Nurse leaders' perceptions of registered nurse professionalism: A narrative inquiry

by

Gina Marietta Richards

Thesis

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Principal Supervisor: Associate Professor Joyce Hendricks PhD, RN, RM

Associate Supervisors: Adjunct Professor Christopher Churchouse PhD, RN

& Dr Julie Shaw PhD, RN

Abstract

Aim:

The aim of this study was to explore nurse leaders' perceptions of registered nurse professionalism; expand knowledge related to registered nurse professionalism, and to identify the essential attributes of registered nurse professionalism.

Background:

Despite the general consensus by members of the public and the healthcare professions that professionalism is essential, a clear understanding of what constitutes professionalism is lacking. Most research studies aim to measure professionalism, with a paucity of research providing clear guidance on how to demonstrate the professional behaviours deemed essential by regulatory authorities and the public.

Research design:

In this study, narrative inquiry was used to examine professionalism as a fresh and innovative approach in the research of this topic. Through storytelling, nurse leaders voiced their perceptions of the professionalism of the registered nurse in the clinical setting. Through the iterative process of the telling and the retelling of the narratives, the nurse leaders' voices were allowed to be heard.

Data collection and analysis:

Twelve nurse leaders were interviewed from the metropolitan healthcare setting in Perth, Western Australia. Data collection consisted of semi-structured interviews, analytical memos and field notes. Focus group interviews were used to verify themes related to the professional attributes of registered nurses in the clinical setting and the influence on these attributes. The two-step approach of Miles et al. (2014) to qualitative data analysis was undertaken.

Findings:

Four attributes of registered nurse professionalism were identified – respect, professional presence, accountability and collegiality. The influences which impacted on the demonstration of professionalism by the registered nurse were identified as a stable work environment. A professional framework was developed with these attributes and influences.

Conclusion:

The professional framework developed provides a functional perspective of professionalism. This framework is significant because the attributes are observable and provide a clear and visible understanding of what it means to be a professional registered nurse.

Keywords:

professionalism, attributes, registered nurses, nurse leaders, narrative inquiry

Acknowledgements

During the time of undertaking this PhD, I began as Gina Mata and returned to my family name, Gina Richards, as a tribute to my parents. The study commenced in Western Australia at Edith Cowan University and was completed in Queensland, Australia, with CQUniversity, due to the movement of my principal supervisor from one side of the country to the other. So, this journey has consisted of more than my scholarly endeavour. My experience has been shared by many, and I am indebted to them for their ongoing support and contribution during the past years. First, I would like to thank my partner Jerzy and my children, Katherine and Andrew for their patience and understanding during the seemingly never-ending PhD journey. This sentiment extends to include my friends for their unwavering support shown to me during this time.

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RHD Thesis Declaration

CANDIDATE'S STATEMENT*

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By submitting this thesis for formal examination at CQUniversity Australia, I declare that all of the research and discussion presented in this thesis is original work performed by the author. No content of this thesis has been submitted or considered either in whole or in part, at any tertiary institute or university for a degree or any other category of award. I also declare that any material presented in this thesis performed by another person or institute has been referenced and listed in the reference section.

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This paper HAS NOT been submitted for an award by another research degree candidate, either at CQUniversity or elsewhere.

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DECLARATION OF CO-AUTHORSHIP AND CO-CONTRIBUTION

Mata, G., Hendricks, J., Sundin, D., & Churchouse, C. (2018, July 19–23)

The importance of role modelling and mentoring to nursing professionalism. *29th International Nursing Research Congress*, Melbourne, Australia

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NATURE OF CANDIDATE'S CONTRIBUTION, INCLUDING PERCENTAGE OF TOTAL

I was responsible for the planning, writing and submission of the conference presentation poster *The importance of role modelling and mentoring to nursing professionalism*. I formed the research topic, collated the literature, interpreted the results and presented the findings. [90%]

NATURE OF CO-AUTHORS' CONTRIBUTIONS, INCLUDING PERCENTAGE OF TOTAL

Associate Professor Joyce Hendricks contribution as the principal supervisor on the thesis and assisted with consultation regarding the poster presentation *The importance of role modelling and mentoring to nursing professionalism.* [10%] Dr D. Sundin & Adjunct Professor C. Churchouse contribution were supervisors on the thesis; not involved in the preparation of the poster.

Key Terms

The key terms relate to the terminology of the roles of the registered nurse within the Australian healthcare system, which may be different in description and delivery than in other countries.

Role titles

Clinical Nurse (CN)

A Clinical Nurse delivers comprehensive, evidence-based, safe and effective patient care, they provide clinical leadership for healthcare staff, often mentoring those nurses less experienced. They may assist with the education and performance management of the staff on the ward. Within this study, CN refers to a senior registered nurse level 1 (Appendix M, p. 24).

Clinical Nurse Specialist (CNS)

A Clinical Nurse Specialist assists staff with the delivery of comprehensive, evidence-based, safe and effective patient care, they provide clinical leadership for healthcare staff, often mentoring those nurses less experienced. Their high level of skill in problem and diagnostic identification, the interpretation and analysis of relevant health data, and clinical decision-making abilities may be utilised across a number of related ward areas. Within this study, CNS refers to a senior registered nurse level 3–4 (Appendix M, p. 25).

Clinical Nurse Manager (CNM)

The Clinical Nurse Manager is key in providing strong leadership within the healthcare team, ensuring the delivery of safe and effective patient care. They are responsible for monitoring and evaluating practice within the ward environment to ensure that clinical governance requirements are met. They may also be responsible for the selection and hiring of qualified staff, manage staff scheduling, determine ward skill mix and competency to

patient acuity, plus management of other health resources and equipment for one or more ward areas. They assist in the management of staff, their professional development and management. Within this study, CNM refers to senior registered nurse level 2–3 (Appendix M, p. 24).

Executive leadership team

"Executive means the executive management team of a hospital or health care facility, district or region. This may include a Chief Executive Officer or General Manager, Director of Nursing, Director of Finance, Director of Medical Services and is generally made up of those senior positions directly reporting to the Chief Executive Officer" (Appendix M, p. 4). In this study, the Director of Nursing and Divisional Nursing Heads are called the senior executive. They may be registered nurses with many years of experience; however, there appears to be a move towards the employ of executive team members who are not representative of the discipline they manage. The members of the senior executive leadership team are the upper levels of the hierarchy of the hospital. Their responsibilities relate to the management of the organisation, fiscal and human resources, as well as the maintenance of the high standard of patient care delivered within the structures of governance.

Graduate nurse

All pre-registration nurse education has been undertaken within the university sector since the 1980s. Across Australia, nursing undergraduate degrees leading to registration with the Nursing, Midwifery Board Australia (NMBA) are three to three and a half years in length. The healthcare sector offers graduate programs to new graduate nurses, the length of which may be from six months to two years. Graduate nurses are provided with additional study days, often a peer mentor and have the services and support of the staff development nurse. Not all new graduates are successful in securing one of the highly competitive positions in a graduate program. Others may be employed through the human resources department from

advertised job vacancies and enter the hospital system. The staff development nurse will still support and supervise these nurses, although it may not be within the more formalised system of the graduate program.

Leadership team

Members of the leadership team within this study may be a clinical nurse, clinical nurse manager, clinical nurse specialist, staff development nurse or nurse researcher. They are answerable to the executive team and managing the clinical area, the staff, other role portfolio responsibilities, patient safety and quality care over a number of wards. They are responsible for meeting the accreditation standards of the organisation, meeting the requirements of clinical governance, reporting on fiscal, equipment and human resource issues as related to their role. In this study, the leadership team refers to senior registered nurse level 2 to level 6 (Appendix M, p. 24).

Nurse

"Nurse means a person registered under the Health Practitioner Regulation National Law (Western Australia) in the nursing and midwifery profession, whose name is entered on Division One of the registers of nurses kept under that Law as a registered nurse" (Appendix M, p. 4).

Nurse leader

A nurse leader within this study may have one of the following roles, that of a clinical nurse, a clinical nurse specialist, a clinical nurse manager or a nurse researcher. Their skills and knowledge will vary dependent on the role they hold. They are, however, part of the organisational leadership team and hold responsibilities commensurate with their role (see above leadership team). In this study, a nurse leader refers to Appendix M, senior registered nurse level 2 to level 5.

Registered Nurse (RN)

"Registered Nurse (6) Definitions (a) Registered Nurses Level 1 (RN-1) Means an RN who is required to perform general nursing duties, where there is access to a higher level of clinical expertise, that includes, but are not confined to:

(i) delivering direct and comprehensive nursing care and individual case management to patients or clients within the practice setting;

(ii) coordinating services, including those of other disciplines or agencies, to individual patients or clients within the practice setting;

(iii) providing support, education, counselling and group work services oriented towards the promotion of health status improvement of patients and clients within the practice setting;

(iv) accepting accountability for the employee's own standards of nursing care and service delivery and professional development;

(v) participating in research, quality improvement and policy development within the practice setting;

(vi) being responsible where applicable for the clinical supervision of enrolled nurses" (Appendix M, p. 23).

Senior nurse (SRN)

"Means an employee who is registered by the Nursing and Midwifery Board of Australia as a registered nurse or midwife, who holds a current practising certificate and any other qualification required for working in the employee's particular practice setting, and who is appointed as such by a selection process or by reclassification from a lower level in the circumstances that the employee is required to perform the duties detailed in this subclause on

a continuing basis. Within this study, senior nurse refers to a senior registered nurse level 1–4" (Appendix M, p. 24).

Staff Development Nurse (SDN)

A Staff Development Nurse may work as a member of the healthcare team on the ward combining the responsibilities of the education and support of staff on the ward. Some staff development nurses do not have ward responsibilities of patient management and solely spend their time in the education and support of staff; others may work across a number of ward areas in their educative role. The staff development nurse delivers comprehensive, evidence-based, safe and effective patient care, they provide clinical leadership for healthcare staff, often mentoring those nurses less experienced. They may assist with the education and performance management of the staff on the ward. Within this study, SDN refers to a senior registered nurse level 1–4 (Appendix M, p. 24).

Chapter One

Introduction

In 1893, Lystra E. Gretter and the Farrand Training School in Detriot, Michigan, wrote a nurse's pledge in honour of Florence Nightingale. The pledge was based on the Hippocratic oath, and was explicitly written for the nursing profession outlining the image and behaviours expected of the nurse, and is considered to be the first nursing ethical standard or code (Miracle, 2009). For many years the pledge was used by nursing schools for their graduating students. Despite the historic nature of the document, and some of the sentiments voiced, the basic tenets still form part of current nursing codes and standards (American Nurses Association [ANA], 2015; International Council of Nurses [ICN], 2012; Miracle, 2009; Nursing and Midwifery Board of Australia [NMBA], 2018).

Figure 1

Nurse's pledge

> *I solemnly pledge myself before God and in the presence of this assembly to pass my life in purity and to practise my profession faithfully.*
>
> *I will abstain from whatever is deleterious and mischievous, and shall not take or knowingly administer any harmful drug.*
>
> *I will do all in my power to maintain and elevate the standard of my profession and will hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in the practice of my calling.*
>
> *With loyalty will I endeavour to aid the physician in his work, and devote myself to the welfare of those committed to my care* (Gretter, 1910).

In the current healthcare environment, professionalism as a concept has multiple meanings which are dependent on the individual, the related health discipline and a given situation. The literature is consensual in the lack of a recognised definition of professionalism and the difficulty in describing this concept, even though it is considered a core component of health professions (Cusack et al., 2019; Morgan et al., 2014; Scottish Government, 2012).

Although the concept of professionalism is introduced to nurses during their introductory nursing courses, there is little attention directed to the attributes or *make-up* of what it means to be professional (Ahmad et al., 2017; Shepard, 2014; Willetts & Clarke, 2014). The nursing profession identifies professional behaviour as a requirement for practice by its inclusion in the regulatory codes and standards within which registered nurses work and therefore, its presence in nursing courses is essential.

Due to its role in quality patient care; positive work culture; increased staff job satisfaction and reduction in staff attrition, it is important that nurses model professionalism during their interactions with patients and colleagues in their workplaces (Celik & Hisar, 2012; Cusack et al., 2019; Fur ker, 2008; Hwang et al., 2009; Sabanciogullari & Dogan, 2015; Wyund, 2003). However, despite this expectation that nurses understand and demonstrate professionalism, there remains a lack of agreement on the definition of the constructs of professionalism as identified by the nursing profession (Cusack et al., 2019). Instead, it is often easier to describe, or have agreement on, the nursing behaviour that is considered not to be professional than it is to describe or agree on what is professional (McLachlan, 2010).

A clear description how nurses can demonstrate the behavioural attributes of professionalism in nursing practice will increase the discipline-specific knowledge of the nature of professionalism, and provide a basis for the assessment of, and the instruction on, professionalism. In order to explore professionalism and its constructs, senior registered

nurses, termed in this study, nurse leaders, were invited to share their stories through the use of narrative inquiry. Due to the nurse leader's position and their years of experience within healthcare organisations, it was believed they were in a position to have witnessed the professionalism of the registered nurse. Throughout the thesis, the term 'nurse' refers to registered nurses.

Background

With no consensual meaning of professionalism, and the discussion of the related behaviours, characteristics, values and attributes differing between studies, it is difficult for nurses to define and understand the concept (Swick, 2000; Tanaka et al., 2014). Mottain (2014) highlights this difficulty through the content analysis of professionalism which noted 162 definitions of the concept: 55 definitions from general literature and 107 definitions of the professional meaning.

The difficulty with the ambiguity of terminology is highlighted when examining both the Cambridge Dictionary (n.d.) and the Merriam-Webster Dictionary (n.d.) for clarification between the commonly used terms of the professionalism of "characteristics and attributes". The Cambridge Dictionary (n.d.) definition of an attribute is given as "a quality or characteristic that someone or something has" and a characteristic is defined as "a typical or noticeable quality of someone or something". The Merriam-Webster Dictionary (n.d.) defines an attribute as "a quality, character, or characteristic ascribed to someone or something." It follows with, a characteristic, is defined as "a special quality or trait that makes a person, thing, or group different from others". The nursing literature also uses these terms interchangeably without discussion of the reason for the choice of terminology.

Within this study, the terminology chosen is that of the attributes of professionalism, as a set of observable behaviours. The reason for this choice, in this study, is that the researcher purports the difference between the two terms is that an attribute is a derivative

quality or characteristic of a person or inanimate thing, in this case, a quality or characteristic which demonstrates professionalism, for example, autonomy. However, autonomy is not an intrinsic quality or characteristic; instead, it is a set of behaviours or attributes which demonstrate autonomy.

Having a consensual understanding of what constitutes professionalism and the related terms would assist nurses, educators, organisations and regulatory authorities in determining best practice for registered nurse professional behaviour. The study by Bunkenborg et al. (2013) and Drach-Zahavy and Srulovici (2019) proffered that support in professional practice resulted in the reduction of medical errors, together with an increase in positive patient interactions and outcomes in patient care. In workplaces where the nurses were working within the bounds of their professional codes and standards (ICN, 2012; NMBA, 2016, 2018) and demonstrating professionalism, patient care was improved (Adams & Miller, 2001; Alidina, 2013; McCardle et al., n.d; Morgan et al., 2014; Registered Nurses' Association of Ontario, 2007).

Professionalism forms the basis of the social contract between healthcare staff and the public, with an expectation that nurses will undertake their work professionally and ethically (Akhtar-Danesh et al., 2013; Belar, 2012; Flexner, 2010; Funder, 2010; Grus et al., 2018; Young 2010). This expectation is highlighted by the various public annual surveys on the ethical standing, trustworthiness and honesty of professions. It is evidenced that nursing each year is named as one of the most trusted professions through the public polls, in the United States Gallup poll (Reinhart, 2020), United Kingdom Ipsos MORI Veracity Index (Skinner & Clemence, 2019) and the Roy Morgan's Annual Image of Professions Survey held in Australia (Roy Morgan, 2017). However, the reports in the United Kingdom of poor patient experiences and standards of care, have encouraged further research and consultation into

professionalism in the healthcare environment (Morgan et al., 2014; Parliamentary Health Service Ombudsman, 2011).

The lack of a clear definition of professionalism to guide newcomers to the profession was identified as detrimental in assisting the understanding by registered nurses and nursing students of what it is to behave professionally (Abalihi, 2019; Bimray et al., 2019). The requirement that registered nurses demonstrate professional behaviours is deemed essential by both the public and the relevant Nursing and Midwifery Boards (Brendley, 2018; Cusack et al., 2019; NMBA, 2018; Morgan et al., 2014; Reed & Dix, 2018). The broad guidelines for nurses' practice are the codes and standards which outline expected standards of practice and behaviour. These codes and standards are provided by the regulatory nursing body in Australia, the Australian Nursing and Midwifery Board, and consist of the International Code of Ethics (ICN, 2012), the Code of Conduct for Nurses (NMBA, 2018) and the Registered Nurse Standards for Practice (NMBA, 2016). Although providing the overarching principles of practice for the registered nurse, the codes and standards do not offer a high level of functional applicability of professionalism for the nurse in their daily practice. This point is supported by Cusack et al. (2019) who reiterated that professionalism is not defined, or described in detail, nor easily applied to practice. Cusack et al. (2019, p. 21) described professionalism as "individual behaviour professionals are supposed to exhibit when interacting with their clients". Morgan et al. (2014, p. 59) outlined the United Kingdom Chief Nursing Officers, description of professionalism as:

> The personal qualities found in individuals' attitudes and behaviours with the resultant outcome of constancy in personal integrity, humility, caring and striving to build therapeutic relationships, challenging and empowering others whilst taking accountability for actions, own learning and delivering up-to-date, evidence-based quality patient-and family-centred care**.**

Although the definition described by the United Kingdom Chief Nursing Officers provided some detail of required practice, it does not provide the specifics of how to demonstrate the attributes of professionalism in their daily practice. Through the provision of a clear framework of the attributes of professionalism and their application to practice, it will result in greater understanding and demonstration by registered nurses of professionalism. This increase in understanding is imperative as the display of professional behaviours has been found to improve the work environment (Abraham 2011; AbuAlRub & Nasrallah, 2017; Alidina, 2012).

Within the workplace, studies by Celik and Hisar (2012), Kim-Godwin et al. (2010), Tanaka et al. (2014) and Tanaka et al. (2016) found high levels of professionalism have a positive correlation with the nurse's years of experience and knowledge. Thus, it is extrapolated that nurse leaders' experience and position imply they are best placed to identify and describe the expected organisational behaviours and attitudes of registered nurses necessary to demonstrate professionalism. These experienced members of the nursing leadership team are expected to role model the professional behaviours required of registered nurses. It is, therefore, imperative that nurse leaders fully understand how best to demonstrate the attributes of professionalism in practice (Clark & Kenski, 2017; Hammer, 2006). Nurse leaders work with staff with different experience and knowledge levels and deal with both the registered nurses at the bedside and those nurses as members of the leadership and senior executive teams. It was for that reason nurse leaders were chosen for this narrative inquiry study, as they could provide a comprehensive view of the professionalism of the registered nurse. This study will, through the analysis of the nurse leaders stories and experiences, elucidate a definitive clarification of the attributes of professionalism.

Aims of the research

The aims of this study are to:

1) Explore nurse leaders' experiences of registered nurse professionalism.

2) Expand knowledge related to registered nurse professionalism.

3) Identify the essential attributes of registered nurse professionalism.

4) Identify influences on the demonstration of the professionalism of the registered nurse.

Purpose of the study

The purpose of this study is to determine the individual attributes that, when combined, demonstrate professionalism in registered nurse behaviour and identify any factors that impact professionalism.

Significance

This study will add to the knowledge related to professionalism, including its attributes and how these are represented in the clinical setting. This will provide registered nurses and nursing students with a description of how best to emulate the professional nurse. A workplace where nurses clearly understand and demonstrate the attributes of professionalism will result in a positive work environment and may enhance the delivery of quality patient care.

