competency, goals, values, and ideals of nursing, and to bring awareness to the ways that they impact nursing practice. Knowledge, competency, values, and beliefs were identified as the social norms of the nurses in this study. Nursing as a relating practice was identified by Hartrick Doane and Varcoe and was evident in all of the experiences of the nurses in my study.

Relating was evident throughout the nurses' experiences. The impact that group social norms had on the ability of the nurses to work together was significant. The norms contributed to their ability to build strong relationships and positive or negative work environments. Being able to work collaboratively and supporting each other in practice underscored the importance of nursing students and experienced nurses to reflect on group social norms to be able to become a part of their work groups. Knowing how to influence group norms through the relationships that they build would allow nurses to provide excellent patient care. Building a curriculum that includes an understanding of social identity, social norms, and social cognition would provide nurses with knowledge that they could use in their practices working in groups.

The nurses talked about the importance of emotional intelligence in working in groups. The five traits of emotional intelligence (i.e., knowing one's emotions, managing emotions, motivating oneself, recognizing emotions in others, and handling relationships; Goleman, 1994) contribute to good nursing relationships (White & Grason, 2019). Incorporating the traits of emotional intelligence into the curriculum of schools of nursing may support nurses in identifying values and beliefs that contribute to the development of collegial relationships that add to the clinical confidence and competence of nursing students (Levett-Jones et al., 2007) and retention of nurses (Reinhart et al., 2020).

Nursing Practice

Being, becoming, and belonging allowed the nurses in my study to identify the values, beliefs, and behaviours important to them and their work groups. They had to learn them through watching, asking, and putting the norms into practice. Many group norms are implicit and contribute to nurses not being able to state them explicitly, such as putting the coffee on if you are first on break, putting linens on the stretchers, putting together patient charts, and knowing how to complete worksheets. Other norms are explicit, such as putting patients first, answering call bells, listening to patients and their families, wearing a uniform, and providing safe and ethical care.

Learning group social norms and how to fit into the work groups are skills not explicitly taught to nurses in school or when they begin their jobs, but they are essential to self-categorizing as a nurse, becoming a part of the work groups, and belonging to the profession. Providing nursing students and experienced nurses with knowledge of SIT and its impact on their practices may help them to mitigate any challenges in working with groups of nurses in the health care setting. Understanding how the system influences their ideas of social norms, such as

what education patients might require, what work is expected of nurses, what autonomy is given to nurses, and the ways that these directly impact their practices, and the group social norms are important for nurses to support patient outcomes. Knowing what impacts the norms of nursing practice would allow nurses to advocate for work environments that support the positive norm development of nursing groups. This knowledge of group behaviours could support them in building trusting collegial relationships that support positive patient outcomes. Group norms can change as nurses are influenced by each other, the employing organizations, patient expectations, and communication within and outside of their practices.

Nurses work in groups in which their own self-identities and their nursing identity are linked. As nurses, we self-categorize as having the same attributes, values, and beliefs of the work groups that we identify with. Once we enter those work groups, we begin to see what prototypical members of the groups are like. Having attributes that are prototypical of group members is important to nurses in connecting to the groups. Use of network ties (i.e., connections to other nurses in their work groups) to spread information regarding group social norms was evident in the experiences of the nurses in needing to connect through friendship and workplace relationships (Zong et al., 2021). These connections supported the nurses as they learned the rules of their work groups, the social norms of the groups, and whether they matched with their beliefs and values to become a part of a group.

Organizations

This section provides details from the results that add value to the extant literature on health care management and organizations. The nurses' experiences of being, becoming, and belonging were the result of examining their practices through the SIT perspective, which allows

us to look at possible interventions or perspectives to retain the nursing workforce within the organizations based on the categories and concepts of the theory.

This study highlighted the benefits of examining health care organizational challenges using the SIT perspective that could help leaders to understand the impact of groups on their members (in-groups), other groups (outgroups) in the organization, and the outcomes of the organization (excellent patient care). Reynolds and Platow (2014) explained that behaviours are shaped by those whom individuals self-categorize as like themselves, such as the members of the groups that they belong to. As such, individuals are more likely to be influenced to change values, beliefs, and behaviours based on the socially valid information that they receive from other group members (Reynolds & Platow, 2014). In this section, implications for improving the retention of nurses are presented.

The nurses felt that they belonged to their work groups and the profession when their own values, beliefs, and behaviours aligned with those of the other group members. This is important for organizations to understand when looking at ways to retain nurses, because supporting nurses to work in groups in which members hold the same values will contribute to good patient care and outcomes that will mean that nurses will want to stay in the profession. When onboarding new nurses, organizations have offered nurse residency programs that have provided a formal education and formal mentorship from 3 to 18 months, with good success in retaining new graduates (CNA, 2020). This residency may have helped the nurses to build relationships and learn the social norms of the groups more quickly.