Research questions

This research intends to understand nurse leaders' views of professionalism. On this basis, two questions were formulated:

1. What do nurse leaders identify as the key attributes of professionalism portrayed by registered nurses?
2. What do nurse leaders identify as the influences on the attributes of professionalism for registered nurses?

Methodology

The most appropriate methodology for this study was determined as narrative inquiry as it allowed the researcher to explore nurse leaders' stories of professionalism. Narrative inquiry, embedded in the interpretive paradigm, is both a qualitative research design and a method of inquiry (Clandinin, 2007). In narrative inquiry, the researcher elicited the perceptions of individuals through their stories about the phenomena, which in the current research, is the individual nurse leaders' perceptions of professionalism (Cohen et al., 2007; Creswell, 2009; Crotty, 1998). The choice of narrative allowed the nurses to share their experience as practitioners (Polkinghorne, 1988).

This repetitive and systematic approach to inquiry endeavoured to understand the human experience, with experience to be understood as that of the individual within a social context (Clandinin & Connelly, 2000). Embedded within the nurse leaders' stories was the potentially rich information of the experience, views, context and history of the individuals' experiences of professionalism. Through the narrative inquiry process, the researcher entered the lives and experiences of the nurse leaders, and through the telling and retelling of those experiences, a vibrant picture and understanding were constructed. Through this iterative process, the researcher compiled these stories into one narrative of nurse leaders' views of professionalism. The researcher's voice interweaves with that of the nursing leaders, and together their reflective viewpoint provided a summary for consideration. The researcher's position outlines the researcher's viewpoint regarding professionalism and their interest in the research phenomena.

The researcher's position

Reflexivity is central to narrative inquiry and makes explicit the effect the researcher may have on the research findings (Palaganas et al., 2017). Most narrative inquiry studies have relatively small numbers of participants, and they use an emic or insider perspective

(Brooke, 2013). Utilising an emic perspective, the researcher formed part of the research as they interpret and give meaning to the participants' stories in a two-way process. There is a partnership between the researcher and the participant in the retelling of the story. As a co-contributor to the data, the researcher needs to identify and narrate their views and beliefs and how they may influence interpretations of participant narratives through outlining the research assumptions and the researcher's reflexive position (Connelly & Clandinin, 1990).

Hence, reflexivity relies on the researcher's capacity for self-reflection and introspection and is documented using analytical memos throughout all stages of the interviews. Etherington (2007, p. 601) explains that "…reflexivity is, therefore, a tool whereby we can include our 'selves' at any stage, making transparent the values and beliefs we hold that almost certainly influence the research process and its outcomes". Pihkala and Karasti (2013, p. 90) attest that reflexivity "…makes visible the dynamics of the research and design process". This process also assisted with the triangulation of results by acknowledging the researcher's position as well as assisting to improve the research design process.

The current study demonstrates reflexivity in the following reflection on professionalism by the researcher. Before the current study, the researcher was situated as the clinical coordinator of an undergraduate nursing program and was privy to many stories from students and staff that related to unprofessional behaviour. This commonly involved instances of incivility either from staff towards the students or students towards clinical supervisors or staff, where both parties would claim that staff/students were unprofessional. Despite being able to describe what constituted the unprofessional behaviour, it was much more difficult for staff and students to discern and describe what were the attributes of professionalism that the staff/student should be demonstrating.

The researcher has since returned to a lecturing role and in this role, facilitated workshops with nurses at a private hospital who expressed positive views about the levels of

professionalism evident in their healthcare environment. There was general unanimity that over the past 20 years, amongst all health professionals, the level of professionalism has improved. The researcher was aware that as the clinical coordinator she had mainly been exposed and involved with the negative aspects and problems concerning professionalism and this meant that she had rarely heard any positive discussions about nursing professionalism in the workplace.

Inevitably, the experience may have contributed to some unintended bias, but through foregrounding these perceptions, narrative inquiry allowed for the greater transparency of the research process (Palaganas et al., 2017). The researcher was vigilant of the potential for unintended bias during the study; however, a return to a lecturing role – together with the lack of recent exposure to hospital staff – reduced the probability of bias and any power imbalance between the researcher and the participants (Creswell, 2014). The participants in the stories, about whom nurse leaders spoke, were not referred to by name and so were unlikely to be identifiable to the researcher. This description of the researcher's position is followed by the summary of the chapter and an overview of the structure of the eight chapters of the thesis.

Summary

This chapter has introduced the study, outlining the background; listed the aims of the study; described the purpose of the study and its significance; listed the two research questions; explained the choice of the methodology used, and described the researcher's position. The background discussed how the lack of consensus of a definition, or the attributes of professionalism, resulted in difficulty understanding the concept. A brief discussion outlined the positive effect experienced when registered nurses displayed professional behaviours on patient care and in the work environment. Following were the three aims, listed as exploring the nurse leader's experiences, expanding knowledge of

professionalism, and identifying the essential attributes of professionalism. The purpose of the study was to determine the individual attributes that, in combination, demonstrated professionalism in registered nurse behaviour and the identification of factors impacting on professionalism. The research questions are to identify the key attributes of professionalism and the influences on professionalism for registered nurses. This was then followed by an explanation of narrative inquiry as both the methodology and the method. Finally, the researcher's position was detailed. The description of the structure of the thesis follows.

Structure of the thesis

The thesis is comprised of eight chapters. Chapter One began the study by introducing the topic, providing the background of the importance of professionalism in the healthcare environment, the aims, the purpose and the significance of the study, research questions, methodology and finally the researcher's position in the study. Chapter Two presents a literature review with critical appraisal of current research which contextualises the study within the relevant nursing and professional literature. Chapter Three presents the methodological approach of narrative inquiry and justifies its use in this research. Chapter Four outlines the research method providing information on the setting, participants, ethical considerations, recruitment, data collection, data analysis, thematic coding, and visual identification of the steps in the study. Chapter Five introduces the 12 nurse leaders with a brief synopsis on their profiles provided to understand their workplace representation. Chapter Six presents the analysis of the nurse leaders' stories with relevant verbatim excerpts provided to demonstrate and support the analysis. Chapter Seven discusses the findings of the study in conjunction with the current literature. Chapter Eight concluded the thesis. The limitations of the study are explained, and the implications for practice are outlined.

Chapter to follow

The following chapter provides a literature review of the current, original research studies relating to professionalism and the registered nurse, from the national and international literature.

Chapter Two: Overview of the Literature

Introduction

The previous chapter introduced the topic of registered nurses' professionalism. This chapter examines the research literature on the professionalism of registered nurses. The broad search aimed to investigate what were the main areas of discussion in current research papers related to professionalism.

Purpose statement

The purpose of this literature review aimed to examine the focus of the current research on professionalism. Of particular interest was examining research which identified the attributes of professionalism of the registered nurse. This review did not intend to formulate a standard definition of professionalism.

Design

The narrative literature review approach provides a suitable method to appraise the published literature, identify any gaps in the knowledge and synthesise current information on a topic (Ferrari, 2015). Cook and West (2012) explained that systematic reviews are best used with a specific question as ideas outside of that focused question may be missed. Ferrari stated that some topics require the wider scoping of a narrative literature review as "the narrative thread could be lost in the restrictive rules of a systematic review" (2015, p. 215). The weakness of a narrative review is the potential for subjectivity or bias in the selection of papers (Ferrari, 2015). To reduce the potential for subjectivity and thereby improve the quality of the narrative review, the Kable et al. (2012) 12-step systematic searching framework was applied. This framework ensured an effective bibliographic research strategy which reduced any potential selection bias through ensuring a logical and sequential approach of the search process (Andrew et al., 2015; Ferrari, 2015; Kable et al., 2012). Table 1 below outlines the research steps undertaken using the framework in this literature review. A critical

assessment of the research papers using the Mixed Method Appraisal Tool (MMAT Version 2011) appraised the quality of the qualitative, quantitative and mixed-method studies to determine inclusion or rejection of the research papers (Ferrari, 2015; Hong et al., 2019; Pluye et al., 2011).

Table 1

A structured approach to documenting a search strategy for publication: A 12 step guideline for authors (Kable et al., 2012).

	12 Steps to documenting a search strategy
1	The purpose statement of the question to be addressed in the literature search
2	Document the databases or search engines used
3	Specify limits applied to the search
4	List inclusion and exclusion criteria
5	List the search terms used
6	Document the search process for each search engine including search engine, terms and number retrieved on a search results table
7	Assess retrieved articles for relevance using inclusion and exclusion criteria
8	Document a summary table of included articles, list type of study, purpose, sample, design, data collection and key findings
9	Provide a statement specifying the number of retrieved articles at the end of the search process
10	Conduct quality appraisal of retrieved literature
11	A critical review of the literature
12	Accurate and complete reference list

Method

Searching databases

In June 2020, a focused search examined six relevant healthcare databases: MEDLINE, CINAHL, ProQuest Dissertations and Theses Global, ProQuest Central, EMBASE and Scopus. The search terms used across all databases were “professionalism” and “registered nurses” with the Boolean term “AND” used to refine the search; that is, “professionalism AND registered nurses”.

Search limiters

The application of the search limiters narrowed the breadth of the search. The following limiters were applied: original research; articles and dissertations; published between the years of 2000 and 2020 and peer-reviewed. The argument for the inclusion of unpublished theses as grey literature is that theses are peer-reviewed original research which has undergone supervised analysis and therefore are considered suitable for inclusion (Cook & West, 2012). Initial searching across the six databases resulted in the identification of 149 papers, with the removal of 29 duplicate papers leaving 120 papers for further review.

At this point, an initial review of the title and skimming of the abstracts of the 120 papers was completed. The application of the inclusion and exclusion criteria resulted in the further exclusion of 59 papers. Inclusion criteria consisted of the crucial features of the target population (Patino & Ferreira, 2018), in this study, registered nurses and professionalism. Exclusion criteria consisted of research related to non-healthcare disciplines; other healthcare disciplines or midwives; not original research and not published in English.

The 61 papers retained were given a "full read" looking for the contents within the paper which discussed the registered nurse and professionalism. Review papers and those papers that were not original research were excluded. Many papers used the word "professionalism" as a search term keyword or listed "professionalism" as a potential outcome to their study or program, yet within the paper, professionalism was not discussed; this resulted in a further 18 papers excluded.

A critical appraisal of the 43 papers was undertaken using the Mixed Method Appraisal Tool (MMAT) - Version 2011 (Pluye et al., 2011). The MMAT allowed for the appraisal and scoring of the methodological quality of mixed methods, qualitative and quantitative research papers. The MMAT does not assess research papers for the quality of writing; instead, it "measures" the methodological quality of qualitative, quantitative and

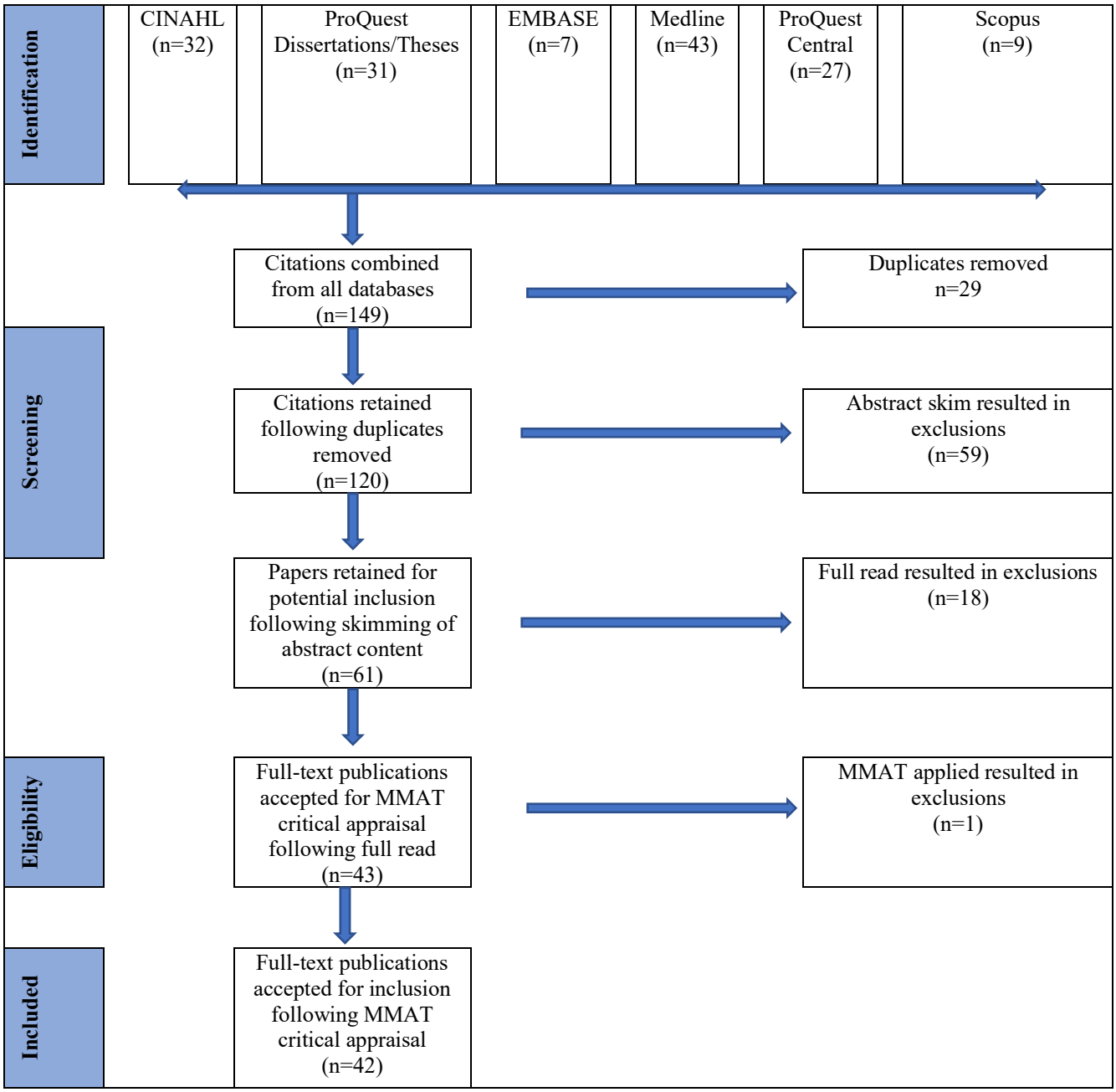
mixed-method research (Pluye et al., 2011). The critical appraisal tool examined the quality of the studies by considering the rigour of the research techniques used, the sample, methods, and data analysis of the studies. Those papers which scored 75% or 100% on the MMAT evaluation were included in Table 3 and are discussed under Findings. The reasons for the exclusion of the research paper by Han and Kim (2014) was that the measuring instruments and statistical analysis methods used did not meet MMAT criteria. Following the MMAT critical appraisal, 42 international papers were retained for synthesis and discussion. These papers represented the literature from 11 different countries. Nineteen were quantitative studies, 21 qualitative studies and two mixed-methods studies.

PRISMA diagram

The literature selection process is displayed through the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram (Moher et al., 2009).

Figure 2

PRISMA literature selection process flow chart



Summary table

The following summary Table 2 outlines the author/s, year of publication, country of origin, paper title, aims or research questions, research design, population and instrument or tool used, the main findings and the MMAT score of all literature included in the narrative review.

Table 2

Summary table of literature review papers

	Author	Title	Aims /questions	Document type, Study design, population & tool	Findings # Comment regarding professionalism attributes	MMAT
	Abalihi, 2019 Minnesota, USA	Effect of multiple entry levels into nursing practice and professionalism	This thesis examined if professional behaviours were influenced by differences in the levels of education of the RN.	Thesis- Walden university - quantitative Purposive sampling n=112 1 The Behaviour Inventory for Professionalism in nursing (BIPN) survey (Miller, Adams & Beck, 1993).	Findings determined professional behaviour levels were higher in the RN with a degree qualification compared to an Associate level qualification. # Characteristics of professionalism, as per the Wheel of professionalism.	100
2	Abraham, 2011 USA	Developing nurse leaders: A program enhancing staff nurse leadership skills and professionalism	This research article aim was to find if leadership skills, promotion and retention of participants were improved by undertaking a leadership program.	Article- mixed methods Purposive sampling n=15 1 Nursing Activity Scale (Schutzenhofer,1987); 2 Leadership Practices Inventory (Kouzes & Posner, 2003); 3 Qualitative feedback	Findings showed that participants demonstrated a change in leadership skills and professional behaviour following the program. Professionalism was discussed only in relation to the survey items. # Attributes not mentioned.	100
3	Adams, 2011 Massachusetts, USA	Professionalism as dissent: Historical insights to the evolution of a collective, rebellious staff nurse identity and the disaffiliation of the Massachusetts Nurses Association from the American Nurses Association	This thesis examined the disaffiliation of a nurse's state-based professional association from the main professional body of the ANA.	Thesis- Brandeis University - Qualitative Grounded theory Purposive sampling n=42 RNs and n=5 (appointed RN) 1 Semi-structured interview	Findings discussed educational stratification; acknowledgment of the power differentials with work roles and oppression; unionism versus professionalism. Examination of the historical dimensions of the profession, through the development of professional associations and the associated union and work rights. # No use of the word attributes. Participants identified these components as important to professionalism: knowledge and formal education; collaborative relationships; professional autonomy; membership of professional organisations.	100

4	Albert et al. 2008 USA	Impact of nurses' uniforms on patient and family perceptions of nurse professionalism	This research article aim was to determine if uniform style and colour affected perceptions of nurse professionalism.	Article- Quantitative prospective comparative design Convenience sample n=499 1 Modified Nurse Image Scale (MNIS) (Magnum et al., 1991) 2 Nurse Image Scale for Children (NISC)	Findings determined that children and young adults view of nursing professionalism is not influenced by uniform colour or style. # Professional nurse image traits were given as "confident, competent, attentive, efficient, approachable, caring, professional, reliable, cooperative, and empathic" p.182.	100
5	Bimray et al. 2019 South Africa	Professionalism experiences of undergraduate learner nurses during their 4-year training programme at a Higher Education Institution in the Western Cape, South Africa	This research article aim was to understand the experiences of undergraduate student nurses regarding nursing professionalism.	Article- Qualitative, exploratory and descriptive design [part of a larger study] Purposive sampling n=1058 1 Focus groups n=8	Findings showed student nurses need clear guidance on how to behave professionally. The lack of a clear definition results in a lack of consistency in the meaning of professionalism. The importance of role modelling of professional behaviours for students was identified. # Use of term values, rather than attributes. Students mentioned respect and dignity to interact in a caring way.	100
6	Birks et al. 2010 Australia	Becoming professional by degrees - a grounded theory study of nurses in Malaysian Borneo	This research article aim was to understand the process of becoming professional for registered nurses in Malaysian Borneo who undertook baccalaureate studies through an off-campus course.	Article- Qualitative grounded theory methodology [part of a larger study] Purposive sampling n=10 1 Semi-structured interview 2 Focus groups	Findings demonstrated that postgraduate studies are an effective means to develop a professional identity and enhance the professionalism of RNs. The RNs experienced an improvement in knowledge and skills, confidence and communication skills, and changed thinking becoming less judgmental. # No discussion regarding the attributes of professionalism.	100
7	Bloomer & O'Connor. 2012 Australia	Providing end-of-life care in the intensive care unit (ICU): Issues that impact on nurse professionalism	This research article aim was to describe how RNs support families in the ICU during and after a death	Article- Qualitative exploratory study using focus groups Purposive sampling of: 1 Two focus groups of up to 6 participants with semi-structured interviews	Findings identified the influences on the RN in delivering professionalism in moments of patient death. Need for peer and organisational support and debriefing sessions to cope with supporting families. # No discussion regarding the attributes of professionalism.	100
8	Cantrell et al. 2005 USA	The impact of a nurse externship program on the transition process from graduate to registered nurse: Part 1 quantitative findings	This research article aim was to determine if an externship program delivered to students then impacted on their socialisation into the new role of an RN; the level of job satisfaction and degree of professionalism compared with RNs with no externship program.	Article- Quantitative descriptive, comparative study Purposive sampling n=52 Did course n=26 Didn't do course n=26 1 Nursing Activity Scale (Schutzenhofer, 1987); 2 Nurses Self-Description Form (NSDF)(Taylor et al, 1961); 3 The Sense of Belonging Instrument (Hagerty & Patusky,1995); 4 McCloskey/Mueller Satisfaction Scale (Mueller & McCloskey, 1990).	Findings did not support that an externship program improved the outcomes as there were no statistically significant differences between the two groups on job satisfaction and sense of belonging which the authors felt may be related to the Magnet standing of the institution. Interestingly the significant difference in the mean scores for professionalism and role socialisation between the two groups was a higher score for the RNs without the program. # Professionalism forms a subscale in the NSDF described as "dependence of thought and action, ability to discriminate at work, and one's own resourcefulness" (p.194) and is an item in the Nurses Activity Scale.	100

9	Carlson et al. 2010 Sweden	This is nursing: Nursing roles as mediated by precepting nurses during clinical practice	This research article aim was to examine how preceptors demonstrated professionalism to student nurses.	Article- Qualitative ethnographic study guided by symbolic interactionism. Purposive sampling n=13 preceptors and n=16 staff nurses 1 Semi-structured interview 2 Focus groups	Findings identified that professional behaviour was role modelled through demonstration and discussion by the preceptor. # No discussion regarding the attributes of professionalism.	100
10	Cohen & Kol. 2004 Israel	Professionalism and organisational citizenship behaviour: An empirical examination among Israeli nurses	This research article aim was the examination of two models to determine if there is a relationship between elements of professionalism and organisational citizenship behaviour (OCB) and if they are affected by justice perceptions.	Article- Quantitative Hierarchical regression analysis Convenience sample n=1035 1 Morrow & Goetz (1988) (later version of Hall, 1968); 2 Organisational justice (Niehoff & Moorman, 1993); 3 Organisational citizenship behaviour - Development of a survey for this study from a combination of Morrison (1993); Organ & Konovsky (1989) and Williams & Anderson (1991)	Findings from the correlation of the three survey tools showed a positive relationship between professionalism and high perceptions of justice in the workplace and these related to OCB. Although the relationship between professionalism and OCB was not strong further research is suggested. Nurses with academic education were found to have higher levels of professional values and behaviours. #The study used Morrow & Goetz (1988) where items in the scale relating to professionalism consist of "profession as referent; a sense of calling; belief in service; belief in self -regulation and autonomy" p.399.	100
11	Diede, 2018 Washington State, USA	Professional identity in the lived experience of hospital nurses	This thesis aimed to identify the workplace influences on hospital nurses' sense of professional identity	Thesis- Washington State University - Qualitative Philosophical hermeneutic phenomenology Purposive sampling n=12 1 Semi-structured interview	Findings related to the lived experience of nurses as they advocated for the patient; worked as a valued team member; were validated as an expert; valued the humanity of the patient and the nurse's practice. # A discussion of professional values, from the American College of Nursing (2008), which listed the values as "altruism, autonomy, human dignity, and integrity" (p. 3).	100
12	Dyess & Parker, 2012 USA	Transition support for the newly licensed nurse: A programme that made a difference	This research article aim was to evaluate a leadership development and RN support program.	Article- Quantitative Convenience sample n=109 1 Nursing Evaluation Competency Assessment (NECA) instrument (Schwirin, 1978, revised Turansky, 2003 unpublished data); 2 Student Leadership practices Inventory (Kouzes & Posner, 2002)	Findings following the program showed positive increases in retention rates, skill acquisition and leadership development while providing ongoing transition support. # No discussion regarding the attributes of professionalism.	100
13	Elayan & Ahmad, 2017 Jordan	Assessment of the quality of nursing care from the perspectives of nurses who experienced hospitalisation as patients	This research article aim was to identify how nurses viewed the quality of care when they, or family members, were recipients of nursing care.	Article- Qualitative design with content analysis Convenience sampling n=231 1 Semi-structured interview	Findings showed four themes for improvement of the quality of care as professionalism, nurses to demonstrate caring, improving skills and competency and organisational factors. # Participants described professionalism as teamwork, ethics and communication.	100
14	Frenn, 2007 Massachusetts, USA	Analysis of registered nurse characteristics, attitudes, and experiences	This thesis aimed to identify information of the nurses who chose to use self-evaluation as a method of	Thesis- University of Massachusetts - Quantitative descriptive study used a cross-sectional survey design Convenience sample N=199	Findings identified a significant difference between levels of professionalism with nurses who undertook self-evaluation and those who did not.	100

		regarding the self - evaluation	determining continuing competence for registration. A second aim was to determine if nurses using self-evaluation had higher levels of professionalism.	1 Registered Nurse Attitudes and Experiences Regarding Self-Evaluation (RNAE)(developed for this research); 2 Behavioural Inventory for Professionalism in Nursing (BIPN) (Miller, Adams & Beck, 1993)	# Discusses Halls (1968) Attitudes of professionalism of self-regulation, sense of calling, sense of autonomy and professional organisation as a major referent. #Uses Miller, Adams & Beck (1993, p 291) behavioural inventory for its professionalism characteristics of "educational background, adherence to the code of ethics, participation in the professional organisation, continuing education and competency, communication and publication, autonomy and self-regulation, community service, theory use, development and evaluation and research involvement".	
15	Goff, 2018 Florida, USA	Intra-professional conflict among registered nurses in hospital nursing: A phenomenological study of horizontal violence and bullying	This thesis examined the behaviours of horizontal violence.	Thesis- Nova South Eastern University - Qualitative Transcendental phenomenological study Purposive sampling n= 6 1 Semi-structured interview	Findings identified that RNs might leave their hospital employ due to horizontal violence and bullying. They discussed failed professionalism in the workplace. # No discussion regarding the attributes of professionalism.	100
16	Hausner, 2002 Iowa, USA	An examination of the relationship between psychological empowerment and professionalism in nursing	This thesis examined the relationship between psychological empowerment, or task motivation (increase in control and a personal sense of meaning), and professionalism.	Thesis- University of Iowa Quantitative Exploratory study Convenience sample N=584 1 Spreitzer's empowerment scale (1992); 2 Hall's professionalism scale (HPI) (1968)	Findings determined moderate empowerment was linked to four of five of Hall's attitudes. These were self-regulation, sense of calling, sense of autonomy and professional organisation as a major referent. # Greenwoods (1972) model of five attributes: a body of knowledge; professional culture; social sanction; autonomy and code of ethics (p. 4) # Halls attitudes of professionalism (1968, p.93) of: "professional organisations as major referents, belief in public service, self-regulation, a sense of calling to the field, and a sense of autonomy".	100
17	Hedenskog et al. 2017 Sweden	Swedish-registered nurse anaesthetists' evaluation of their professional self	This research article examined the value the nurse anaesthetist places upon their professional self. It considered the individuals value against that of their peers, age, gender and experience.	Article- Quantitative, an explorative prospective cross-sectional design. Purposive sampling n=87 1 The Professional Self-Description Form (PSDF) (National Aeronautics Space Administration with a later factor analysis performed by Andersson, Jylli, Kajermo & Klang, 1987)	Findings elucidated that perceived professional self, of the nurse anaesthetist, was influenced by age and work experience. #The tool used measured professionalism factors: drive, grasp idea, ability to teach, independence, resourcefulness and leadership.	100
18	Hickson, 2012 New York, USA	Nursing hostility and job satisfaction as perceived by new graduate nurses: Magnet versus non-magnet hospitals	This thesis aimed to compare Magnet versus non-Magnet new graduate nurses to understand nursing hostility and job satisfaction.	Thesis- Columbia University- Quantitative Descriptive study Purposive sampling n=1165 1 Negative Acts Questionnaire-Revised (Einarsen, Hoel, & Notelaers, 2009); 2 McCloskey/Mueller Satisfaction Survey (Mueller & McCloskey, 1990); 3 Casey-Fink Graduate Nurse Experience Survey (Casey, Fink, Krugman, & Propst, 2004); 4 Demographic questionnaires	Findings showed that nursing hostility is a large-scale problem within the profession. Nursing leaders held an important role in developing a healthy work environment through role modelling and reinforcing a non-hostile work environment. # Describes the attributes of professionalism as "professional comfort, confidence and support" (p.131).	100

19	Hunter & Cook, 2018 New Zealand	Role-modelling and the hidden curriculum: New graduate nurses' professional socialisation	This research article aimed to identify strategies supporting a professional identity development of new graduate nurses and hospital-based settings	Article- Qualitative descriptive design Purposive sampling n = 5 1 Semi-structured interview	Findings determine that graduate nurses socialised to their new work environment quickly. They further developed moral agency and critical thinking. # Professional attributes described by participants as: "speak politely; cared for patients; patient focus; treat everyone as individuals, and respect their dignity and privacy; calmness; good time management; empathetic; positive attitude" p.3161.	100
20	Jackson, 2017 UK	Student nurse professionalism: repertoires and discourses used by university students and their lecturers	This thesis aimed to examine professional language and language adoption by nursing students.	Thesis- Qualitative social constructionism Convenience sample n=17 n=7 students; n=8 lecturers 1 Semi-structured interviews	Findings elucidated the lecturers and nursing students' use of language around professionalism and its link to professional socialisation. # Lecturers and students described professionalism characteristics as attributes and behaviours, which consisted of "respect, honest, polite, 'have a sense about them' and reliable" p.304.	100
21	Keeling & Templeman, 2013 UK	An exploratory study: Student nurses' perceptions of professionalism	This research article aimed to examine nursing students' perceptions of professionalism.	Article- Qualitative phenomenological approach Convenience sample n=10 1 Semi-structured interviews n=5 2 focus group n=5	Findings highlighted that final year student nurses are cognizant of the impact of practice scenarios and observational influences, affecting their own perceptions of professionalism. # Professionalism discussed by students as the personal values of honesty, caring, altruism.	100
22	Kim-Godwin et al., 2010 USA	Factors influencing professionalism in nursing among Korean American registered nurses	This research article aimed to determine factors associated with professionalism among Korean American nurses and the levels of professionalism.	Article- Quantitative, Correlational descriptive study Convenience sample n=221 1 Use of a revised Halls Professionalism Scale (1968) revised to a 25-item scale by Snizek (1972)	Findings determined that multiple internal and external factors are associated with professionalism among Korean American RNs # RNs discussed their professional values and attributes as related to the items from the revised HPI by Snizek (1972, p.109) of: "use of the professional organisation as a major referent, belief in public service, belief in self-regulation, sense of calling to the field, and a feeling of autonomy".	75
23	Kollie, 2016 USA	Experiences of nurses and midwives during the Ebola outbreak in Liberia, West Africa	This thesis aimed to explore the experiences of nurses and midwives during the Ebola outbreak in Liberia	Thesis- Loma Linda University- Qualitative, Grounded theory Convenient non-random sampling, n=30 1 Semi-structured interview	Findings showed the influences on the nurses' and midwives' work decisions to be involved in treating Ebola-related to family, professionalism, god, safety, institutional and government influences and community stigmatisation. # No discussion regarding the attributes of professionalism.	100
24	Konukbay et al., 2014 Turkey	Determination of professional behaviours of nurses working in an educational and research hospital	This research article aim was to undertake a comprehensive assessment of the professional behaviour of nurses.	Article- Quantitative cross-sectional and descriptive Convenience sample n= 115 1.The Behaviour Inventory for Professionalism in nursing (BIPN) survey (Miller, Adams & Beck, 1993)	Findings determined the nurses in the study had low scores for professional behaviour. An increase in the level of education was identified as the most important feature affecting the level of professionalism in nursing. #The study identified professional behaviours using the BIPN. They examined: "education, publishing, research, participation in occupational organisations, community service, qualification and continuing education, nursing codes, theory, autonomy" (Konukbay et al. p. 634).	75
25	Makeda, 2010 California, USA	The degree of professionalism among actively practicing registered nurses in South Texas	This thesis aimed to determine methods to understand the level of practicing registered nurses in South Texas. Professionalism.	Thesis- Trident (TUI) University - Quantitative exploratory study descriptive statistics Convenience sample n=244 1 Use of a revised Halls Professionalism Scale (HPI) (1968) revised by Snizek (1972) and Schack & Helper (1979)	Findings elucidated that by targeting measurable professional behaviours, professionalism can be improved throughout the career of the RN. The initial qualification forms the basis, and then nurses are "re-socialised" throughout their career. # RN professional behaviours examined using a revised HPI examining: "use of the professional organisation as a major referent, belief in service to the public, belief in self-regulation, sense of	100

					calling to the field, autonomy, belief in continuing competence" (Snizek, 1972, p. 241).	
26	Malizia, 2000 Buffalo, USA	Professional socialisation of the registered nurse returning for a baccalaureate degree	This thesis aimed to determine differences between professional socialisation entrance and completion scores of RNs.	Thesis- State University of New York at Buffalo- Quantitative cross-sectional research design Convenience sample n=148 1 Nursing Activity Scale (NAS) (Schutzenhofer, 1987).	Findings determined that for a returning RN (RRN), a degree has a positive influence on their professional growth. RRNs found to have the highest levels of professionalism. #The NAS only measured autonomy as a factor of professionalism. The researchers examined professional behaviours through their own questionnaire items: a member of a professional organisation, read professional journals, attend continuing education programs, professional certification.	100
27	Manias et al., 2003 Australia	Agency-nursing work: Perceptions and experiences of agency nurses	This research article aim was the examination of the professional relationships of the self-employed agency nurse.	Article- Qualitative research design Purposive sampling, Stratified sampling technique n=10 1Semi-structured interviews	Findings were that agency nurses chose this mode of work as it offers flexibility. Agency nurses reported a commitment to professionalism which within the article focuses on education and professionalism. # The theme of professionalism contained the sub-themes of career development, educational provision by the agency, hospital; individual responsibility to address educational needs; and enhancement of clinical skills. Attributes not identified.	100
28	Mrayyan, 2008 Zarqa, Jordan	Predictors of hospitals' organisational climates and nurses' intent to stay in Jordanian hospitals	This research article aim was to examine nurses' intent to stay and hospitals' organisational climates.	Article- Quantitative descriptive design Convenience sampling n=362 1 Farly's Nursing Practice Environment Scale (NPES) (Farly & Nyberg, 1990); 2 McCain's Behavioural Commitment Scale (McCloskey, 1990)	Findings showed the main influences on nurses' intent to stay, and hospitals' organisational climate was quality of care and professionalism. # Professionalism as it related to the items included in Farly's Nursing Practice Environment Scale (1990), consisting of a supportive environment; accountable; autonomy; image; research.	100
29	Nahigian, 2003 New York, USA	Factors associated with the advocacy decisions of registered professional nurses employed as staff nurses in inpatient adult care hospitals	This thesis aimed to explore the personal characteristics, organisational and advocacy role of nurses.	Thesis- State University of New York at Buffalo- Quantitative exploratory, correlational and descriptive study. Convenience sample n=300 1 Cho's (1996, 1997b) Conceptual Structure for Client Advocacy; 2 Weiss and Schank's (2000) Nursing Professional Values Scale (NPVS)	Findings determined the RNs level of professionalism; management type and advocacy types are connected. # This study described professional values: caregiving, activism, accountability, integrity, trust, freedom, safety and knowledge and found in the Nursing Professional Values Scale (NPVS) (Weiss & Schank, 2000).	100
30	Nuttall, 2010 New Mexico, USA	A comparative study evaluating the impact of participation in a VALOR nurse externship on job satisfaction, sense of belonging, role socialisation and sense of professionalism: Transitions from graduate to registered nurse	This thesis aimed to examine the effects of an externship program on two groups of RNs. The first group had completed the externship program the other group hadn't.	Thesis- University of New Mexico - Quantitative quasi-experimental non-equivalent comparison group study Convenience sample n=662 Cantrell survey tool comprising of four instruments was used in this study. 1 Nursing Activity Scale (Schutzenhofer, 1987); 2 The Nurse Self-Description Form (NSDF)(Taylor et al., 1961); 3 The Sense of Belonging (SOB)(Hagerty & Patusky,1995); 4 McCloskey/Mueller Satisfaction Scale (MMS) (Mueller & McCloskey, 1990);	Findings highlighted an externship is not an essential element of new graduate nurse transition. # This study described the professional behaviours of autonomy, delegation skills, joining a professional organisation and further education.	100

31	Lúanaigh, 2011 UK	Becoming a professional: What is the influence of registered nurses on nursing students' learning in the clinical environment?	This thesis aimed to understand how registered nurses influence the learning of nursing students in the clinical environment.	Thesis- The Open University Qualitative, Yin's (2009) case study approach Purposive sample n=5 1 Semi-structured interview and focus groups	Findings determined that nursing students learn through being active participants, constructing and managing their learning with the aim of becoming an RN. # Professional values described as "caring, confidentiality, maintaining professional boundaries, honesty and trustworthiness" p.147.	100
32	Porr et al., 2014 Newfoundland, Canada	Patient perception of contemporary nurse attire: A pilot study	This research article aim was to determine patient preferences of nurses' uniform style, colour and pattern and if this was linked to the nurses' professional image. A second aim was to see if this was age or gender-related.	Article- Quantitative Purposive sampling n=43 patients 1 Used a Modified Nurse Image Scale (MNIS) co-developed by Albert et al., 2008)	Findings found patients preferred the solid white pantsuit than either coloured or patterned uniforms. The white pantsuit was linked to higher levels of professionalism. # This study purports that professionalism is conveyed by the appearance of the nurse with a uniform as a major factor. They were describing that a nurse is viewed as "confident, competent, attentive, efficient, approachable, caring, professional, reliable, cooperative, and empathetic" dependent on their appearance p.154.	100
33	Shepard, 2009 Minnesota, USA	Examining the effectiveness of a preceptorship on clinical competence for senior nursing students in a baccalaureate program	This thesis aimed to evaluate nursing students' perception of a program of preceptorship for nursing students.	Thesis- Walden University A sequential explanatory mixed-methods study Purposive sampling n=34 Focus group n=9 1 Preceptorship Effectiveness Questionnaire: Student Perceptions (PEQ-SP) [study specific]. 2 Focus groups with semi-structured interviews	Findings showed students found their professionalism, communication and clinical skills were improved by interactions with experienced preceptors. The preceptor's role model and discuss professional patient care with students on placement. # Professionalism components consisted of teamwork, trust, work ethics, being accountable, respect, being self-directed in learning.	100
34	Wall, 2011 Alberta, Canada	Self-employment in nursing: Precariousness, professionalism, and possibilities in non-traditional nursing work	This thesis aimed to understand the influences on nurses' working lives. A second aim was to develop a related conceptual framework.	Thesis- University of Alberta -Qualitative Ethnography Purposive sampling n=21 1 Semi-structured interview 2 Participant observation 3 Document analysis.	Findings determined that self-employed nurses demonstrate professional ethics and nursing knowledge when working across a range of "autonomous practice settings" (p.220). # Discuss professionalism as a values system; the importance of autonomy, knowledge, and professional ethics described as caring, nurturing, communication, collaboration, patient/client empowerment, respect, and trust.	100
35	Wang et al., 2019 Sichuan, China	Social media usage and online professionalism among registered nurses: A cross-sectional survey	This research article aimed to understand nurses' use of social media and online professionalism.	Article- Quantitative cross-sectional descriptive survey Convenience sampling n=658 1 Researcher designed questionnaire [specific to study]	Findings determined that Chinese nurses' online professionalism is a challenge with exposure of confidential patient information relatively common. # Professionalism discussed as professional boundaries, confidentiality and privacy.	75
36	Wheeler, 2017 Pennsylvania, USA	Registered nurses' experience with professional courage	This thesis aimed to increase the knowledge of professional courage. A second aim was to understand the barriers to nurses demonstrating professional courage.	Thesis- Widener University A qualitative interpretive naturalistic approach Purposive sampling n=10 1 Semi-structured interview	Findings discussed professional courage as relating to decisions made by nurses. The importance of mentorship, supportive organisational workplaces were identified. The characteristics were denoted as "knowledge, advocacy, confidence, autonomy, working relationships, commitment to the profession, ethical principles, and mentorship" (p.123).	100