Organizations may want to consider offering more mentorship opportunities to experienced nurses who are changing units or organizations, keeping in mind that there are benefits and drawbacks to mentoring programs. There are documented benefits to mentorship in

the literature, such as the growth in knowledge of both mentors and mentees, increased connectedness to the workplace, socialization to the profession, increased staff retention, and improved clinical outcomes (Grossman & Valiga, 2021; Lam et al., 2003; Salisu et al., 2019). Drawbacks from the perspective of mentors were their inability to understand others, unawareness of their own weaknesses, poor communication with mentees, lack of training of the mentor role, inability to sustain the relationship, and lack of formal recognition by employing organizations of the mentorship role (pay and recognition of mentors' skills and contributions; (Grossman & Valiga, 2021; Kato et al., 2021).

The CFNU (2022) asserted that mentorship is an important strategy to retain nurses. From a SIT lens, the ability of experienced nurses to support nurses in learning the group norms enhances the nurses' perceptions that they are becoming a part of their work groups and eventually will belong to the groups. The caveat is that group social norms must align with their own for them to feel that they belong. The nurses in my study found it difficult to learn the norms of their work groups: It often was through trial and error, and they were either praised or ostracized for what they did or did not do. Having a mentor who is recognized by the group members as being a prototypical member of the group would support nurses in learning the norms in more supportive ways and could contribute to their becoming part of the work groups more easily. Mentoring would support new nurses as well as nurses with previous experience who have joined new work groups.

The following statement by Patricia supported the need to encourage and aid the groups in making internal changes that could contribute to building values and beliefs sand supporting each other. Organizational leaders need to ask the group members what they need and then

support them in developing relationships and teamwork so that they can enact their values and beliefs in supporting each other and their patients.

Patricia said:

> The ones that didn't work as a team, they were more needy as a unit. Could I change that while I was there? Because now I'm management. It was impossible. I think it needs to be changed at a unit level. As a team player, those are the people that are going to influence how effective that team is going to work. There were nights where there was a different combination of staff, where you'd have more staff that were floating into the units, that seemed to work better for the unit. That's what I noticed as a X unit. Same with sick calls. Could they cope with sick calls? Sometimes they could cope depending what the dynamics of the group were.

R. L. Moreland et al. (2012) cautioned that the ability of individuals to self-identify as prototypical members (i.e., belonging to a group) is not straightforward. As Patricia noted, many elements of context identified in the theory may have stronger or weaker influences on the development of social norms and group socialization.

Addressing workloads is one important way to retain nurses already working in the health care setting. All 19 nurses in this study talked about the impact of workloads on their feeling that they could not maintain their values and beliefs around their nursing practices. They identified the social norms of their practices as being caring, empathetic, compassionate, and knowledgeable; having expertise; and putting their patients first. When they experienced high patient loads, they were unable to provide the quality of empathetic care that they felt that their patients needed, causing them to feel that they could not maintain the values and beliefs of nursing. Their perceptions of not being able to provide proper care because of context and events out of their control were supported by Jones-Bonofiglio (2021), who defined moral distress as "feeling that a situation is morally or ethically off track and having a sense of obligation to act" (p. 12). They also shared that it was difficult to support colleagues whom they saw struggling with work when their own workloads were high. The nurses talked about working as teams to

support each other based on the relationships that they were able to build with each other. Organizations need to be cognizant of the ethics of care and how policies can contribute to the moral distress of nurses who are unable provide care to patients that reflects the values and beliefs of the nursing profession, such as policies around workload and nurse to patient ratios.

Organizations with workplace environments that support the work of nurses would be more able to retain nurses. Providing opportunities for nurses to build relationships with each other in practice is an important part of retention. A quantitative study by Reinhardt et al. (2020) found that a healthy work environment where nurses felt supported, had autonomy to make decisions, were able to manage conflict, and were able to maintain relationships with each other, contributed to their wanting to stay in their work groups and the organization. A systematic review by Wei et al. (2018) found that the following strategies encouraged the retention of nurses: The organizations have a clear vision and mission that support nurses in meeting these, acknowledge the contributions of nurses to the outcomes of patients, and create a culture of caring.

Involving the nurses in work groups in identifying interventions that would better support them in developing relationships is paramount. In my study, the nurses identified differences in the social norms of their work groups and those of other groups. These differences highlighted the importance of including nurses working on the units in collaborating with management when changes in policies and care protocols are being considered. Through these conversations, social norms that either support or deter change may be identified and addressed before any changes are implemented. This communication would help management to better understand why and how nurses in different work groups respond to changes if they understand the implicit and explicit norms of the work groups.

Organizational policies have the potential to disrupt open communication between and among nurses, resulting in the loss of mentorship and relationship building, both of which contribute to nurses feeling that they belong. The ability of nurses to communicate effectively and openly with other group members was seen by the nurses in the study as important to knowing how colleagues were managing their patient loads, sharing knowledge and consulting with each other about changes in patients' health and appropriate interventions, and connecting socially and emotionally with other group members.

The nurses also spoke about the loss of verbal reports at the end of shift when they handed over patient care to the next nurses coming on shift. Some of the organizations mandated summary reports on patients' computer charts, which impacted the nurses' ability to learn from each other and become socialized into the practices of nurses on the unit. Willetts and Clarke (2020) noted in their ethnographic study examining the professional identity of nurses that nursing handover strongly encouraged the belongingness and commitment of the group.

Throughout the interviews, the nurses talked about the ways that the physical layouts of units affected their ability to communicate. If they did not see each other, they did not always go around to check in. The change in formal reporting at the end of shift impacted their ability to share information easily and learn from other staff. Building relationships by sharing professional and social information allowed the nurses to get to know each other, understand other nurses' values and beliefs, and see how these and their own fit in with the social norms of the work groups. Reinhardt et al. (2020) identified belongingness and supportive workplaces as contributing to the retention of nurses.

Organizational environments that provide opportunities for nurses to socialize and have easy access each other to offer and request help are important to the development of group social

norms that result in better group relationships and patient care. Duddle and Boughton (2007) conducted a qualitative study following an explanatory multiple-case design to explore nurses' intraprofessional relations. They reported that nurses' personal attributes and behaviours impacted the workplace environment and affected the retention of new and experienced nurses. The nurses in my study recognized the importance of emotional intelligence and their ability to identify and deal with conflict, but contextual workplace factors such as workload, physical layout, ability to communicate easily, and supportive relationships all impacted the ways in which the group members worked together. Behaviours were the result of the social norms of the groups (R. L. Moreland et al., 2012). Emotional intelligence is a skill that can be learned (Goleman, 1994). Organizations may be able to provide professional development such as online modules and working groups to support nurses as they increase their emotional intelligence.

Building relationships within the group and developing the social norms that the group identified with allowed the nurses to work to the full scope of their practice to support patients' health outcomes. Groups in which individuals felt that they were supported by each other, leadership, and the organization in operationalizing their values and beliefs demonstrated citizenship behaviours. Individuals manifest citizenship behaviours that support their coworkers and the organization. Organ (1988) defined organization citizenship behaviours as "individual behaviour that is discretionary, not directly or explicitly recognized by the formal reward system, and that in the aggregate promotes effective functioning of the organization" (p. 4). The nurses in this study demonstrated many citizenship behaviours, such as taking on the work of other nurses without being asked, staying late to help colleagues to finish their work, emotionally supporting colleagues, and teaching and sharing skills and knowledge freely. One needs to ask what cultural

aspects of the organization impede nurses from moving through the transitions of being, becoming, and belonging.

Organizational management and nurses working in groups can share input to develop strategies to address the norms and behaviours of nursing groups in building and sustaining trusting and respectful relationships between and group members. Formal routes of communication for nurses to offer input into changes that support their practices on units could be developed by the organizations. Communication was one contextual element essential for the nurses in this study to learn the norms of the work groups and to feel that they belonged. Having a stronger social identity with the group allowed the nurses to better address negative group norms such as learned helplessness and the inability to confront conflict (J. J. Moreland & Apker, 2016). Being able to communicate openly with the group was supported by the work of J. J. Moreland et al. (2015) and resulted in nurses staying in the groups in which they worked. Informal communication among nurses, managers, and organizations could contribute to innovative ideas to support the practices of nurses working in groups. Zong et al. (2021) discussed the positive social effects of gossip in developing workplace relationships. This informal communication could be supported by managers and nurses on the units to develop positive relationships and share group social norms.