					# The descriptors of professionalism included teamwork, responsibility, autonomy, advocacy, knowledge and skills, reflection, altruism, and ethical competency.	
37	William & Day, 2009 California, USA	Employer perceptions of knowledge, competency, and professionalism of baccalaureate nursing graduates from a problem-based program	This research article aim was following an educational program; to identify the perceptions of graduates' competence, knowledge, and professionalism by employers.	Article- Descriptive qualitative study Purposive sampling n=53 1 Focus groups n=10	Findings were that following a problem-based educational program, where graduates demonstrated behaviours which were considered professional, with developing leadership skills although in need of further practise with basic nursing skills and care. # No discussion regarding the attributes of professionalism.	100
38	Wocial et al. 2010 USA	Impact of paediatric nurses' uniforms on perceptions of nurse professionalism	This research article aim was to determine the impact of uniform styles and colour on patient and visitor's perception of professionalism.	Article- Quantitative prospective, comparative design Convenience sample of Paediatric patients n=138 and Adult visitors n=144 1 The nurse image scale for children (NISC), a 5-item scale adapted from Mangum and colleagues (1991) 2 A median modified nurse image scale (MNIS)	Findings showed that perceptions of professionalism are not related to uniform preferences from paediatric patients and visitors. # The study tools compared uniform with nurse image traits described in the literature (confident, competent, attentive, efficient, approachable, caring, professional, reliable, cooperative, empathic).	100
39	Wuerz, 2017 Minnesota, USA	The influence of leadership on nursing professionalism	This thesis explored nursing leadership and its influence on nursing professional behaviours.	Thesis- Walden University A qualitative descriptive, phenomenological study Purposive sampling n=8 1 Semi-structured interview	Findings illuminated a lack of professional identity; an inability to see the link between clinical practice and professionalism. # This study used Adams and Millers' (2001) nine professional behaviours to guide interview questions. Nurses described the characteristics as appearance or dress, interaction and communication with others, quality of patient care, being positive. Professional activity included "community service, continuing educational activities, professional organisation participation, autonomy, and research in practice" p.62.	100
40	Wyund, 2003 Ohio, USA	Current factors contributing to professionalism in nursing	This research article aim was to determine attitudes toward professionalism using Halls Professionalism inventory scale.	Article- Quantitative descriptive comparative/correlational design Descriptive statistics Convenience sampling n=774 1 Hall's Professionalism Inventory (HPI) scale (1968)	Findings determined that professionalism was positively related to the attitudes represented by the HPI. # A professionalism discussion, examining the attitudinal attributes of the HPI of self-regulation, sense of calling, sense of autonomy and professional organisation as a major referent.	100
41	Wyund & Gotshall, 2000 USA	Knowledge attainment, perceptions, and professionalism in participants completing the didactic phase of an army reserve critical care nursing residency program	This research article examined professionalism and increase in knowledge from attendance at an army reserve critical care course.	Article- Quantitative, a quasi-experimental repeated-measures design Convenience sample n=57; control n=30; experimental n=27 1 Basic Knowledge attainment in critical care BKAT-4 (Toth & Ritchey, 1984) 2 Perceptions of Critical Care Nursing Questionnaire PCCNQ (Oermann, 1992) 3 Hall's Professionalism Inventory (HPI) (1968)	Findings determined there was an increase in knowledge. However, on entry and exit professionalism scores were found to be high. # A professionalism discussion of the attitudinal attributes of the HPI of belief in self-regulation, commitment to the profession beyond that of financial incentive - a sense of calling, autonomy and professional organisation as a major referent.	100

42	Zibrik, 2019 British Columbia, Canada	Rural acute care nursing in British Columbia and Alberta: An interpretive description of professionalism	This thesis aimed to develop an understanding and definition of the nature of rural and remote nursing practice in Canada	Thesis- University of British Columbia, qualitative interpretive descriptive method Purposive sampling n=8 1 Descriptive interpretation of narratives taken from a larger study	Findings determined a positive relationship between how nurses experience professionalism and job satisfaction. # The study explained there was little said about professionalism in the interviews. Thus, the discussion was on the indicators of teamwork, continuing education, collaboration, communication and adequate resources are present for professionalism to occur.	100

Results

The 42 international review papers spanned 11 countries. Of the 42 reviewed papers, professionalism was the main focus of 13 papers' research. Of those 13 papers, nine discussed professionalism from the perspective of their survey tools. There were 24 different instruments and scales used within the papers of the review, some papers using up to four different instruments in the one study. It was found the methodology and discussion used within the review papers related strongly to the survey tool used.

Within the review papers, professionalism was used in either the title or the abstract thereby meeting the criteria for inclusion; however, in many papers, the professionalism was not a significant part of the discussion of the study. One example is the study by Cantrell et al. (2005) of a transition program for new nurses in a Magnet hospital. From the results of the study, it was difficult to understand how the significant findings related to professionalism. Although the authors stated that there were significant differences in the findings for professionalism and role socialisation, the authors had not clearly defined professionalism and did not discuss outcomes based on demonstrating professionalism (Cantrell et al., 2005).

A similar example was a study of a new registered nurses' transition program by Dyess and Parker (2012). Despite stating that the program resulted in positive outcomes of professionalism, skills, leadership and patient care, the authors had not defined or discussed what was meant by professionalism. Professionalism was only listed in the paper as part of the lecture and program content. A paper where further elucidation would have been beneficial was that by Abraham (2011) when discussing the results of a work-based leadership program at the Mayo Clinic on the relationship between professionalism and leadership, as there was no description given of what it meant to be professional. Nevertheless, the study results showed that undertaking the course led to a change in leadership skills, increased professional activities, leadership promotion, and retention rates

of participants, which promoted professionalism. Some studies use the term "professionalism" as almost a "throwaway line", almost as if it provides credibility and value to various programs and studies. However, there was little discussion of, and no consensus on, what professionalism means, nor how the registered nurse portrays it. Examination of the review papers resulted in the consolidation of the information into three broad themes of – the language of professionalism; the influence of education; and the work environment.

Theme One The language of professionalism

This theme examined the language of professionalism, as used within the review papers. Due to the different terminology when discussing professionalism, this theme was felt to be important to demonstrate the difficulty for the registered nurse to understand what is meant by professionalism.

Nursing research has investigated the concept of professionalism since the 1960s, yet Hausner (2002) purports that the vernacular of the word "professional" is still not indicative of the full meaning of professionalism. Instead, as Keeling and Templeman (2012, p. 18) outline, "professionalism" remains a generic and nebulous term used by several professions. Jackson (2017, p. 290) claimed that "…professionalism is not one thing, it will mean different things to different people, at different times and in different contexts". Jackson's position is evident in the diverse descriptions of professionalism within the papers reviewed.". It is evident from the review papers, there is a paucity of recent definitions and terminology concerning nursing professionalism formulated within the last ten years. Many of the papers within the review use definitions from other healthcare disciplines when explaining the concept of professionalism (Abalihi, 2019; Adams, 2011; Hausner, 2002; Jackson, 2017; Makeda, 2010; Wuerz, 2017).

The lack of clear guidance and direction on professionalism has resulted in difficulty for those new to the profession in understanding the concept, and understanding what is

required to demonstrate the required professional behaviours (Abalihi, 2019; Bimray et al., 2019). Student nurses explained that they received mixed messages regarding what it meant to be professional and felt it was important that registered nurses role model professional behaviours to undergraduate students in the hospital setting via roles as formal or informal mentors and preceptors (Abalihi, 2019; Carlson et al., 2010; Jackson, 2017; Lúanaigh, 2011; Shepard, 2009).

A lack of consensus prevails in defining professionalism, or the use of standard descriptors. The descriptors of "characteristic" and "attribute" appeared to be applied interchangeably in the review papers, but the reason for the choice of terminology within the studies was not provided. Adams based his discussion of the characteristics of professionalism on the ANA Code of Ethics (2001) as "advocacy, compassion and respect, commitment to the patient, responsibility and accountability, higher education, knowledge development and collaboration" (Adams, 2011, p. 146). Four studies within the review used Miller's Wheel of Professionalism (1988) or its associated survey instrument of the Behaviour Inventory for Professionalism in Nursing (BIPN) (Miller, Adams & Beck, 1993) which defined the descriptors of professionalism as characteristics. The nine BIPN characteristics of the registered nurses were listed as "educational background, adherence to the code of nurses, participation in the professional organisation, continuing education and competency, communication and publication, autonomy and self-regulation, community service, publication and communication, theory use, development, evaluation and research involvement" (Miller, Adams & Beck, 1993, p. 291). The BIPN appeared in some studies (Frenn, 2007; Konukbay et al., 2014; Miller, Adams & Beck, 1993). Those studies using this survey tool described their findings in relation to the items from the instrument or model. The studies by Abalihi (2019) and Wuerz (2017) used Miller's Wheel of Professionalism model (Adams & Miller, 2001; Miller, 1988), to describe their findings. However, Abalihi's 2019

study used the descriptor “attributes” when describing professionalism which embodies the confusion with terminology.

The six review papers which used Hall’s (1968) Professional Inventory (HPI) scale used the descriptor of attitudinal attributes (Cohen & Kol, 2004; Hausner, 2002; Kim-Godwin et al., 2010; Makeda, 2010; Wyund, 2003; Wynd & Gotshall, 2000). The HPI (Hall, 1968, p. 93) outlined the five attitudinal attributes of professionalism as “use of professional organisations as major referents, belief in public service, self-regulation, a sense of calling to the field, and a sense of autonomy”. Therefore, the studies using this survey tool described professionalism from the perspective of the items in the scale.

Three studies which utilised the term attributes of professionalism focused on the attribute of appearance. It was purported by Porr et al. (2014, p. 2) that “not unlike that of other professionals (e.g. airline pilots), the registered nurse’s professional attire should signify professional membership, project competence, and offer a sense of safety, security and assurance that one is in good hands”. The three studies examined uniform colour, uniform style and the relation of appearance to professionalism through the use of their survey tool (Albert et al., 2008; Porr et al., 2014; Wocial et al., 2010).

Zibrik (2019, p. 20) examined how rural nurses in Ontario experienced professionalism and how professional practice utilised the descriptors of attributes from the Registered Nurses Association of Ontario (RNAO) project of “knowledge, a spirit of inquiry, accountability, autonomy, advocacy, innovation and visionary, collegiality and collaboration, ethics and values”. Zibrik noted that “definitions of professionalism and the corresponding elements of professional practice are a collection of characteristics which can vary from study to study” (2019, p. 109). The importance of educational programs to professionalism is further discussed within the following theme on the influence of education on professionalism.

Summary of the language of professionalism

The use of terminology between these main groups of studies using attitudes, attributes or characteristics is confusing. Both Adams, Miller, and Beck (1993) and Hall (1968) use the descriptors of autonomy, self-regulation, public or community service as the necessary elements of professionalism. Yet, one describes them as attitudes of professionalism while the other, as the characteristics of professionalism. This highlights the confusion regarding the terminology. Professionalism has been described as a nebulous term meaning different things to different people. However, this lack of a definitive understanding of the meaning is confusing to those new to the profession. The profession needs clarity of this concept to provide a functional perspective for the registered nurse to understand how to demonstrate the attributes of professionalism. Consideration by future authors and researchers by explaining the reason for that choice of terminology will assist in reducing confusion. The next theme identified from the review papers was that of the influence of education on professionalism.

Theme Two The influence of education on professionalism

This theme discusses the influence of education on professionalism. The discussion is extended to include how experience influences professionalism then examines the discussion within the review papers on orientation and graduate programs.

Education is an integral part of the development of professionalism and the understanding and demonstration of appropriate professional behaviours in the clinical area for undergraduate and baccalaureate nursing students in the reviewed papers (Abalihi, 2019; Birks et al., 2010). The papers reviewed indicated that baccalaureate-prepared registered nurses demonstrated higher levels of professionalism and related professional behaviours than a registered nurse with a lesser qualification (Abalihi, 2019; Birks et al., 2010). However, there is a lack of research considering if the additional time is taken in an

educational environment, or the level of content delivered in further education, are responsible (Abalihi, 2019).

Interestingly, Malizia (2000), Wynd and Gotshall (2000) and Wuerz (2017) found that if a registered nurse working in a clinical area already demonstrates a high level of professionalism on the entrance to a course of further education, then the research showed there was no further increase. Wall (2011) and Manias et al. (2003) purported that professionalism was enhanced through career development, educational provision and the nurse's responsibility to meet educational and clinical skill requirements.

Education takes different forms, not relating only to lectures and workshops, with "on the job" education provided through role modelling and mentoring by more experienced staff members. Shepard (2009) explained that role modelling by registered nurses helped student nurses develop the professional behaviours of self-direction, a positive work ethic, and punctuality. Through the demonstration of ethical awareness in decision-making when dealing with difficult situations, students were assisted in planning their responses when confronted with similar situations in future clinical practice (Carlson et al., 2010; Hunter & Cook, 2018). Thus, registered nurses were described as good role models to demonstrate professional behaviour when dealing with difficult patient-nurse situations. Ward-based education through workshops, courses and role modelling has been found to be beneficial in improving the professionalism of the registered nurse.

Ward-based orientation, transition or graduate programs generally fulfil the education of new graduates or nurses new to ward areas. The nomenclature associated with these programs is dependent on the country; in Australia, these programs are known as graduate programs, while in the United States, they are orientation or transition programs. These programs have the additional benefit to that of the role socialisation of new graduates, as they also develop their sense of belonging and encourage and support professionalism which also

results in job satisfaction (Cantrell et al., 2005; Dyess & Parker, 2012; Nuttall, 2010;). In supporting new graduates, the allocation of a mentor with high levels of experience and professionalism is beneficial. They educate the new graduate on the organisational systems and processes and advise on what is the expected level of professional behaviour with patients, colleagues and the public, as well as to orient new nurses to the hospital environment and assist them to feel part of the organisation (Cantrell et al., 2005; Dyess & Parker, 2012; Kim-Godwin et al., 2010; Nuttall, 2010).

The importance of education and experience in increasing registered nurse professionalism was demonstrated in several studies within the review (Hausner, 2002; Kim-Godwin et al., 2010; Wyund, 2003). Interestingly, Makeda (2010) found that targeting measurable professional behaviours throughout a nurse's career can result in improved professionalism, as registered nurses of all educational levels and ages are continually re-socialised throughout their career.

Studies (Hausner, 2002; Hedenskog et al., 2017; Kim-Godwin et al., 2010; Wyund, 2003) found higher levels of professionalism and empowerment were related to a higher number of years of experience as a registered nurse and the attainment of a higher qualification with continuing education found to increase both nursing competence and professionalism. A study by Frenn (2007) determined that nurses who self-evaluated their professional competence demonstrated higher levels of professionalism. However, the researcher discussed that little research had been undertaken in the area of the self-evaluation of professional competence by nurses. The ability to self-evaluate is based on the nurse's level of accountability and integrity as it is reliant on the nurse's honesty or professionalism in accurate reporting.

Summary of the influence of education

The papers in the review demonstrated that education is integral in the development of professionalism and the understanding and demonstration of appropriate professional behaviours in the clinical area. Professionalism education is varied in its delivery, through the formal education of university or workplace courses, the role modelling of exemplary staff, or through the attainment of experience across years of clinical practice. All of these may lead to an increase in the level of registered nurse professionalism in the work environment. Interestingly, within the review papers, there were no studies which investigated the comparison of workplace education versus university-based education in improving professionalism levels. Instead, studies measure one or the other environment and its effect on professionalism; this may be an area for future research.

Theme Three The work environment

This theme contained papers which discussed the issues of location and type of work environment, autonomy in decision-making and power, teamwork and professional behaviours in the workplace. The first of these areas to be discussed is that of registered nurse professionalism within the different work environments.

Within the reviewed papers, the work environments discussed in relation to the professionalism of the registered nurse were varied in their locations and type. The different environments raised different perspectives of professionalism as relatable to that particular work environment. Wang et al. (2019) discussed the online professionalism of both nursing students and nurses, which is an area of concern to professionalism. Their study found patient privacy and confidentiality violations, inappropriate posts and excessive self-disclosure as examples of areas of concern with professionalism online (Wang et al., 2019).

In the work environment in rural and remote Canada, nurses live and work with their community members; therefore, their professionalism is judged through their work and

actions when both on and off duty (Zibrik, 2019). A further paper in which nurses were judged by their community was that by Kollie (2016). The study explained that participants chose to be part of the unit treating Ebola patients, despite their safety concerns, due to their sympathy for dying people, an obligation to their professional oath, public appreciation and spiritual duty. Despite their sense of professional obligation, they suffered professional role strain. The nurses believed that if they chose not to work in the Ebola unit, their future role as a registered nurse would be negatively impacted as they would be seen by others as not meeting their professional duty. Despite working in an environment where their safety was at risk, the nurses did not identify that they were courageous in undertaking their work in the unit. A quote by Bloomer and O'Connor (2012) applies to the Kollie (2016, p. 28) study, saying that nurses maintain their values and emotions in traumatic times by "maintaining their professionalism and stoicism". The work environment can be seen to impact on the professionalism of registered nurses in different ways, as highlighted by Zibrik (2019) and Kollie (2016). This is also applicable to the demonstration of the registered nurse's autonomy in different work environments.

Registered nurses need to demonstrate autonomy in decision-making to enable quality care delivery; the work environment may constrain the ability and level of decision-making. Autonomous decision-making requires registered nurses to have the ability, knowledge base, and confidence in decision-making; plus the authority to determine clinical judgements in patient care (Diede, 2018; Wall, 2011; Wheeler, 2017; Wuerz, 2017; Zibrik, 2019). Wheeler (2017, p. 115) noted that the autonomy of the decision-making of the registered nurse increased saying, "as self-efficacy increases, perceived risk decreases, and courageous actions prevail".

Wall (2011) and Zibrik (2019) described that nurses within their studies felt their unique work environment required them to demonstrate autonomy based on their advanced

knowledge and skills as practitioners. Juxtaposed is the proposition by Adams (2011, p. 9) who tendered that respect and professional autonomy within the profession of nursing remains indistinguishable compared with that of other healthcare professions, with registered nurses having "little or no voice of expert authority". Diede (2018, p. 65) described the nurses' lack of power explaining that at times nurses in the work environment felt ignored, "…voiceless and dehumanised". Diede asserted "when nurses perceived themselves as empowered, they had the potential to affect change and improve patient outcomes" (2018, p. 72). The work environment influences the autonomy to practice with higher levels of autonomy required in the rural and remote context (Zibrik, 2019) as opposed to some ward areas in acute care hospitals (Diede, 2018). A further aspect discussed concerning the work environment is that of teamwork.

Within the review papers, teamwork, although complex in nature, allowed nurses to collaborate on patient care, with improved outcomes. Diede (2018) and Nahigian (2003) discussed that registered nurses, through their insightful and unique relationships with each patient, advocate for their patients with the healthcare team. The importance of collaboration, teamwork and communication were discussed by Zibrik (2019) and Elayan and Ahmad (2017). The importance of collaboration and teamwork in nursing was discussed in many of the review papers (Abraham, 2011; Birks et al., 2010; Diede, 2018; Elayan & Ahmad, 2017; Frenn, 2007; Goff, 2018; Hickson, 2012; Hunter & Cook, 2018; Jackson, 2017; Makeda, 2010; Mrayaan, 2008; Nahigian, 2003; Shepard, 2009). Juxtaposed to these positive discussions regarding teamwork, Hunter and Cook (2018) described graduates finding teamwork difficult, complicated by team members not always demonstrating collegial behaviours.

Professional behaviours are demonstrated by registered nurses and their colleagues in meeting the requirements of the codes and standards of the profession in the work

environment (Goff, 2018; Hickson, 2012). However, Hickson (2012, p. 131) stated "it is unsettling that overall, new nurses who participated [in the study], reported significantly low levels of professional comfort, confidence, and support. These attributes of professionalism, necessary for new nurses to succeed, are clearly lacking". This is supported by Goff (2018) who reported that, due to horizontal violence and bullying in the work environment, registered nurses reported that they experienced difficulty in meeting the professionalism characteristics outlined in Miller's (1988) Wheel of Professionalism.

A relatively new area of concern regarding unprofessional behaviour was that of the online environment frequented by both student nurses and registered nurses alike. Wang et al. (2019) found the unprofessional behaviours of the study participants consisted of patient privacy and confidentiality violations, excessive self-disclosure and inappropriate posts. The online environment is identified as a potential area of concern to professionalism.

To address these unprofessional behaviours in the work environment, Hickson (2012) stated that emphasis should be given to orientation programs, collaborative academic and industry partnerships and zero tolerance for poor behaviours to address nursing hostility issues. Nursing practice standards and codes promote positive professional behaviours and assist in the promotion of professionalism in the workplace (Hunter & Cook, 2018; William & Day, 2009). Goff (2018, p. 7) described that within their study when the new registered nurse was asked the meaning of professionalism, they replied, "professionalism means respect, to communicate and respect me as an equal".

Summary of the work environment

In summation, studies within this theme had wide and varied foci without necessarily examining professionalism as the focus. Generally, professionalism formed one element of a more extensive discussion of the topic of interest. The review papers in this theme discussed

the different type and location of the work environment, the issues of autonomy and power which affected the registered nurse, teamwork and professional behaviours in the workplace.

Results summary

There were three themes identified in the broad review of the literature which identified professionalism as part of its title or abstract. The first theme of the language of professionalism discussed the descriptors of professionalism, together with the use of the term professionalism within the reviewed papers. The second theme discussed the influence of education on professionalism. The theme discussed the effects of university education, work-based education, orientation programs, and experience on professionalism. The third theme of the work environment discussed the different locations and type of the work environment, the issues of autonomy and power, teamwork and professional behaviours in the workplace.

Strengths and limitations

Strengths

The strength of this narrative review was the use of the Kable et al. (2012) twelve-step structured search guideline, which ensured a logical search sequence, with rigour and transparency of the search method. The critical appraisal of the literature utilising the MMAT system resulted in a compilation of methodologically-sound research regarding clinical nurse leaders' views of professionalism.

Limitations

The choice of "registered nurse" as a search term may have reduced the number of review papers when compared to the use of the term "nurse"; however, it allowed for a detailed and precise review of the current literature as it relates to the focus of this current study. The selection criteria excluded other healthcare professionals, including midwives and non-healthcare occupations; limiting the research to the focused area of interest meant that

studies were not considered where they did not discuss registered nurses and professionalism within their abstract. Review of the 42 papers revealed that the use of the various instruments or tools to survey participants resulted in a focused, narrow discussion of professionalism as it related only to those attributes identified from the instruments.

Conclusion

This literature review has identified three gaps in the registered nurse professionalism literature: "the who, the what and the how". This first gap incorporates the "who" of the research, and this refers to undertaking original research which asked for the current view of registered nurses as opposed to consolidating information through the use of survey tools. The first gap in the research literature is that research did not question nurses "at the coalface". The second gap, or "the what", is asking what nurses in the clinical setting consider to be the attributes of registered nurse professionalism. There is a paucity of research which determines the attributes of professionalism by nurses, about nurses. The third gap is that of "the how" referring to the method of research. Primary research using narrative inquiry to understand the stories of nurse leaders has not been used.

Studies within the review had a wide and varied focus without examining professionalism as the primary focus. Rather professionalism was discussed as an umbrella term for a variety of topics. However, some studies would have been considered as important, and ground-breaking research in their time. Given that the survey instruments used in many of the studies are more than 25 years old, they may not be reflective of the current view of the professionalism of the registered nurse. This review demonstrates that research in this area is well overdue.

Chapter to follow

The following chapter discusses narrative inquiry as an appropriate and innovative methodology for examining nurse leaders' perceptions of professionalism in the clinical

setting. The chapter to follow discusses constructivism, narrative inquiry and its relationship with language and stories, together with the trustworthiness of the research.

Chapter Three: Methodology

Introduction

In the previous chapter, the literature related to nursing professionalism was reviewed. There is a paucity of research that examines the views of nurse leaders on registered nurses' professionalism, despite a direct relationship between professional behaviours and staff morale in the workplace (Hwang et al., 2009). When this relationship exists, it also extends to positive patient outcomes (Pugh, 2011).

The research paradigm chosen for this research is constructivism and encompasses the qualitative research methodology, narrative inquiry, which provides the basis for understanding the professionalism in nursing concept. The following section explains constructivism and justifies its use in this study. Narrative inquiry methodology is then explained as to how narrative inquiry fitted well with the aim of this research.

Constructivism

The determination of the appropriate research paradigm to be used is dependent on the research question and the researcher's ontological and epistemological viewpoints. The ontological assumption of "what is reality" (Crotty, 1998) and the epistemological assumption of "how knowledge is created and utilised" (Crotty, 1998; Guba & Lincoln, 1994; Morse, 1991a) also assists the researcher to choose the appropriate methodology and methods suitable to meet the needs of the inquiry (Cohen et al., 2007; Crotty, 1998).

The interpretive and constructionist paradigms take the ontological view of relativism that each person will view reality differently, and that reality is subjective (Guba & Lincoln, 1994; Scotland, 2012). The epistemological view is based on "real-world phenomena", which also is subjective where meaning is "constructed through the interaction between consciousness and the world" (Scotland, 2012, p. 11). The relevance of the interpretive and constructivist paradigms to the question of nursing professionalism stems from the need to

understand the phenomena from the participant's viewpoint, trying to understand the interactions between the individuals within their environment that forms their experiences (Creswell, 2009; Crotty, 1998). Constructivism emphasises that an individual's knowledge and understanding of the world are continuously being fabricated as they are dependent on the individual's values, the assimilation of their past and present experiences, and the historical and social context in which the phenomena is occurring (Bakhtin, 1986; Moen, 2006). This constructivist approach allows the underlying unseen forces and interplays present in the participant's social world to be identified by the researcher through the interaction with, and examination of, the participant's stories of their experiences (Cohen et al., 2007; Creswell, 2009).

An individual's social world is comprised of the interpretations and judgements of the behaviours and experiences of themselves and of others with whom they are interrelating. The personal and subjective nature of these social interpretations may sometimes result in a misinterpretation of another person's, or group's, behaviour, communication, or behaviour which does not conform to accepted "social norms". Constructivist methodology acknowledges that each individual perceives a situation differently, and values the individual's perception of that situation equally. An individual's perspective will continue to change through discussion with others and with the addition of further new experiences (Morse, 1991b). It is essential that the researcher in the interpretive paradigm be cognitive that every participant's perception/story/interpretation of reality was correct for them at the time of the research and represents their current view of their experiences at the time of research (Cohen & Crabtree, 2006; Guba & Lincoln, 1989). In the current study, for example, the nurse leaders describe the views they have of professionalism at the time of the interview, but this does not mean that at a later time their view will remain the same.

Ontologically, realities are "socially and experientially based, local and specific in nature" with an epistemology where the researcher and participant "literally create" the findings together through their interaction as the research goes on (Guba & Lincoln, 1994, p.111). Reality is, therefore, subjective, multilayered and complex (Cohen & Crabtree, 2006; Creswell, 2014; Guba & Lincoln, 1989; Laker, 2001). As members of a discipline, nurse leaders are likely to have formed, or constructed, their understanding of the meanings of professionalism through their interactions with, and observations of, others in social and work settings; thus, creating the reality through their experiences. Brooke (2013) asserts that epistemologically, interpretive research acknowledges human efforts to describe what something is, why it exists, and how something works as the active construction of meaning and a valid form of knowledge.

Understanding relates to the ideas, beliefs and experience of others and is dependent on the individual's expression, which provides meaningfulness to the listener. This meaningfulness is bestowed on expression by interpretation (Maclean, 1986; Polkinghorne, 1988). Crotty (1998, p. 8) explains interpretation and collective understanding in the following:

> A tree in the forest is a tree, regardless of whether anyone is aware of its existence or not. As an object of that kind, it carries the intrinsic meaning of treeness. When human beings recognize it as a tree, they are simply discovering a meaning that has been lying in wait for them all along.

Moreover, understanding is not without a history, nor is it an independent, ahistorical, human activity, rather it is an intermediate through which the world is interpreted and given meaning, thereby, providing a basis from which one can characterise self and others. Language provides the medium, through which the meaning and interpretation of the world are achieved. This world is shared, shaped and sustained through the mutual understanding of

language. The language "actively shapes and moulds reality" (Frowe, 2001, p.185) through interaction with the social environment (Scotland, 2012). Thus, understanding is linguistic, historical and ontological. The researcher and the nurse leader encounter professionalism as something within the nursing world and therefore has meaning because of the collective experience of being a nurse.

The *hermeneutical circle*, whereby the concept of the whole can be understood by the parts that make up the whole and vice versa (Crotty, 1998), can be used to describe the relationship between the researcher and the participants of a study. In the current study, the hermeneutical circle implies that for nurse professionalism to be understood those concerned with experiencing the phenomena must have a pre-understanding of the concept to understand the phenomenon. Odman (1988) explains this understanding as a history; thus, to understand professionalism, one must have experienced the phenomenon and examined and reflected on the phenomenon to bring understanding to its meaning. Interpretation, therefore, is never an assumption, nor is the capturing of something as presented to the researcher, instead, it is founded on what the researcher already knows and their experiences of it (Maclean, 1986). This point is highlighted by Crotty's (1998, p. 43) tree analogy which states "We need to remind ourselves here that it is human beings who have constructed it as a tree, given it the name, and attributed to it the associations we make with trees".

Interpretation places in the open that which is already understood (Heidegger, 1977). Thus, the construct of nurse professionalism results from the dialectical relationship of the researcher and the participants (Guba & Lincoln, 1994). That is, the researcher's and nurse leaders' beliefs of the professionalism construct as one informs the other and vice versa. Neither the words of the nurse leaders nor the subjective intentions will result in meaning and understanding; rather, it is through the use of language that the meaning is imparted.

The constructivist approach is suitable for exploring how the professionalism of the registered nurse from the perspective of nurse leaders is both interpreted and situated within the clinical and historical context.

Narrative inquiry

This study used narrative inquiry to interrogate both the language and stories provided by participants to gain an understanding of how they view their world and their meanings which correspond to their understandings to better articulate and understand nurse leaders' views of registered nurses' professionalism. Narrative inquiry emphasises everyday interactions between people and their use of language, and as all experience is rooted in a historical moment, it is also firmly embedded in the local culture (Andrews, 2012; Creswell, 2013). Narrative inquiry lends itself to research that explores the experience of people giving new and deeper insight into the complexity of their experiences; in this case, of registered nurse professionalism.

Narrative inquiry emanated from a number of disciplines, those of medicine, cultural studies, literature, psychology, sociology, and more recently, nursing (Mishler, 1995; Riessman, 1993). Clandinin contends that the researcher using narrative as a form of research must recognise and "embrace the interactive quality of the researcher-researched relationship; primarily use stories as data and analysis; understand the way in which what we [sic] know is embedded in a particular context and finally, that narrative knowing is essential to inquiry" (2007, p. 7).

Connelly and Clandinin (1990, p. 2) point out it is acceptable to say, "inquiry into narrative" as it is "narrative inquiry". That is, narrative is both phenomenon and method. Clandinin and Connelly (2000, p. 20) define narrative inquiry as:

> … a way of understanding experience. It is a collaboration between researcher and participants, over time, in a place or series of places, and in social interaction with milieus. An inquirer enters this matrix in the midst and progresses in the same spirit, concluding the inquiry still in the midst of living and telling, reliving and retelling, the stories of the experiences that made-up people's lives, both individual and social.

Clandinin and Connelly (2000) assert that people construct their daily lives by the stories of who they and others are, and their understanding and interpretation of their lives is through these stories. In later work, this definition was expanded to incorporate the idiom that the understanding of experience is:

> … an exploration of the social, cultural and institutional narratives within which individual's experiences are constituted, shaped, expressed and enacted - but in a way that begins and ends that inquiry in the storied lives of the people involved. Narrative inquirers study an individual's experience in the world and, through the study, seek ways of enriching and transforming that experience for themselves and others (Clandinin & Rosiek, 2006, p. 42).

Narrative inquiry is grounded in interpretive hermeneutics and phenomenology. It aims to gather the meanings that people ascribe to their experience by focusing on how stories are constructed, for whom and how. Narrative inquiry may use the verbal or written accounts of individuals to tell a story (Andrews, 2012) and the process of narration includes past actions and how individuals understand and make meaning of those actions. This narrative space has three dimensions which are clearly described by Clandinin (2006, p. 45) as:

> The three dimensions of the metaphoric narrative inquiry space are: the personal and social (interaction) along one dimension; past, present, and future (continuity) along a second dimension; place (situation) along a third dimension.

Clandinin and Connelly (2000, p. 59) provide further insight into narrative inquiry with the following:

> … using this set of terms, any particular inquiry is defined by this three-dimensional space: studies have temporal dimensions and address temporal matters: they focus on the personal and the social in a balance appropriate to the inquiry: and they occur in specific places or sequences of places.

In summary, narrative inquiry has three components to be considered when used as a methodology: sociality, which consists of the participant and their environment together forming the social conditions related to that particular context; temporality relating to the experience of the participant with a past, present and future as the context; and finally the physical location of where the experiences occurred in that particular story.

In narrative inquiry, temporality and inquiry do not remain static; instead, it is a moving feast of information and experiences, changing each second, meaning it is a process in constant transition (Clandinin, 2013; Clandinin, Pushor & Orr, 2007). Thus, the researcher needs to consider that when nurse leaders recounted their stories of professionalism, their understanding of professionalism was couched in a particular historical timeframe, within a set of social circumstances in which the experiences of the story occurred and is therefore meaningful to that individual or group of people within that context (Clandinin, 2013). The story may be of a specific event or experience, which involved one person, or many, a person's life history or a specific aspect of one's life such as work, marriage, or a significant health issue (Clandinin, 2007; Denzin & Lincoln, 2005). This storytelling method relies on

the verbal and written expressions of meaning, with these expressions providing the "window into the internal life of the person" (Denzin, 1989, p. 14).

Language

A story is told using language that is both familiar and idiomatic when describing an event that is recalled or reconstructed from memory (Clandinin, 2007). Language contains signs, symbols and metaphors that are understood within a sociocultural context. In language, signs and symbols are complex forms of representation and may have additional secondary meanings that need interpretation and understanding. Symbols may be culturally specific to a group of people with commonalities (Deakin, Crick & Grushka, 2009), such as nurse leaders. Furthermore, the words used in stories have prescribed meanings within that social and cultural context (McCormack, 2000). This means that to comprehend the nurse leaders' stories, the language and cultural contexts are required to be understood by the researcher and the understanding is representative and accurate of the meaning that was implied (Dibley, 2011). The researcher is a registered nurse who has an understanding of the social and cultural nursing environment in which the current study is situated. In the attempt to connect a participant's story to broader social meanings the researcher sets out to understand "the whole of the story, or text, from its detail, and the detail of a text from its whole – the hermeneutic circle" (Khaghaninejad, 2015, p. 92). Khaghaninejad (2015) claims this requires the text to be read and re-read, with an end reading of the text being unachievable

The challenges of language and the interpretive paradigm are highlighted by Khaghaninejad (2015, p. 92) who states "Language shows rather than tells. *Telling* concentrates on the idea of language as referential, *showing* concentrates on the idea of language as manifestation". Subsequently, the connection of participants' stories to broader social meaning involves the viewing of text as a means by which teller/participant and

listeners/reader/researcher share an effect not described in language but shown by a language. There is an interaction of the two voices, that of the participant and the researcher with meaning not fixed. Rather it is decentered, and reality becomes a play of language, where neither the voice of the participant nor the researcher is ever determined as correct or incorrect.

Viewing the text in this way recognises language to be social and institutional, acknowledging meaning as "a continual flickering, spilling and defusing of meaning" (Eagleton, 1983, p. 134). In the current study, this would mean that the ability to describe professionalism is dependent upon the individual's capacity to use language. Thus, attempts to understand the experience of nurse professionalism depends upon establishing a language which reflects not only a universal understanding of a singularly experienced phenomenon, but an understanding which contextualises, and validates, the behaviours of a nurse embodying professionalism. Being a nursing professional is subjectively and culturally derived, with divergent influences affecting how the experience is perceived and how it is articulated (Dibley, 2011).

Stories

A story is a narrative which creates, interprets and gives meaning to experience as it is being told (Behar-Horenstein, & Morgan, 1995; Denzin, 1989). Stories may be single or multi-episodic (Holmes & Marra, 2011) dependent on the context of the story and the rationale for the story. Coates (1996) describes a story as an account or anecdote which has a structure of a beginning, a middle and an end. Heggestad and Slettebo (2015, p. 2323) state that "…according to theories on life-story telling and identity, an individual constructs a version of their life through narration, stories tell one who they are". Stories unfold by connecting the past, present and future in their telling. This enables an understanding of life events and allows the potential for the reinterpretation of events for the teller.

The narrative is “a sequence of temporally ordered clauses used to recapitulate past experience” (Labov, 1972, p. 359). Through the examination of daily experiences, a narrative identifies similar core values of both the storyteller and the listener, which are then positioned with the broader social and cultural context (Dolby-Stahl, 1985). It creates an intimacy between the storyteller and the listener who connect in the context of the shared experiences (Connelly & Clandinin, 1990). For example, in the current study, the stories of nurse leaders become shared sequences of events that were significant for the participants. They made sense to the listener (researcher) as a temporal, causal sequence of events related to the participants’ experiences of professionalism (Denzin, 1989).

The current study demonstrates how narrative inquiry uses the story or personal experience narrative, as outlined by Denzin (1989) and Dolby-Stahl (1985), to develop an appreciation of the contextual understanding of the inquiry. In the current study, this refers to the nurse leaders’ perceptions of professionalism. The experience of nurse professionalism and how it has been constructed from the point of becoming a registered nurse, to becoming a nurse leader, then to the date participants attended the interview with the researcher, provide the scope of the story captured for analysis. This causal sequence represents the significant moments in the ways nurse leaders conceived of their idea of professionalism and how professionalism should be represented by registered nurses while working at the bedside. Thus, the story is told within and about the experiences of professionalism in nursing as it unfolds. Interpretive research attempts to synergise the ongoing interaction of the participants with the stories that come from their experiences (Denzin, 1989).

Narrative and story

The terms “‘story’ and ‘narrative’ are words often used interchangeably, but they are analytically different” (Riley & Hawe, 2005, p. 227). People tell stories and stories are present in everyday lives in speech, discussions, in media, in the written format of novels,

newspapers, magazines, television and theatre. All adults grew up with their parents telling them stories at bedtime. As children, they told stories to the teacher in their school, told stories to their parents, to their friends, with their work colleagues and finally with their children and grandchildren. Storytelling is ubiquitous. Stories are told in every country in the world by people of all ages, gender, religion, culture and race.