Limitations and Challenges of the Study

I used the constructivist grounded theory methodology to construct this theory based on the experiences and perspectives of the participants and built on the interactions of the researcher and participants, all of whom were situated in the social context of their interactions and the meanings (Charmaz, 2014; Charmaz et al., 2018). The theory that I developed reflected the experiences of the 19 nurses in my study sample and might not have reflected all nurses'

experiences in developing the social norms of their work groups. Most of the nurses in the study worked in acute care, but two of them worked in community clinics in northwestern Ontario. Three of the nurses self-identified as RPNs; 16 self-identified as RNs. Their ages ranged from 25 to 69 years. One participant identified as male and the rest as female. All of the participants worked in groups in the health care setting in northwestern Ontario. Although the theory was developed based on the interview responses of the participants, the premises, methodology, central RQ and subquestions, and interview questions could be applied to other nurses working in groups in health care to develop a formal theory applicable to their unique circumstances and context (Charmaz, 2014).

This study sample comprised nurses working in any group in any health care setting in northwestern Ontario. They did not have to be working within the same groups. Having the inclusion criterion of working as nurses in any group in health care was based on the premise of SIT that when individuals join a group, they do so because they perceive themselves to be members of the same social category (Turner, 1982) and must learn the implicit and explicit norms of the group to belong to that group and to see themselves as prototypical members of the group. Future researchers may look at the social norms of nurses working in the same groups to see if there is consensus on what members feel are the social norms of their particular groups. According to Turner (1982), individuals self-identify as having the same attributes as members of the group that they feel they are prototypical of.

Initial recruitment of the participants was through the employing organizations' nursing email rosters. The nurses were given a gift card worth $10 to either Tim Hortons or Starbucks, and they were entered into a draw for a $50 Visa card for participating in the study. This initial recruitment effort resulted in no participants expressing an interest in joining the study. The

recruitment was expanded to include social media venues. I used a WhatsApp site directed at nurses working as clinical instructors and added snowball sampling to the recruitment methodology, which resulted in obtaining the 19 participants needed to reach theoretical saturation and who met the inclusion and exclusion criteria. All of the participants worked as nurses in the health care setting. This also resulted in more variation in the health care groups within and outside of acute care, which may have increased the applicability of the theory to other groups.

The setting for the study was a small community, where I have had the privilege of teaching nursing students for the past 18 years. Of the nurses who participated in the study, 10 may have remembered me in this capacity, which may have impacted the experiences that they chose to share with me. I did not work with any of the participants in a "power over" role. The participants emailed me directly after viewing the recruitment poster to volunteer to join the study. I reviewed the information and consent with each participant prior to initiating the interviews, and I went over the procedures to maintain their privacy and confidentiality, as outlined in the consent. They indicated that they understood that they could withdraw from the study at any time without any repercussions.

Another limitation of the study was my experience as a novice researcher using the constructivist grounded theory methodology. To mitigate this novice experience, I followed the constructivist grounded theory methodology informed by Charmaz (2014) and consulted with researchers who had expertise using this methodology to discuss how I needed to analyze, conceptualize, and manage the data. I coded and analyzed the data as I collected them and continuously returned to the data while maintaining an iterative approach. I wrote field notes and

memos to reflect on the data collection and analysis processes and what the data revealed, thus providing me with rich data to form the categories and theory (Charmaz, 2014).

Future Directions

Knowledge Mobilization

I have an ethical requirement to disseminate the results of my study to the individuals who contributed to the research and those who may benefit from the substantive theory, including organizations employing nurses, educational institutions, nursing organizations, and the general community. Underpinning the research was SIT, which is based on the meanings that we socially construct of ourselves, the groups that we belong to, and the behaviours that we engage in. We are social beings; as such, we have a need to belong to groups. It is important information to share not only with the nursing community but also with the community at large because nursing practices impact all of our lives. Gaining insight into the complex process of social norm formation in nursing will contribute to supporting positive norms that build group cohesiveness, nursing identities, and patient outcomes.

To disseminate the results, I intend to present my findings at provincial, national, and international conferences related to nursing practices, and education and organizational conferences that address issues of nursing retention and group belongingness. Publishing my findings in peer-reviewed journals and open access journals will facilitate broader dissemination of the results. To give the public and nonacademic communities access to my study, I plan to reach out to community resources such as public libraries; community organizations interested in health care; health care organizations; and organizations such as the Gerontological Nurses Association of Ontario, CFNU, and the RNAO through email, webinars, blogs, and podcasts. Disseminating the findings will contribute to stimulating conversation around social norms and

their importance to nursing practice, the retention of nurses, and the understanding of group practices.

Direction for Future Research

This study may contribute to current understanding of the process of social norm formation of nurses working in groups in the health care setting. The results may indicate how norms are identified and developed by nurses' values, beliefs, and behaviours in work groups. Further research into the contextual elements within and outside of the work environment that impact the ability of nurses to adhere to the social norms of the groups to support work relationships and patient outcomes is essential. In this study, contextual elements significantly positively and negatively affected the nurses' work environment. There also may be other contextual elements that affect the process of social norm formation in groups of nurses that may influence their ability to enact the social norms that they feel are essential to their nursing practice. Research addressing the contextual elements that impact group social norms may contribute to improving the environment of the nursing workplace.

This study examined the process of social norm formation based on the experiences of 19 nurses (RNs and RPNs) working in groups in the health care setting. One inclusion criterion was that the nurses had to be working in groups in the health care setting, but not necessarily in the same groups. Further research is needed to examine how the theory that I developed applies to the process of social norm formation within a single group of nurses who work together. Such a study could also more directly examine the impact of specific social norms and their development on the functioning of the group and the retention of its members within a specific context.

Based on the nurses' responses to the interview questions, I found that they perceived group social norms as fluid structures impacted by such contextual elements as the personal attributes of the nurses in the work groups. All of the nurses commented that they brought their own values and beliefs to nursing and that when these values and beliefs fit with their work groups, they felt that they belonged. More research might help to address the challenges faced by nurses from other cultures entering the Western biomedical system whose own self-concepts and identities as nurses may be based on different social norms. The theory that I developed may provide a framework for this research.

There is an opportunity for the application of the premises of social network analysis in understanding the development and communication of the social norms of nurses working in specific groups in the health care setting. Social network analysis has been used with nurses to examine the communication structures of groups and has been found to be helpful in learning how information flows between and among nurses (Benton et al., 2015). Nurses who are considered prototypical of the other nurses in their work groups may have more influence on the group norms and be better situated to communicate the social norms of the group to nurses new to the groups. Group prototypes are communicated to one another and affected by the contexts in which they are situated (Ellemers et al., 2003). Organizations might consider supporting research using social networks within and between groups in the organizations to better understand how informal and formal communication can occur. Individuals who are essential to communication between and among group members, who are prototypical of the group, and who have knowledge of the social norms of the group could be used to support nurses new to the units in becoming a part of the work groups. Social network analysis has the potential to identify members who have the greatest ability to influence the group social norms. These group

members have already established communication connections with the majority of individuals in the work groups.

Incorporating the theories of psychology may add a dynamic dimension to nursing research. Psychology's theories of human behaviour may add depth to understanding the behaviours of individual nurses and their work groups and the impact on practice outcomes. Theories and concepts such as personality theories, Bandura's (1982) self-efficacy theory, and reciprocal altruism may help to predict the behaviours of individual nurses working together in groups. For future research the following, the questions in Table 2 could be investigated using different paradigms and methodologies.

Table 2

Future RQs and Suggested Methodologies

Question	Methodology
Are individuals with similar personality traits attracted to the profession of nursing? Do these traits facilitate or limit their ability to learn the social norms of the group and work collaboratively in nursing groups?	Quantitative, use of surveys to measure personality traits, quality of work life, connectedness to the group
Is the norm of helping one another related to reciprocal altruism? Would nurses continue to help other nurses with patient care if they did not receive help in return?	Quantitative, use of personality and Altruistic Personality Scale, Organizational Behavioural Scale, Helping Behaviour Scale, Big five models of personality Qualitative, ethnography to examine the way in which nurses work on the unit
What experiences lead nurses to feel comfortable and uncomfortable in following the social norms of the group? Do they feel they can change the norms of a group?	Qualitative, the nurses lived experiences of comfort and discomfort in their role as a member of a group of nurse.
Organization culture, does tight versus loose cultures or weak versus strong situations affect the fluidity of social norms? Is there a mismatch between the	Quantitative, quality of work life survey, citizenship behaviours
organizations norms and those of the individual nursing groups (Yip et al., 2020)? Does this contribute to organizational expectations of nursing groups that nurses feel they cannot meet? How does this impact the group to work and support each other?	Qualitative, phenomenology, how do nurses perceive the organization supporting their values and beliefs, work expectations and does this impact their intent to remain in the profession?

Understanding the systems in which nurses practice will facilitate expansion of the current understanding of the expectations that nurses, patients, families, society, and employing organizations have about the ways that nurses practice and the values and beliefs that drive the

behaviours and social norms of nurses working in groups in the health care setting. Adding the perspective of the ways that gender and power influence the process of social norm formation of nurses would increase the profession's understanding of the impact of social norms and societal expectations about the ability of nurses to practice.