In contrast, the narrative is the way or manner in which the events are told in linear, chronological order, moving from one event to the next through a beginning, a middle and an end. Contrastingly it may fluctuate within a timeline; it can be written in the first person, or the third person (Sandelowski, 1991; Coates, 1996). Connelly and Clandinin (1990, p. 2) explain the difference between story and narrative as:

> …calling the phenomenon "story" and the inquiry "narrative". Thus, we say that people by nature lead storied lives and tell stories of those lives, whereas narrative researchers describe such lives, collect and tell stories of them, and write narratives of experience.

Essentially the information is the story and the method used to tell the story is the narrative. Clandinin, Cave and Berendonk (2016, p. 92) explained that in narrative inquiry "the shift is to think with stories instead of about stories". Storytelling may use different modes of communication, such as oral interviews, discussions, documentation of written records, transcripts of interviews, or may consist of photos or other meaningful memorabilia (Connolly & Clandinin, 1990). The researcher wants to hear the views of the participants to understand their experiences and perspectives. Listening carefully to the participants' stories gives voice to their perspectives within relevant contexts and timelines as one of the most important aspects of narrative inquiry (Clandinin, 2007). Connelly and Clandinin (1990, p. 4) state:

> In narrative inquiry, it is important that the researcher listen first to the practitioner's story, and that it is the practitioner who first tells his or her story. This does not mean that the researcher is silenced in the process of narrative inquiry. It does mean that the practitioner, who has long been silenced in the research relationship, is given the time and space to tell her or his story so that it too gains the authority and validity that the research story has long had.

Herein lies the significant difference between "story" and "narrative". Frank (2000, p. 354) asserts that "people tell stories, but narratives come from the analysis of stories. The researcher's role is to interpret the stories to analyse the underlying narrative that the storytellers may not be able to give voice to themselves". Other early work using narratives was undertaken by feminist researchers to give voice to women and disempowered marginalised and oppressed groups. Narrative inquiry has also been useful in providing participants with the opportunity to give voice in research areas which required a high level of sensitivity when discussing the participants' social and cultural realities (Trahar, 2009).

This interactive quality of the researcher-researched relationship described above by Connelly and Clandinin (1990) explains the biographical method of storytelling used in this study, where the participant tells his or her own story, and the researcher interpreting the participant's story with the researcher then becoming an integral part of the study. The interactive quality of the researcher-researched relationship facilitates the need, identified by White and Drew (2011) that researchers remember to approach interviews with care, not taking the information at face value. That is, researchers need to ensure that there is depth in analysis and that an idealised view of voice is not taken as a "special truth" but rather as one aspect of data (White & Drew, 2011, p. 2).

Jones (2013, p. 401) states "many published qualitative studies stop at the first phase of analysis, the identification of codes, and thus could be considered too premature and

lacking theoretical depth". This premature analysis can be eradicated by the researcher checking back with the participants, allowing them to discuss with the researcher the themed analysis to ensure the accuracy of what was discussed, with the understanding, however, that the final interpretation of the story is made through the researcher's lens.

Other witnesses or people involved may be principal players in the stories, as witnesses to the event that took place. These witnesses then also form part of the participant's story. The relevance of other characters or players is that they may have supported the participant during the event or may have been complicit in the event (Clandinin, 2007; Cresswell, 2013). Where the event took place, or the setting may be described in detail. This account of the setting may be full of descriptive information as this gives the text more richness and depth, allowing the reader to understand by being better able to visualise the context entirely (Cresswell, 2013). However, the participants may not understand that describing the setting may have any significance in the story and instead may feel that it holds them up from telling what they consider as the more critical aspects of their story so they may not always bring forward such information (Cresswell, 2013). It is up to the researcher to draw out this information by questioning the participant. For example, in the current study, when participants did not provide information on the setting relevant to the story being told, the researcher asked probing questions to elucidate further explanation.

Time, context and the participant determine the truth of the story; there is no one truth; instead, there are multiple truths (Clandinin, 2007; Erlingsson & Brysiewicz, 2013). To the participant at the time of the telling of the story within the given context, the story is true. Stories are told from the memory of an event; all people view their memories through their viewpoint, their culture, education, and past experiences all of which have an influence, which is then overlaid with emotions. The researcher moves temporally both "forwards and

backwards through time" (Clandinin & Connelly, 2000, p. 57) with the participants as they explain their experiences of professionalism.

Pivotal or turning points in the narratives are often identified by the high points and the low points of the story (Holstein & Gubrium, 2012; McAdams et a., 2003). For example, this current study on professionalism explored the high and low points shared by the nurse leaders concerning professional behaviours. It entailed a discussion on storied behaviours and any subsequent impact these behaviours had on the nurses or patients. In other words, any events identified by nursing leaders as significant or life-changing in the way that they conceived professionalism equated to a turning point in that person's way of thinking and was highlighted (McAdams et al., 2003).

One of the advantages of narrative inquiry is that the researcher is required to reflect on their position in the research and be aware of their interactions with participants and the interpretations they construct, commonly referred to as personal justification (Clandinin, 2013). At the same time, the researcher must be aware of issues relating to practical justification – whereby the research process itself may generate practice change (Palaganas et al., 2017). In the current study, for example, the narrative inquiry process may also result in changes in the way nurse leaders view the support given to professionalism within their organisation. Furthermore, narrative approaches may inform social and policy change which Clandinin (2013) refers to as social justification. Suppose there are common supportive elements which assist registered nurse professionalism in the workplace, for example. In that case, it may be that hospitals may use that information to try to improve the level of registered nurse professionalism in their facility. Hence, a narrative inquiry is particularly beneficial in systematically studying personal experience and how personal experience is actively constructed and given meaning (Riessman, 1993). Narrative inquiry may not be as useful, however, for studies with large numbers of participants because the interview and

transcription processes are laborious, as is the arduous and painstaking analysis of the transcripts into specific and representative themes.

Narratives in research

The everyday life experiences of nurse leaders have connected the history of nursing professionalism and literature through the use of the story. Sandelowski (1991) describes that the conception of human beings as credible tellers of their own stories and the producers of their texts and identifies the analytical problem of attempting to understand life events, epiphanies so to speak, which may elude the conventions of objectivity and validity. Sandelowski (1991, p. 161) deems these problems as ones relevant to:

> The ambiguous nature of truth, the metaphoric nature of language in communicating putatively objective reality, the temporality and liminality of human beings' interpretation of their lives, the historical and social constraints against which individual's labour to impart information about themselves to other individuals, who in turn, labour to listen, and most significantly, the inherently contradictory project of making something scientific out of everything biographical.

In the interpretive context, the concept of truth (like the concept of cause) is reclaimed from the pure sciences and is the most important criterion (Connelly & Clandinin, 2006; Polit & Beck, 2014). The emphasis of biographical truth is its emphasis on the reality of the story, the fictional; often literary production contrived from experience (Denzin, 1989; Sandelowski, 1991). Here, fictions are not meant to be truths in the narrative context, but instead, they are truths within the stories which contain them. The interpretation of the narrative results in the form of fictional truth; that is, the understanding of what happened and the construction of what something means, which forms the truth of the event (Sandelowski, 1991). Moreover, the subjectivity of stories is both a weakness and a strength. The weakness

is the creation of a set of facts which may not be reliable; the strength is in illuminating an encounter between self and the interaction with society (Sandelowski, 1991). Life stories must be developed, with each story forming a part of the whole; each joined with another and another, with a culmination of the telling of a life history constrained only by the purpose for which it was composed. Despite the extensive life histories of individuals, the individual will only include those aspects pertinent to the fundamental purpose of their narrative (Bellaby, 1989).

The current research, in keeping with Bellaby's (1989) perspective, is concerned with the display of ideas, perceptions, and meanings integral to the nurse leader's stories identified through a shared language and system of representation. Stories, as a part of life, meld the personal with the ubiquitous, to illuminate characteristic features contained in personal stories to a latent structure which is both cultural and social (Bellaby, 1989).

Storytellers, in a *remembering moment,* endeavour to determine a consistent and reliable interpretation of their past, present and their anticipated future. Within the hermeneutic circle of interpretation and re-interpretation, "stories with common elements can be reasonably expected to change from telling to telling, making the idea of empirically validating through consistency or stability in the stories; completely alien to the concept of narrative truth (Sandelowski, 1991, p. 165).

Bruner (1990) contends that the preoccupation of the storyteller and the researcher is not how to identify and determine the truth, but rather to apply meaning to the experience. Further, the interpretation of the teller's text forces the researcher to first attend to what is placed immediately before them; in the current study, the nurse leader's story of professionalism. Gusdorf (1980, p. 38) explains autobiographical understanding as a "second reading of experience" which may be considered more authentic than the first. However, Riessman (1993) points out that the interviewees will decide which parts of their narratives

they wish to share, as the narratives become their version of the reality of the experience which is neither unbiased nor objective. The narrative informs us, however, of what was paramount to the construction of the registered nurse professionalism in the research interview, and how sense is made of these experiences (Anderson, 1981).

Temporal productions

The narratives told by participants are temporal productions. They are reliant upon autobiographical memory, as Garro (1994, p.776) explained: "like other processes of memory, autobiographical memories are best understood as reconstructions rather than reproductions of past events". When one speaks about personal experiences, the past is reconstructed in a way that is "congruent with current understandings. The present is explained concerning the reconstructed past, and both are used to generate expectations about the future" (Garro, 1994, p.776).

Similarly, self-represented is the best self. That is, in storytelling about oneself, one portrays the self in the best possible way, minimising or tempering any recollection which may cast doubt upon the stories told, or actions within the story being told (Behar-Horenstein, & Morgan, 1995). These limitations also apply to the researcher who interprets the stories told by way of restructuring past experiences and biases to represent the story as closely as possible to the story being heard.

The schema of autobiographical memories is similar to other cognitive processes. They provide a framework for organising, interpreting and drawing conclusions about the world in which one lives (Polkinghorne, 1988). Thus, this framework or schema may be individual or shared with others. If shared with others, it is created by the influence of context and culture. The relevance of autobiographical memories as cultural schema, for professional behaviour in nursing, assist nurses to make sense of given episodes of professional behaviour

and provide the basis for actions taken in response to the same and may change through experience (Holland & Quinn, 1987).

Narrative inquiry methodology provides a framework in which the readings of nurse leaders' stories account for meaning whether it be inherent in the text or transmitted from the teller to the researcher. This method is not preoccupied with the need to find and validate meaning as absolute truth, rather the existence of meaning and the coherence of the story told, in a historically determined setting. It is paramount in uncovering; first, the ideas contained within the story and second, the significance of identified themes to the nurse leader and how they experience registered nurse professionalism.

Trustworthiness of the research

Within qualitative research, trustworthiness determines if the findings can be trusted. In this study, in keeping with the contemporary understanding of trustworthiness in qualitative methodology, the tenets of Guba and Lincoln (1984) were applied. That is the criteria of credibility, transferability, dependability and confirmability.

Credibility

Credibility in research findings is having confidence that the results are a truthful and accurate representation of the participant's perspective of events (Korstjens & Moser, 2018; Lincoln & Guba, 1985). Credibility in this study was enhanced by engagement with participants by the researcher during the interview when sharing their experiences of professionalism in nursing. The researcher ensured participants' data was an accurate interpretation of each participants' interview through the application of a pseudonym. Member checking was undertaken through the focus group interviews, and participants verified the themes gleaned from the interview transcripts from nurse leaders on professionalism. All interviews were digitally recorded to ensure the accuracy of the data. The evidence of similarity across the data from different participants was seen to strengthen

the consistency of the findings (Lincoln & Guba, 1985). Review of individual narratives and themes by supervisors also strengthened the credibility of findings (Korstjens & Moser, 2018). Conducting a review analysis by a different researcher clarified new points and, as noted in the literature, helped to elucidate parts of the study that the researcher could no longer see due to over familiarisation with the data (Loh, 2013; Shenton, 2004).

Transferability

Transferability is the "degree to which the results of qualitative research can be transferred to other contexts or settings with other respondents" (Korstjens & Moser, 2018, p. 121). Within this study, transferability was established by the provision of thick descriptions of the participants, context and the settings of their experiences which highlighted the applicability of participants' accounts to other situations (Lincoln & Guba, 1985).

Dependability

Dependability of research refers to the stability of conditions experienced by the participants and depends on the nature of the study; it also refers to the stability of the data over time (Korstjens & Moser, 2018). When research questions are clearly articulated, with paradigms and theoretical constructs linked to the study methods and outcomes, the researcher's role within the study is explained, and data collection protocols followed, then a study's dependability is apparent (Miles et al., 2014). The dependability of a study allows a study to be replicated with consideration of conditions of this study at that time (Lincoln & Guba, 1985). A further method to ensure dependability was the use of a data audit trail of the research method used in this study. This was provided in the methods chapter where the methods used were discussed explicitly and in detail how data was collected, processed, condensed, transformed and displayed for conclusion providing a record that is detailed enough to be followed or audited by an outsider (Loh, 2013; Miles et al., 2014).

Confirmability

Confirmability means the neutrality or degree to which the outcomes are consistent and repeatable and are derived from the research data (Korstjens & Moser, 2018). In this study, the decisions and analysis made by the researcher were discussed in regular meetings with their supervisors, thus preventing possible bias of presenting only the researcher's perspective. Confirmability requires the researcher to determine whether personal values have impacted the study and the degree to which the findings of the research are representative of the participants' views (Korstjens & Moser, 2018).). The researcher provided a summary of their reflexive position to ensure this provision was met.

Establishment of the dependability and confirmability of the current study was enhanced by having people external to the research audit both the processes and findings of the study (Creswell, 2014). This external audit resulted in a stronger or better articulation of the themes and findings, although it was acknowledged that the meaning of a text is interpreted differently by another and there were multiple ways of interpreting the text; it is understood that the researcher assumes responsibility for the document created (Clandinin & Connelly, 2000; Denzin, 1989). Dependability of the research was also enhanced by the detailed account of the methods involved in conducting the research. Credibility and transferability were assured all through the thick descriptions and detailed accounts from the participants, with member checking of the identified themes when sharing their experiences of professionalism.

Summary of chapter

Given that this research is concerned with understanding how nurse leaders interpret and construct professionalism, it was essential to utilise a methodology that could ensure that the participants' stories were heard. The essence of their experiences, both as individuals and

then as a collective, required a methodology which was true to their stories. Thus, narrative inquiry was determined to be the most appropriate fit. Within this chapter, the researcher has discussed why the research examining the registered nurse leaders' view of professionalism can best be answered using the narrative inquiry process. Some of the benefits and limitations of narrative inquiry have been discussed; however, the researcher continues to believe that using narrative inquiry will garner rich descriptive text for the thematic analysis allowing the researcher to understand the nurses' experiences. The next chapter provides the methods by which these narratives will be collected and analysed.

Chapter to follow

The following chapter is the method of how participants came to be in the study; the ethical process which was followed; data collection methods; analysis of the transcripts into the resultant themes and sub-themes; and finally, member checking of the results with the nurse leaders to ensure that the themes identified were representative of their experiences and stories.

Chapter Four: Methods

Introduction

The previous chapter discussed and defended the choice of narrative inquiry as to the most appropriate method to undertake this study. Narrative inquiry allowed the researcher to examine the stories of nurse leaders' experiences of professionalism in the workplace. This approach, couched within the constructivist paradigm, allowed the researcher to work with the participants as shared understandings of professionalism, evolved from stories of their experiences. The following chapter describes and discusses the application of narrative inquiry as a research method in this study.

Setting

The setting consisted of three tertiary hospitals located in the metropolitan area of Perth, Western Australia. Each of these hospitals employs more than 2000 nursing staff. Each of the facilities has between 60,000 and 80,000 emergency admissions and over 80,000 admissions per year.

Ethical considerations

Initial ethical approval was granted from the Edith Cowan University Ethics Committee (Appendix A). Following this, approval from the overarching public Health Department Human Research Ethics committee (HREC) was sought. In Western Australia, before commencing any research study that involves humans or human tissue, the National Ethics Application Form (NEAF) (Appendix B) is to be completed by the researcher and then submitted to the HREC. Once HREC approval was granted for this study, site-specific applications for research governance approval were made to each of the three hospitals' ethics committees involved in the study (Appendices C, E & F). Following the granting of ethical and research governance at each hospital, research was able to be conducted at each hospital site. Continuation of ethics beyond the initial time frame provided was granted

through both the centralised ethics application for public health system access and to the private hospital site (Appendix D & G). At the termination of the study, a final ethics report was provided to both the public hospital and private site (Appendix L).

Selection of participants

Once ethics and research governance approval were attained the researcher then contacted the Directors of Nursing of each facility by email with an attached study flyer describing details of the research, the time required of the participants, and the researcher's contact details. The researcher met with each Director of Nursing to explain the study, the recruitment method of participants, and ethics approval. Each Director of Nursing identified their preferred dissemination strategy of the information to their nurse leaders. Notably, all Directors of Nursing elected to send an email, using the hospital's intranet, to the nurse managers asking for the research study information and flyer to be disseminated to all registered nurses within their span of control (Appendix H). The nurse managers were asked to display the study flyer on notice boards on the ward (Appendix J). Participants were invited, through the email and flyer, to contact the researcher via email or telephone for any further information about participation in the study and to determine their suitability for inclusion in the study (Appendix I). If participants met the inclusion criteria, then they were invited to join the study. This process was just and ensured that there was fairness in the selection of research participants (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1979). The researcher responded by email or phoned each applicant, and established that the participant met the inclusion criteria. Once suitability to participate was established, an interview at a venue, time and day that was suitable to the participant was organised. There was a time lag of a week or more following the initial conversation before the interview could be undertaken at a venue and time that was suitable to both the participant and the researcher.

Participants were invited to join the study if they met the following criteria. Participants were required to:

- Be a registered nurse who is working as a level two and above in the West Australian Health Department Nursing career structure or the Ramsay private hospital career structure.
- Have a current registered nurse registration with the Australian Health Practitioner Regulation Agency (AHPRA).
- Have experience working in a substantive leadership role (were not in acting positions).
- Currently employed in a tertiary hospital, in Perth, Western Australia.

At each of the hospitals, nurses employed as nurse leaders (Level 2 +) were recruited using a purposeful sampling strategy. Where nurses had dual qualifications of registered nurse and midwife, they were considered eligible to participate in the study. It was explained to participants that only their role and experiences as a registered nurse were considered pertinent to this study. Twelve participants met the criteria and consented to participate in the study. This number proved sufficient with no further emerging new thematic data following analysis of the participants' data. The researcher did not need to recruit further participants for the study.

Autonomy and informed consent

The time between the researcher organising the interview and the actual interview allowed the participants time to reflect on their involvement in the study and ask questions of the researcher if they had any concerns regarding the study. As discussed by Beauchamp and Childress (2013), informed consent and autonomy are indistinguishably linked, so having that time available to reconsider if they wished to be part of the study allowed the participants greater autonomy over their decision to participate in the research. Polit and Beck (2010),

outlined that this time delay, coupled with the participants' understanding that they could withdraw from the study at any time without prejudice, ensured that they had independently chosen to continue in the study. At the time of the interview, each participant was given a fuller verbal explanation of the research, including complete details of the duration of the research, the time required from the participants, the nature and aims of the research and the processes involved, and were again offered the opportunity to withdraw if they wished. No one chose to withdraw.

The explanations at the interview were accompanied by the presentation of a written participation letter and consent form (Appendix I). Once these documents were read, there was an opportunity given for participants to ask questions of the researcher. Those participants wishing to participate in the research were requested to sign a Consent Form (Appendix I). All twelve participants signed the formal consents agreeing to participate in the study.

To ensure there was the safeguarding of the human rights of all participants within this research: Participants were made aware that they were able to voice concerns, make comments or withdraw consent, at any time during the research, without fear of penalty; Participants were made aware of their right to read transcripts of their interviews if they so requested; Participants retained the right to either cease the interview or to turn off the recorder during interview sessions.