Conclusion

I conducted this study using a constructivist grounded theory methodology to understand the process of social norm formation of nurses working in groups in the health care setting. I developed a theoretical model based on the process of social norm formation of nurses working in groups in the health care setting that is essential for nurses to move through the three transitions of being (identifying as a nurse), becoming (fitting into work groups), and belonging to the profession and group (values and beliefs aligned with those of the groups and the profession). The nurses in the study shared details about their experiences and reflections related to the development of their own values and beliefs. They also were able to identify the values and beliefs of the groups that they worked with as well as those of the profession. The contextual elements that impacted their ability to learn, enact, and accept the social norms of their work groups were identified as personal attributes, workplace, relationships, and communication. Each element influenced the ability of the nurses to move through the transitions of the theory to feel that they belonged in the work groups and in the profession. The results showed that the process of social norm formation of nurses is complex, temporal, and relational, and is facilitated by the communication that nurses in work groups have with one another, the employing organizations, and society, along with and the meanings that the nurses ascribed to these interactions.

This study provided a different view of nursing through the discipline of social psychology by applying the premises of SIT. Understanding the formation of social norms in

nurses' work groups will contribute to the understanding of nurses, organizations, and society of the complexity of nursing practice. The theory identified the need to support nurses in their practices to develop norms supporting their ability to work together and support each other to provide excellent patient care. Nurturing environments allow healthy social norms to develop and thrive. Building strong relationships through social networks with other nurses supports individuals in identifying as a nurse, becoming a part of the group, and belonging to the profession.

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APPENDIX A: SEMISTRUCTURED INTERVIEW GUIDE

	Demographic questions (age, gender, education, yr working as a nurse, specialty where currently working, and yr in specialty area) Review the information letter and the consent form with the participants. Data collection questions Research Subquestion 1: What are the components or the systems of the rules and observations that comprise the social norms of a group of nurses?	
	Choosing to become a nurse	Prompting and probing questions
4	What attracted you to the nursing profession?	Can you give an example?
5	What do you like about the nursing profession?	Looking for characteristics and behaviours that identify you as a nurse.
6	What do you think has influenced you to consider yourself as a nurse?	Can you explain? Can you give me an example?
7	How did nursing education influence your perception of what a nurse is?	Can you give examples?
8	What are the characteristics and behaviours you associate with being a nurse?	Can you give me an example?
9	How did nursing education influence your attitudes, values and beliefs?	Is this in relation to how you now view nursing?
10	How did these attitudes, values and beliefs influence your decision to continue in nursing?	Can you explain?
11	What does it mean to you to be a nurse?	Can you explain?
	Learning to work within your group	Prompting and probing questions
12	Can you describe how you felt when you first started working with the group of nurses on your current unit?	Can you give me an example?
13	Can you describe how these feelings have changed over the time you have worked with these nurses?	Can you give me an example?
14	How would you describe the behaviours of the group you are working with?	Can you tell me what happened that made you feel that way?
15	How would you describe the communication and interaction among the members of the group?	Look for informal and formal communication
16	Can you give examples of when you feel comfortable working with this group?	Can you give an example of this in practice?
17	Can you give examples of when you feel uncomfortable working with this group?	You mentioned that…how did you feel about it? Could you tell me more about…?
18	Describe the type of support you have received from your group during your daily practice?	Can you give experiences, look for clues such as workload, stress, knowledge
19	Can you give me examples of behaviours that you perceive to be common to most of the nurses in your group?	Do you have any other examples of this?
20	Do the behaviours of the group support your perception of what nurses should do in practice? Can you explain?	Could you say something more about that? Would you tell me how you define it, so that I have it in your own words?
21	Can you give me examples of how the nurses you work with interact with each other?	Can you think of a situation in your practice?
22	What do you think have contributed to the development of the behaviours of the nurses?	Do have other examples?
23	What behaviours do think nurses should demonstrate in their practices?	Can you explain these examples?
24	How have your behaviors changed since you joined the group of nurses you work with?	How did that affect your understanding of the expected behaviours of the group? Can you give me an example?

25	Can you explain what has influenced this to change?	Do you have an example of this from your practice?
26	Can you give me an example of a time you may have tried to influence the behaviour of other nurses or the group?	What happened? Can you explain how you felt? Can you explain what made you want to influence the group behaviour?
27	What motivated you to influence the behaviour of others?	Can you explain?
	Research Subquestion 2. How do the social norms of a group of nurses develop?	
	Learning group behaviours	Promoting and probing questions
28	How did you identify the behaviours of your group?	
29	How do you think the behaviours of the group were established?	Can you give me an example?
30	What do you think has influenced the development of the behaviours of your group?	Probing questions. What has supported changes and limited them.
31	Which behaviours do you see as acceptable?	Can you give me an example?
32	Which behaviours do you see as not acceptable?	
33	Which behaviours did you feel were important to you to become part of the group?	Can you tell me more about your ideas?
34	Describe a situation when you felt you did not know how to behave with your group?	Would you be able to explain the situation?
35	How are the group behaviours, values and practices similar to or different from your own?	How did it get to be that way? When or how or where did you notice or learn this?
36	How are the group behaviours, values and practices similar or different from other groups of nurses in the hospital?	Influences? Factors drivers? When or how or where did it get to be that way?
37	Can you describe what the behaviours of your group are as compared to other groups within the hospital?	What do you think may have lead your group to feel this? What influenced you to think this way?
	Research Subquestion 3. What are the impacts of the group's social norms at various levels?	Prompting and probing questions.
	Future decisions	
38	What contributes to you feeling you belong to the group of nurses you work with?	Would you be able to give me an example of when you felt you belonged to the group?
39	Can you give me an example of when you did not feel you belonged to the group of nurses you work with?	Would you be able to explain this further?
40	How do you think the behaviour and interaction with your group members impact your work environment?	Would you be able to give me examples?
41	What experiences within the group influence your sense of belonging to the nursing profession?	Can you elaborate on your answer?
42	What experiences and interactions within your group have contributed to your decisions to remain in the profession?	Can you give me an example? Can you explain?
43	Have your ideas about what it means to be a nurse changed as a result of your interactions with the groups you have worked with?	In what ways? Can you give me any examples
	Concluding questions	
44	Is there something you would like to add that I may have missed?	
45	Is there something else you think I should know?	
46	Do you have any questions?	

APPENDIX B: RESEARCH ETHICS BOARD APPROVAL

Research Ethics Board
t: (807) 343-8283
research@lakeheadu.ca

October 26, 2021

Principal Investigator: Dr. Mirella Stroink
Co-Investigator: Dr. Idevania Costa
Student: Ms. Catherine Schoales

Health and Behavioural Sciences\Psychology
Lakehead University
955 Oliver Road
Thunder Bay, ON P7B 5E1

Dear Drs Mirella Stroink and Idevania Costa, and Ms. Catherine Schoales:

Re: Romeo File No: 1468927

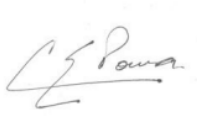
On behalf of the Research Ethics Board, I am pleased to grant ethical approval to your research project titled, "The development of a substantive theory of the process of social norm development in nurses working in groups in the hospital setting: A Constructivist Grounded Theory Study".

Ethics approval is valid until October 26, 2022. Please submit a Request for Renewal to the Office of Research Services via the Romeo Research Portal by September 26, 2022, if your research involving human participants will continue for longer than one year. A Final Report must be submitted promptly upon completion of the project. Access the Romeo Research Portal by logging into myInfo at:

https://erpwp.lakeheadu.ca/

During the course of the study, any modifications to the protocol or forms must not be initiated without prior written approval from the REB. You must promptly notify the REB of any adverse events that may occur.

Best wishes for a successful research project.
Sincerely,



Dr. Claudio Pousa
A/Chair, Research Ethics Board

/sa

APPENDIX C: RESEARCH ETHICS BOARD AMENDMENT

Approval to Amend REB Project- Romeo #1468927

Inbox

R

research.ethics@lakeheadu.ca via researchservicesoffice.com Mon, Aug 29, 2022, 11:44 AM

to Stroink, me, Costa, research.ethics

Date: August 29, 2022

To: Dr. Mirella Stroink, Primary Investigator

From: Dr. Claudio Pousa, Chair, Research Ethics Board

Subject: Approval of Amendment for REB Romeo #1468927

Thank you for your request for amendments for your project titled "The development of a substantive theory of the process of social norm development in nurses working in groups in the hospital setting: A Constructivist Grounded Theory Study ".

Your request to include nurses working in healthcare settings not just hospital settings is acceptable to the Research Ethics Board.

Please continue to advise us of any future changes to your research project.