The participants chose the venue, time and day for the interviews. The interview venue varied, ranging from a coffee shop at their workplace, or in proximity to their workplace but external to the hospital, or the researcher's office. The researcher ensured there was an appropriate level of privacy and comfort during each interview. Where the interview was held in a coffee shop as requested by some participants, the researcher chose a table away from the rest of the customers and maintained a quiet voice to ensure they could not be

overheard. The researcher was cognizant of the importance to the participant that their anonymity was assured (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1979). At the commencement of the interview, the researcher described how the confidentiality of each participant's involvement in the study, and their information, would be managed.

Confidentiality/anonymity

Through the adoption of the following measures, the confidentiality of each participant was managed. Confidentiality was ensured and has been maintained to protect participants from any possible harm resulting from their engagement in this research. Steps were taken to ensure the confidentiality and anonymity of participants, by the use of pseudonyms, which complied with the ethical guidelines outlined by the National Health and Medical Research Council (NHMRC) and the regulatory bodies of the three hospitals involved in the research. A person external to the research transcribed all audiotaped conversations, this person signed a confidentiality agreement and remained unknown to any of the participants. The signed consent forms, transcribed interviews, and all recorded data will be held by the researcher for five years following the completion of the research and then destroyed in compliance with the NHMRC guidelines (2007). All research hard copies of data are stored in a locked cabinet to which only the researcher has access. All electronic data is stored on a password-protected computer. No information about the participants will be revealed to other persons unless written authorisation is gained from participants.

Minimising participant risk

Participants were informed of their rights, to ensure that they understood that the researcher was fair, and considered their well-being when conducting the research (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1979; Owonikoko, 2013). Research participants were assured rights of privacy and

confidentiality through safeguards applied by the researcher to ensure that their identities and that of their healthcare organisations are not identifiable, thereby reducing any risk to their reputations. At all times, the researcher applied the principles of non-maleficence and beneficence to ensure that any possible risks of undertaking the research did not outweigh the potential benefits (Waller, Farquharson, and Dempsey, 2016). The researcher considered any potential adverse outcomes from the research, using pseudonyms for all participants with only the researcher having access to the participants' real identities. Any personally identifiable information is de-identified in such a way as to make recognition of the participants difficult.

Should any participants experience distress in recalling their experiences, the researcher identified the processes to be followed, and pathways to attain care through counselling. The researcher identified that they would terminate the interview if a participant became distressed at any time. Participants would be provided with a referral to appropriate supportive personnel if deemed necessary or requested. However, no instances of participant distress were reported, and some participants felt that the interview process was beneficial as someone was finally interested in listening to their experiences and viewpoints.

Data collection

Interviews

The data collection methods consisted of semi-structured interviews, focus group interviews, analytical memos and field notes, all of which are crucial to conducting narrative inquiry research, as discussed in Chapter Three. Face-to-face semi-structured interviews of approximately one hour in duration were conducted and audiotaped at a time and place of convenience nominated by the participant. The choice of semi-structured interviews, where the researcher had some general open-ended questions (Appendix K), allowed the participants to freely discuss the stories of their experiences, in a conversational manner

(Morse, 1991b). Interviewing took the form of "creative interviewing", as fashioned by Douglas (1985, p. 15), whereby the researcher and the nurse leader, in a trusting and egalitarian manner, openly shared ideas and experiences to gain further understanding on the topic of professionalism. Commencing data analysis following the completion of each interview, together with reflection upon field notes, and analytical memos, allowed for improvement with the following interview structure (Creswell, 2014).

The researcher introduced themselves, welcomed the participant and thanked them for their time, which helped to establish a convivial atmosphere and rapport between the participant and the researcher. All efforts were made to ensure the interview was conducted as a friendly conversation between colleagues of the same profession in a non-threatening environment. Before the commencement of the interview, participants were offered a glass of water, a coffee, or use of the bathroom facilities, thus also allowing participants additional time to feel at ease. After the researcher provided detailed explanations of the processes for data collection and estimated the duration of the interview, written consent was obtained.

The researcher used active listening techniques throughout the interview to show their enthusiasm and interest in the participant's narrative. Stories are told for an audience, in this case, for the researcher. The narrator (or participant) of the story unconsciously wants to tell the story in a manner that will suit and interest the listener (Connelly & Clandinin, 1990). The researcher understands that the participant looks to the researcher's verbal and non-verbal cues for guidance in how they may answer and be careful to reduce any potential influence. Techniques to communicate active listening by the researcher, such as head nodding or leaning forward together with verbal encouragers ("really", "go on", "mmm") (Weger et al., 2014) were used to encourage the participant to keep talking and to expand on issues when required.

Demographic questions

Demographic information is essential to provide insight into the characteristics of the nurse leaders participating in the study, as these may have some impact on the experiences and understanding of the experiences of the nurse leaders. Initial demographic questions consisted of age, gender, place of schooling, place of registered nurse training, further education was undertaken and the educational institution/s that provided the education, length of time as a registered nurse, place and area of employment, tenure at that facility, and the level at which the participant worked. The aim of these demographic questions was twofold: firstly, to provide insight into the characteristics of the nurse leaders in the study, as these characteristics may have some impact on the nurse leaders' experiences and their understanding of these experiences, as well as provide some indication for variance in data (O'Leary, 2005); and secondly, through these initial closed questions participants were given the opportunity to begin to relax within the interviewing environment (Jack, 1999).

Open-ended questions

The use of semi-structured interviews allowed for the use of open-ended questions which allowed participants to speak freely (O'Leary, 2005) and guide the conversation. Prompts were used sparingly and only when necessary to focus the discussion. This questioning method resulted in a richer discussion of the topic, which helped to glean a fuller interpretation of events and situations as it encouraged participants to recount their feelings and their meanings of the experiences. The use of this style of interview allowed for the narrative of the nurse leaders to take twists and turns enriching the context of the narrative. These kinds of interactions allow for a more in-depth exploration of the meaning of their experiences and what they represented to the participants (Ford-Gilboe et al., 1995; Sandelowski, 1991).

An example of one of the first professionalism-related questions which followed on from the demographic questions was – *Describe what you believe demonstrates professionalism in nursing?* This open-ended question allowed the nurse leaders an opportunity to give their opinion on the central tenet of the study and opened the discussion. The question did not require any specific knowledge; instead, it was related to their experiences and views of registered nurses' professionalism.

Temporal ordering of events

During the progression of the interview, the researcher noted as field notes any significant events, behaviours and attributes pertinent to the participant's story of professionalism. These field notes were then cross-checked against the telling of the story in the transcribed text, remembering, as Sandelowski (1991, p. 162) contends, that stories include "a temporal ordering of events and an effort to make something out of those events, to render, or to signify, the experiences of persons-in-flux in a personally, culturally coherent and plausible manner".

Participants outlined their past, present and future experiences of professionalism during their nursing careers (Clandinin & Connelly, 2000). They began with their early career experiences, then moved onto their current understandings, and finally, they discussed the future of professionalism and how it could be encouraged and supported. Participants were invited to share their story, recounting experiences relating to their witnessing or participating in the event that exemplified professional nursing and to describe what they considered as essential attributes of what they considered professional behaviour. The narrative from the nurse leaders provided the focus for the interview, with the researcher asking the participant to expand on particular sections of the narrative to give or enhance insight into the topics or issues raised. The participant was then asked to elaborate on leadership qualities and to discuss specific attributes and behaviours that they viewed as professional and those they did

not. The temporality, sociality and place of participants' stories were continuously considered by the researcher both during and following the interviews. This practice ensured that the nurse leaders were given voice, thereby providing them with the possibility of informing clinical practice (Clandinin & Rosiek, 2006; Lindsay & Schwind, 2016).

Through the use of paraphrasing, the nurse leader's words were summarised. The researcher would occasionally repeat back the summary of the narrative to the participant to both check if they felt the rendition was correct and to allow for clarification of meaning. This resulted in a co-authoring of the data between the nurse leader and the researcher (Miles et al., 2014).

Focus group interviews

Focus group interviews were another method of checking that the participants agreed that the information collected was a true reflection of their narrative. A focus group can be used to supplement interviews and to establish the trustworthiness of the data, as discussed later in this chapter. A focus group is an efficient and effective way to procure a substantial amount of information in a shortened time frame (Krueger & Casey, 2015). All participants were invited to join the focus group at the time of their interview to verify the themes identified from the analysis of interview transcripts and to identify any outlying themes.

Five participants from the 12 nurse leaders volunteered to join the focus group, but despite multiple attempts, the leaders were unable to arrive at a consensus for a suitable day and time for the focus group meeting. It was therefore decided to conduct an additional individual interview at the day and time that was suitable with each of the nurse leaders who had indicated a willingness to participate in the focus group. The interviews were approximately 30–40 minutes in duration and were transcribed by the same person who had transcribed the original interviews. Allowing the participants to examine and discuss the main themes as identified by themselves and their peers, allowed for an equivalent level of

understanding of the different issues identified within the study. The diverse clinical backgrounds of leaders allowed for only broad and generic issues to be explored in this second interview rather than issues that related to any particular speciality area or facility. Loh (2013, p. 6) confirms that this member checking "increases trustworthiness and verisimilitude of findings" and in the current study it provided an essential validation of the themes by nurse leaders who all shared a similar current level of nursing experience.

Saturation

The question of the number of interviews undertaken was determined by the construct of saturation. Glaser and Strauss (1967) discuss that the saturation of data is achieved when the researcher sees similar instances being reported again and again by the participants, and it appears unlikely there will be new information forthcoming.

Analysis of the interview transcripts was taken alongside the interviewing of new participants for the purpose of being able to identify saturation. In the early stages of analysis, the main objective was to read and read each transcript looking for similarities in content. The development of the early codes and themes provided the determination for when saturation of information was reached. Once there appeared to be little new information resulting in new codes or themes, the researcher determined the time to stop further interviews. This is supported by Urquhart (2013), who describes saturation as reached when no new emergent themes come from the data. A consensus of what constitutes the exact point of saturation is recognised as being a problematic concept for researchers (Saunders et al., 2018). However, within this study, when little further new emergent information appeared, that was taken to be the point of saturation, and to stop interviewing.

Researcher's reflective, analytical memos

Reflective, analytical memos were kept by the researcher containing thoughts and feelings, opinions, ideas about the research direction, research questions and methodology as

a means of reducing any unconscious bias of the researcher. These were used as discussion prompts during supervisory meetings to assist in the researcher's reflections on the aspects of the research process by the PhD supervisors. The use of reflective journals or commentary about self and method is recommended by Cresswell (2014) because they help to clarify emergent themes and to identify reflexively where the researcher fits within the study. These reflective, analytical memos also assisted with organising the personal information from the interviews as well as providing an audit trail of the development of the researcher and the research (Birks, Chapman & Francis, 2008). The researcher's personal feelings regarding the interviews and the participants were examined from a reflective perspective and noted. This process assisted the iterative process of the research whereby important emergent issues could be incorporated into future interviews (Birks, Chapman & Francis, 2008).

Fieldnotes

During the interview, the researcher also made fieldnotes. Creswell (2014, p. 193) confirms the importance of using an "observational protocol for recording information while observing" such things as "… portraits of the participants, a reconstruction of the dialogue, a description of the setting, accounts of particular events, or activities … demographic information about the time, place and date of the field setting where this takes place". Fieldnotes considered aspects that may have required further elucidation of information, about the setting, the participant's demeanour, interviews, and researcher insights. This information assisted with the writing of the introduction to each of the participants into the research, as seen in the following chapter.

Data analysis

Within narrative inquiry, data analysis examines the intrinsic individual experiences of individuals through the telling of their experiences (Ennals & Howie, 2017; Miles et al., 2014) and how analysis is undertaken varies, depending on the intent of the researcher.

In this study, the commencement of data analysis began following each interview, with each of the recorded interviews being listened to several times while the interviews were being transcribed. Fieldnotes were expanded upon at this time to allow for a clear revision of what had occurred within the interview.

Each transcript was read and re-read to immerse the researcher in the stories of professionalism and to get a sense of the interview as a whole. The stories were then re-read looking for relevant chronological and logical sequencing. As each narrative was reviewed, the important concepts, behaviours and events relevant to the research questions were identified by the researcher. Following this review, a story was constructed of each participant, by the researcher, illustrating significant moments and events which formed their past, present and future stories of professionalism. These stories of the nurse leaders are presented in Chapter Five. Following the researcher's immersion into the data, analysis of the transcripts began using the Miles et al. (2014) process of two cycles of coding and looking for patterns and themes.

Thematic coding and analysis

Miles et al. (2014) outline two cycles when coding: the first cycle identifies codes, and the second identifies patterns or themes. The application of the Miles et al. (2014) coding to the data of the transcriptions permitted a deeper analysis of, and within, the transcripts.

First cycle coding. The first cycle coding permitted analysis of transcriptions into sections that had meaning for the researcher. A code was assigned to a word or a phrase that captured the essence of what the participant was saying. Miles et al. (2014, p. 71) state, "a code is the label that assigns symbolic meaning to the description or inferential information compiled during a study". Within this first cycle of coding, the primary codes were established. The further analysis of the data allowed the development and application of secondary codes. The use of secondary sub-coding assisted in narrowing the broader initial

first cycle code to allow for further indexing, categorising and subcategorising into hierarchies. Simultaneous coding was also applied where needed. Simultaneous coding applies where there may be more than one code applied to a section of data where there are "multiple meanings" (Miles et al., 2014, p. 81). For example, the primary code that was labelled "components of professionalism" was reduced to a more specific code "communication". An example of simultaneous coding was when the primary code of "influences on professionalism" was reduced to "communication". Thus, communication was relevant across multiple codes.

Initially, to assist with the organisation of the data, the researcher used a Computer-assisted Qualitative Data Analysis Software (CAQDAS) program to store, search and retrieve large volumes of data. A CAQDAS system is very efficient (Waller, Farquharson & Dempsey, 2016). The program chosen was NVivo 11 by QSR International. NVivo was a useful tool for the initial exploration of the data developing "nodes" which related to different chunks of data. Waller, Farquharson and Dempsey (2016) state that "a CAQDAS can be used for an initial exploration of the data to make refining a coding scheme less unwieldy" (p. 169). However, the researcher returned to manual coding after it was found that the researcher's use of NVivo segmented the data to the extent that the meaning in phrases and sentences were lost. Waller, Farquharson and Dempsey (2016) contend that the "de-contextualisation of data" may be a limitation with CAQDAS. However, it was noted that despite using computer software to manage data, the analysis of the data remains centred on the researcher. Thus, once the researcher had analysed the data, the use of NVivo assisted in the quick retrieval of data by using words and sentences to exemplify a theme. It was also beneficial in retrieving chunks of the transcription material related to the different themes and sub-themes due to the initial coding using the "nodes" of NVivo.

The researcher was reminded of the sentiment espoused by Miles et al. (2014), who describe coding as an efficient and timely means of investigating findings more deeply. At the completion of the first cycle, similar codes were clustered to create a smaller number of categories or pattern codes.

Second cycle coding. The second cycle coding summarised segments of data into a number of categories, themes, or constructs. This study used descriptive coding which Miles et al. (2014, p. 74) describe as "the use of the data which summarised in a word or short phrase the basic topic of a passage of qualitative data". Descriptive coding was most appropriate for this study, as it allowed for the examination of the social environment of the participants' experiences of professionalism in nursing. Through the extraction of passages with a similar coding, a detailed compilation allowed for the construction of a narrative related to each identified topic area. This resulted in the iterative and reflexive process of moving from data to interpretation and then back again (Srivastava & Hopwood, 2009). From this detailed compilation, a final set of themes was developed which described the nurse leaders' views of professionalism through the narratives of their experiences.

Third cycle of analysis. Following the two cycles of coding, which elicited the initial four themes, the third cycle of analysis was undertaken, which involved a re-immersion into the narratives. This third cycle of analysis assisted with further elucidation and consolidation of the themes and resulted in the subsequent development of a framework which described the findings of the study.

This chapter has outlined the methods undertaken to analyse the information obtained through the participant's semi-structured interviews. Through the first cycle analysis of the transcriptions of the interviews, various primary codes were revealed. More specific secondary codes were then identified from within each of these primary codes. Once the list was completed and no new information could be gleaned from the transcriptions, second

cycle coding began. This resulted in the combination of some primary codes until eventually, the researcher was left with the main central themes. These themes were checked through the use of focus group interviews which helped to determine that there had been no information or ideas not identified from the interviews. The identification of the central themes aided in determining the main ways in which nurse leaders thought and spoke about their workplaces and the interactions that occurred. The checking of the themes by the nurse leaders worked as a form of triangulation whereby multiple methods of data collection are used, for example, interviews, focus groups, field notes and journaling (Carter et al., 2014). The checking applied rigour to the reliability and validity of the themes developed as representative of the views of the nurse leaders.

Visual identification

Throughout the analysis stage, the researcher represented the themes and subthemes in diagrammatic charts. The data visualisation assisted in identifying the themes and subthemes and allowed for the identification of overlap, which resulted in some subthemes being combined. The different versions of the development of the themes displayed in this visual fashion allowed the researcher to review the development of the central tenets throughout the research (Janicke et al., 2017; Miles et al., 2014).

Summary

This chapter has outlined the methods applied to the research questions using a narrative inquiry approach. Twelve nursing leaders from metropolitan acute care setting hospitals in Perth Western Australia were recruited through the use of an email and flyer in each of the hospitals. Ethics approval was granted by each of the hospitals and the university to conduct semi-structured interviews with each of the participants. The use of field notes and analytical memos assisted the researcher to reflect on the research process and make adjustments before each new interview being undertaken. Analysis of the data followed the

Miles et al. (2014) cycles of coding. This resulted in the development of a set of central themes and the related subthemes. Diagrammatic representation at each stage of the theme development assisted with a clearer understanding of any overlap, which was then adjusted. Following the identification of the themes, further, interviews were undertaken with five of the 12 participants as a form of triangulation to check the reliability and validity of the themes.

Chapter to follow

The chapter to follow introduces the nurse leaders. Each nurse leader is introduced in turn in alphabetical order by their pseudonym, with the introduction explaining how they came into nursing and where they currently work.

Chapter Five: Nurse Leaders

This chapter follows the discussion of the methodology and methods which were used to analyse the nurse leaders' narratives of their experiences of nursing professionalism. This chapter continues the story creation, where each nurse leader is introduced within the context of their role as a nurse. Leaders shared how their professionalism was shaped or began, their current experiences in the workplace, and finally, the future as they see it, of professionalism in the workplace.

The nursing leaders

There were twelve level three nursing leaders interviewed; they worked in both private and public hospitals in metropolitan Perth, Western Australia. In alphabetical order, the nurse leaders are Andrew, Diane, Jerzy, Julie, Karen, Katherine, Lee, Louise, Maureen, Nicola, Page and Wendy. The following tables summarise the demographic details of the leaders. Their age is their age at the time of interview.

Table 3

Age distribution of leaders

Age	Number of nurse leaders
36–40	3
41–45	1
46–50	3
51–55	3
56–60	1
61–65	0
66–70	1

The demographic tables outline the average age of the nurse leaders is 50 years, as the appointment to a level three position requires years of experience before consideration would

be given for this promotional level (Table 3). The gender breakdown of two males and ten females is representative of the small percentage of males within the profession (Table 2). The participants were predominantly females (Table 4) with the majority working in public hospitals (Table 5) in a variety of senior roles and holding or engaged in post-registration qualifications (Table 6).