/sa

APPENDIX D: AMENDED SEMISTRUCTURED INTERVIEW GUIDE

	Demographic questions ((age, gender, education, yr working as a nurse, specialty where currently working, and yr in specialty area) Review the information letter and the consent form with the participants. Data collection questions Research Subquestion 1: What are the components, or the systems of the rules and observations that comprise the social norms of a group of nurses?	
	Choosing to become a nurse	Prompting and probing questions
4	What attracted you to the nursing profession?	Can you give an example?
5	What do you like about the nursing profession?	Looking for characteristics and behaviours that identify you as a nurse. Can you explain these?
6	What do you think has influenced you to consider yourself as a nurse?	Can you explain? Can you give me an example? Can you give me more details?
7	How did nursing education influence your perception of what a nurse is?	Can you give examples? Can you explain these?
8	What are the characteristics and behaviours you associate with being a nurse?	Can you give me an example? Can you explain these?
9	How did nursing education influence your attitudes, values and beliefs?	Is this in relation to how you now view nursing?
10	How did these attitudes, values and beliefs influence your decision to continue in nursing?	Can you explain? Can you give me more examples?
11	What does it mean to you to be a nurse?	Can you explain? Can you give me more details?
	Learning to work within your group	Prompting and probing questions
12	Can you describe how you felt when you first started working with the group of nurses on your current unit?	Can you give me an example? Can you give me more details?
13	Can you describe how these feelings have changed over the time you have worked with these nurses?	Can you give me an example? Can give me examples of how you felt?
14	How would you describe the behaviours of the group you are working with?	Can you tell me what happened that made you feel that way? Can you explain these?
15	How would you describe the communication and interaction among the members of the group?	Look for informal and formal communication Can you tell me how you like to communicate? Can you explain these? Can you give me more examples?
16	Can you give examples of when you feel comfortable working with this group?	Can you give an example of this in practice? Can you explain these?
17	Can you give examples of when you feel uncomfortable working with this group?	You mentioned that…how did you feel about it? Could you tell me more about…?
18	Describe the type of support you have received from your group during your daily practice?	Can you give experiences, look for clues such as workload, stress, knowledge Can you explain these?
19	Can you give me examples of behaviours that you perceive to be common to most of the nurses in your group?	Do you have any other examples of this?
20	Do the behaviours of the group support your perception of what nurses should do in practice? Can you explain?	Could you say something more about that? Would you tell me how you define it, so that I have it in your own words?
21	Can you give me examples of how the nurses you work with interact with each other?	Can you think of a situation in your practice?
22	What do you think have contributed to the development of the behaviours of the nurses?	Do have other examples? Can you explain these?

23	What behaviours do think nurses should demonstrate in their practices?	Can you explain these examples?
24	How have your behaviors changed since you joined the group of nurses you work with?	How did that affect your understanding of the expected behaviours of the group? Can you give me an example?
25	Can you explain what has influenced this to change?	Do you have an example of this from your practice?
26	Can you give me an example of a time you may have tried to influence the behaviour of other nurses or the group?	What happened? Can you explain how you felt? Can you explain what made you want to influence the group behaviour?
27	What motivated you to influence the behaviour of others?	Can you explain?
	Research Subquestion 2. How do the social norms of a group of nurses develop? Learning group behaviours	Promting and probing questions
28	How did you identify the behaviours of your group?	
29	How do you think the behaviours of the group were established?	Can you give me an example?
30	What do you think has influenced the development of the behaviours of your group?	Probing questions. What has supported changes and limited them.
31	Which behaviours do you see as acceptable?	Can you give me an example? Can you explain these?
32	Which behaviours do you see as not acceptable?	
33	Which behaviours did you feel were important to you to become part of the group?	Can you tell me more about your ideas?
34	Describe a situation when you felt you did not know how to behave with your group?	Would you be able to explain the situation? Can you explain these?
35	How are the group behaviours, values and practices similar to or different from your own?	How did it get to be that way? When or how or where did you notice or learn this?
36	How are the group behaviours, values and practices similar or different from other groups of nurses in the hospital?	Influences? Factors drivers? When or how or where did it get to be that way?
37	Can you describe what the behaviours of your group are as compared to other groups within the hospital?	What do you think may have lead your group to feel this? What influenced you to think this way?
	Research Subquestion 3. What are the impacts of the group's social norms at various levels? Future decisions	Prompting and probing questions.
38	What contributes to you feeling you belong to the group of nurses you work with?	Would you be able to give me an example of when you felt you belonged to the group? Can you explain these?
39	Can you give me an example of when you did not feel you belonged to the group of nurses you work with?	Would you be able to explain this further?
40	How do you think the behaviour and interaction with your group members impact your work environment?	Would you be able to give me examples? Can you explain these?
41	What experiences within the group influence your sense of belonging to the nursing profession?	Can you elaborate on your answer?
42	What experiences and interactions within your group have contributed to your decisions to remain in the profession?	Can you give me an example? Can you explain?

43	Have your ideas about what it means to be a nurse changed as a result of your interactions with the groups you have worked with?	In what ways? Can you give me any examples
	Concluding questions	
44	Is there something you would like to add that I may have missed?	
45	Is there something else you think I should know?	
46	Do you have any questions?	

Note: Additional prompts and probes are highlighted in yellow