Table 4

Gender

	Number of nurse leaders
Female	10
Male	2

Table 5

Area of work

Public hospital	Private hospital
9	3

Table 6

Job role

	Clinical Nurse	Clinical Nurse Specialist
Speciality team		2
Management	1	3
Staff education	2	
Research	1	
Ward/ ED	1	2

Table 7

Qualifications

	Number of nursing leaders completed further qualifications	Number of nursing leaders enrolled in further qualifications
Diploma of Nursing	4	2 re-reg. to degree
Bachelor's degree	8	
Postgraduate certificates/ diploma	7	
Master's degree	4	1
Nurse practitioner	1	2
PHD	0	1
Other courses non-university-based	3	

A narrative approach examines context by dividing stories into how participants saw professionalism as they began their career (beginning), how they currently saw it (middle) and how they envisaged professionalism in the future (end). Each nurse leader approached their interview in an individual way; some were eager to discuss their current working environment and their experiences of professionalism within that context, others began by explaining how they began their nursing journey and the role models that had shaped their views of the profession. It was evident that each nurse leader had an individual view of nursing professionalism.

Nurse leaders described how their professionalism began, either as a student nurse having role models and mentors from senior staff, which included their charge nurses, or outlining experiences they have had since completing their degree program. In many instances, nurse leaders discussed the previous apprenticeship model of nursing where nurse education was based in the hospital, with the majority of time spent in ward areas, with blocks of theoretical education undertaken twice a year. Given the age of many of the nursing

leaders, this was the most prevalent nursing education method of that time resulting in the acquisition of a nursing diploma qualification (McMillian & Dwyer, 1989) In the 1980s in Australia, nursing education transitioned to the university education system with subsequent changes in the student nurse experience.

The middle of the nurse leaders' stories described the current environment of where they were working. They described professional behaviour using incidents which they had witnessed, or that involved them as participants. They had much to say regarding the current state of professionalism. The end, or in this case, the future, of nursing professionalism, was discussed as areas which required intervention or support that facilitate nurses to demonstrate professionalism. Each of the nurse leaders will be introduced with their "beginning, middle and end" discussion of nursing professionalism. Andrew is the first of the twelve leaders to give his story.

Andrew

Andrew is Australian-born and one of only two males of the 12 nurse leaders. He is 37 years old and qualified in 2003 with a Bachelor of Nursing degree from a West Australian university. He had a hospital-based certificate in emergency nursing and a postgraduate Diploma in Clinical Nursing and is currently enrolled in a Nurse Practitioner Master's degree. He works as a Clinical Nurse in the emergency department (ED) of a large public metropolitan hospital in Perth.

Andrew was in the process of moving from one hospital to another, moving to rural Australia. This was a big move for him; he and his family found it difficult to organise a face-to-face meeting between his packing and work commitments. As a result, Andrew elected for a phone meeting which was successful in engaging him to talk for over an hour. Currently working in an acute care hospital emergency room, Andrew is a clinical nurse where some of

his weekly hours are dedicated to staff development. Andrew was very keen on professionalism in nursing, and he felt this was an important study.

Andrew stated that people pursue nursing as a career for a variety of reasons; for example, it may be that within their family there have been other nurses and so they also become a nurse, or they may have been exposed through watching either themselves or family members being nursed and decided that they also wanted to become one of those caring nurses they had encountered. Andrew did not offer any discussion as to why he came into nursing.

Over the years, Andrew had been lucky enough to encounter senior staff who emulated professionalism in nursing. He provided the example of a Clinical Nurse Specialist (CNS) in the Emergency Department (ED) who remained calm when staff were responding to high patient flow volumes and under considerable pressure. Despite her seniority, this nurse would step back and allow Andrew to take the lead rather than taking control. This gave him and other shift coordinators confidence and the opportunity to ask how they could improve their management of the situation at the time without losing face. Another example was that of a clinical nurse on night duty who held a demented patient's hand while the nurse talked and sang songs to her until 45 minutes later the lady fell asleep; having that personal, empathetic quality as second nature. He identified empathic communication as an important aspect of professionalism. Andrew felt that all nurses in his setting responded to patients in a professional manner.

Infrastructure was something that Andrew felt was an area neglected by organisations. For instance, he felt that as shift workers with people working around the clock, organisations should provide support facilities for staff such as a functioning kitchen, gym equipment, a lounge area, and a garden or open space that is secured from the public so they could get some sunshine in their breaks. Andrew felt it was important that they could go somewhere

and not feel threatened by the person that they have just kicked out of ED. He explained that nurses would feel they wanted to support nurses looking after their well-being. Andrew goes on to discuss that the tearoom for the ED department is a cupboard in which they put the kettle, table and some chairs because it is too far to go all the way to the cafeteria as they may be needed back in ED. He believed it "makes staff feel as if people do not give a damn about them and they're not treated as professionals so then those people won't treat the place professionally as well" (verbatim). So, for Andrew, being professional was not simply about his behaviour but also about the way he was treated by his employers. The next nurse leader to describe her experiences with nursing professionalism was Diane.

Diane

Diane had agreed to meet me at a coffee shop at lunchtime near the hospital where she worked. Diane arrived on time, dressed in her hospital uniform. We ordered coffees and a sandwich each and had a conversation about the hospital and the changes happening. We stayed away from the interview topic until we had finished our lunch. We sat outside and, although it was cold, it offered a greater measure of privacy for our discussion and the taping of the interview. Following the completion of our quick lunch, we then turned on the tape recorders and began.

Diane had been a nurse for 31 years, qualifying in 1983, in an Australian hospital. Diane, a 53-year-old woman, returned in 2008 to undertake a Bachelor of Nursing (Science) degree at a local university to upgrade her Diploma of Nursing to degree status. A master's degree followed which was converted to enrolment in a PhD with completion expected in 2018. Diane had worked as a clinical nurse on the floor, in staff development, and at the time of the interview was working in a nursing management role, developing hospital policy, at a private hospital in the metropolitan area.

Given her training through the apprenticeship system, Diane expressed that she believed she was a dinosaur based on her opinion of uniforms. Diane believed that people needed to adhere to the organisational uniform policy rather than be an individual. She was not sure if the uniform made a difference as to the quality of the nurse but felt that it was her demographic group and training that influenced her to make sure she was dressed in the correct shoes, the correct uniforms and the correct earrings. Diane had seen some senior staff have double standards, for example, when they told a student off for not having the correct uniform, yet they did not adhere to the policy themselves. She described this as a form of bullying.

The problem of bullying, or horizontal violence, had been experienced by Diane through interactions with a manager on a ward area in which she had worked. She said she believed that ultimately people vote with their feet, that is, they leave and get other jobs. Diane believed that when a workplace was not happy people leave. Diane felt she could comment due to her own experience of bullying in the hospitals and what she had seen happening to other people. Despite being in her position for several years, a new manager came in, and due to the bullying, she experienced, she left the ward area and eventually left the organisation.

Diane explained that ethical standards and integrity, together with honesty, are extremely important aspects of nursing professionalism. *"Being upfront when you've made a mistake"* (verbatim) is important. Diane explained that she finds *"it's quite common that if the mistake or patient error was perceived to not affect the patient, then errors do not get disclosed or documented or spoken about"* (verbatim) until somebody actually finds out and mentions it. They do not appear to understand the *"no-name, no-blame, we do not want to make the mistake again and are interested in the factors that led to this mistake"* (verbatim).

Diane did not believe that integrity, or professionalism, were age or gender-related but that integrity was related to the type of person that you are.

When discussing how to support and influence levels of professionalism, Diane explained that she felt that more education increases discernment, understanding and critical thinking processes which then translate to practice. Therefore, postgraduate qualifications are beneficial to the organisation, but she did not feel they were encouraged within the organisation in which she worked. She explained that because management did not have the qualifications, they did not see the need for further education of staff, as they did not have the experience, or belief, that education would influence doing the job better with extra education. She believes that the result of education was all about improvement in patient care, but that management did not seem to 'get' that connection.

Diane believed that professionalism was influenced by the Director of Nursing and the senior hierarchy, and they influenced the culture of the organisation. She felt that it would be helpful if these senior managers were more visible and approachable at a grassroots level, although she did understand that trying to find time to come back and work at a ward level was difficult. She explained that it was important for the culture of the organisation that senior nurse and management were visible and available, preferably on the floor. However, having role models of senior nurses who did have the qualifications, were down to earth, who came and worked alongside the nurses, were the people who combined the clinical role and leadership model very well. The next nurse leader to describe his experience and views of nursing professionalism was Jerzy.

Jerzy

I met Jerzy at the hospital at which he worked. We had organised for me to arrive after lunch and we would go to a boardroom to talk. I arrived and parked, went to reception

and asked for him and within five minutes a tall, well-presented gentleman arrived asking if I was Gina and offering me a handshake. I then followed him back to the boardroom, where I set up for our interview.

British-born Jerzy was the second male nurse leader and was 67 years of age. He commenced nursing in 1975 and attained his hospital-based Diploma of Nursing in the United Kingdom (U.K.). He took pride in telling me that he had been a nurse for over 40 years. Following his diploma of nursing, he undertook the U.K. Graduate Certificate in Education through the U.K. Council for National Academic Awards and had since completed a master's qualification in a local university. Jerzy currently worked as a Nurse Educator and Clinical Nurse Specialist in a large acute public hospital.

He explained that in the days of his education no one would question any element of nursing saying, "the matron was tough, but they were fair, and you could not possibly challenge, but nowadays they (Nurses) do challenge, and as they (Nurses) do challenge it makes you think" (verbatim). He went on to explain that challenging methods of care and systems and processes was a good thing and should be encouraged as it made nurses examine practice.

Another aspect of Jerzy's history regarding the beginnings of his views on professionalism stemmed from a research project he undertook 20 years ago as an RN. He had asked patients and their families questions about how they perceived nurses. He remembered that the findings were, that patients wanted someone who would greet them, whom they could go to, and they *"would provide information to them in the nicest way",* who was *"approachable and reassuring"* and had a *"professional attitude"* (verbatim).

Jerzy described that in his beginning practice as an RN, nurses who took up senior nursing roles were well prepared through ward experience and undertaking further education, for example, a management course. He did not feel it was the same structure in Western

Australian hospitals. He expressed his view that the transition of education from hospital-based to university-based was a good thing, giving nursing a more professional status; compared to hospital-based training. However, he felt nursing had *"thrown the baby out with the bathwater, meaning that there was a lot of good stuff in the hospital-based training that could have gone into the university courses"* (verbatim), especially, he felt, in regard to mental health training.

Jerzy believed that through the university-based nurse education, nurses learnt their skills and knowledge and changed their attitudes to learning about demonstrating professional conduct. He believed that best practice was learnt through the role modelling of nurse managers, senior staff and their peers and that mentoring were very important to the progress of new graduates. Jerzy believed that when a new nurse started working as a graduate nurse, they do act professionally, but from time to time may need to be gently reminded to manage their professional image both in and outside of work. The example he gave was that of social media and how nurses needed to be reminded that they could not post photos and comments which could be considered unprofessional. He also explained that the new graduates were told if they ever saw or heard anything that was contrary to best practice, they were not to keep quiet about the poor practice. They were then advised how to go about reporting any such behaviours and to whom. In the hospital in which Jerzy worked, there was the same concern as voiced by other nurse leaders, that the new large hospital took many senior staff, leaving junior staff to act up into those positions without the necessary skills and knowledge required. This then puts stress on those acting up positions, but also on those around them who supported them while they were learning their job. He explained that improvement was needed in the areas of communication, appearance, ongoing education, professional development, and peer review.

When talking about how to improve and support professionalism, Jerzy discussed how nurses progress up the career ladder from being a graduate nurse through to applying for more senior positions. Jerzy was concerned that there appeared to be a lack of people applying for positions who had a postgraduate qualification related to that position. He said that positions were still being filled by people who did not have further professional qualifications from the university sector. He felt this was because many of the senior leaders, already in positions of power, also did not have these qualifications, therefore did not appear to feel they were necessary. This attitude then permeated down through the organisation where many people asked why they should do any further education when they could still attain positions without any more time, effort and work. Jerzy felt that if all Job Description Forms (JDF) stipulated that professional qualifications were necessary for promotional positions, it may encourage people to seek further education with the betterment of both themselves and the organisation.

Jerzy felt that linking attendance at conferences and publishing papers through research with the yearly performance appraisals of staff members within the organisation could only improve both patient outcomes and staff satisfaction. This related to not only the senior leaders but also those nurses on the wards; however, he believed there was a lack of interest in these areas. He also discussed that a small number of nurses join professional nursing organisations and felt that this should also be a compulsory part of ongoing yearly performance appraisals because nurses demonstrate involvement in the profession through interaction with these professional organisations. He felt that to improve professionalism, these last areas of conference attendance, research, professional organisation membership, and further educational qualifications should be tied to both yearly appraisals and any promotional positions.

It was interesting that Jerzy discussed there are few champions in nursing in either Western Australia, or Australia, who are letting the public know about what is going on in health from a nursing perspective; and getting exposure for the profession of nursing in newspapers, radio, and television. He felt that doctors portrayed themselves in the media but that nurses were silent and that this should change. The next leader to be introduced is Julie.

Julie

Julie, a 37-year-old woman, was born in the UK and undertook her registered nurse education in 1996. Julie was currently enrolled in a Nurse Practitioner course at the master's level, which she began in the UK. Julie had been in Australia for five and a half years and was working as a Clinical Nurse Specialist/Manager Level III in a private hospital in Perth.

Julie undertook her training in the UK, as part of project 2000. It was a new system of training for nurses where they were contracted to work in the hospital and supported with a bursary, the student nurses lived in the nurses' home and during the day would undertake either theoretical education or work on the wards. Julie and her colleagues had the option, upon finishing, to stay on an extra year which gave this cohort of students a Bachelor of Nursing degree. Julie continued her nursing education by changing her place of employment. This change meant that she gained experience in a new modern hospital that was very different from her training hospital, as the new hospital was very modern with a lot of new technology. After graduating with a Bachelor of Nursing degree, Julie undertook a National Health Service Institute of Management course. Since then, Julie had begun a master's qualification in Nurse Practitioner through a university in the U.K.

Having graduated in 1999, it was surprising Julie felt that the hospital where she was educated, was "*really behind the times"* (verbatim) as the nurses had still worn hats, nursing belts and their aprons in the old-fashioned style of nursing uniforms. Appearances within the

private hospital in which Julie now worked did not appear to be an area of contention. The only comments from management on uniform matters was that gel nails were having a bit of a comeback and staff were being told that they have to remove them before the next shift. The inappropriate wearing of jewellery had also been a big issue recently within the hospital, especially necklaces, due to the danger that they may pose to the nurse from a patient.

Occasionally staff were pulled up on their performance and interviewed, especially if there was a complaint from a patient. This then resulted in performance objectives being set that assisted staff to understand the areas in which they needed to improve. Any comments regarding a staff member's performance would be made to staff in a staff room or office away from patients and other staff members. Julie felt that generally, people were very professional in the way in which they worked.

Julie said that she continued using the old-fashioned values, even though at that time they had appeared very strict. Julie provided an example: "*In those times patients always referred to the sister as Sister So-and-so and Doctor So-and-so, but that's gone now, so it* (nursing) *doesn't appear as professional to the patients"* (verbatim). She went on to explain that nurses and doctors socialised a lot together, as the doctors' living quarters and the nurses' quarters were in the same area. However, when on the wards and in the public eye they were always very professional when speaking to each other – "it was strict; you kept your private life and work-life very separate" (verbatim).

When on the wards, she discussed that the sister-in-charge never really seemed to do anything, yet they knew every patient on the ward. Julie said she understood she had practised within a very "*old school"* (verbatim) way of looking at things but believed if management were doing everything right or handling situations correctly then hopefully staff would see positive examples and think perhaps that they should follow suit. Where the nursing manager was not around, was not hands-on, did not really see what was going on in

the wards and did not lend a hand, then they were not really supporting the staff and setting a good example, especially if the nursing manager just sat in an office rather than go out on the floor.

Julie believed that in the past staff showed each other a high level of respect. She felt that there was a lot more backstabbing and playing one nurse off against another: "*she is a bit slow at doing this or that, or I do not like the way she does this, and I have to go and repeat it and redo it you know"* (verbatim). Julie believed that the reason this occurred was that in the past, patients were in the hospital a lot longer, so things could be done more slowly. In the current health field, new procedures are undertaken, drugs are given that were not available in the past, and patient turnover is very fast, which increases pressure on nursing staff.

Julie believed that the best way forward to improve professionalism in the workplace was to improve communication. The way that nurses talk to patients indicates that information sessions on professional conduct related to communication skills are needed. Julie suggested perhaps showing YouTube clips and things which provided examples of really poor behaviour in the workplace and some really good examples so that we can all *"squeal and curl our toes up because we've all had the bad example, was not on a daily basis but you may have come across it"* (verbatim). People needed a reminder, or perhaps to be included in the mandatory updates, to ensure nurses remember how they should be talking and doing things with patients as people can become complacent. The next nurse leader to share her stories and experiences was Karen.

Karen

Karen, who came from Perth, began her training at a public hospital in 1973. Upon qualifying she began a midwifery course and completed five months; however, her husband then took a mining job, and they left to live in the country for ten years. During that time,

Karen began her family and did not work as a nurse. When they moved back to Perth in 1987, Karen came back to the public hospital and completed a re-registration Bachelor of Nursing course and has been working ever since at her original training hospital. Karen had contemplated undertaking a nurse practitioner course in her specialty. However, she found it too expensive and said there would have been much time rushing to get away from work, and she thought that perhaps a work-life balance was more important to her at this point.

Karen believed that she derived her understanding of nursing professionalism from the living examples of the senior nurses who role modelled professional behaviours while working on the wards with her. She explained that although the ward sister may have been *"a bit of a Tartar*" (verbatim), she ran things a certain way and had expectations of how she wanted her ward run, how she conducted herself when the consultants or people were doing doctors rounds, how she conducted herself with junior medical staff and junior nursing staff. Karen explained that they learnt to say, *"yes sister, no sister, how high sister*" (verbatim), when asked to do anything. She reminisced that the sister who was second-in-charge would run the ward when the Charge Nurse had gone home, and although they may not have been as strict or dogmatic about duties as the Charge Nurse, there was still that element of following the in-charge sister's structure. Senior nurses on the ward, Karen explained, were supportive of the students, for example when she was a new first-year nurse, Karen spent three hours taking patients' temperatures; however, nobody complained about the time it took her. In her second year, she reminisced, once the junior nurses' tasks were completed, they would go to the senior nurse and ask if there was anything they wanted to be done. The more senior nurses would then give them various jobs to do, but they always thanked the junior and acknowledged what a great job they had done. Karen felt this then allowed for dialogue if things were not done right, you did not feel that you were being victimised, it was rather "okay if this is the example then we need to emulate that".

At present, Karen expressed that nursing professionalism had changed and improved, at least in her speciality area. Karen stated that she admired "*the kids that come in from uni"* (verbatim) as she felt they knew a lot more, but she still felt that the on-the-job training that she did was better. She did, however, feel that nurses were now more professional in some ways because they were more responsible for their actions and how they work, rather than the less autonomous, more directed and task-orientated manner of their previous work approach.

Karen expressed that there was currently a high level of professionalism in specialty teams and this was demonstrated by nurses' advocacy for patients and the nurses' ability to question and present alternate opinions and facts to medical teams. Karen also stated that the relationship between nurses and the consultant doctors had improved. She felt that this might be due to the nurses improved and effective communication skills and being able to give a "*better story"* (verbatim) with a more comprehensive assessment, thereby assisting the doctor to make a clinical decision. She felt that the doctors: respected the knowledge base of the nurses; asked nurses to regularly consult with them about patients through their active role in multidisciplinary meetings; and provided important perspectives about patient experience and choices.

Karen did acknowledge, however, that in other contexts, such as administrative settings, this same degree of professionalism was not in evidence. She described a relieving administrator who was extremely abrupt, and she felt that despite all of the positive nursing actions "*the one thing that they* (patients) *remember most is/was? the negative*" (verbatim), so it was important that a professional attitude was demonstrated by all staff. She felt that the best work as nurses was done behind the scenes and in advocating for the patients, and as such "…*nursing does not necessarily have to be out there"* (verbatim).

Karen expressed the belief that, in the future, nurse professionalism could be influenced by simple measures. Karen noted that, in the past, nurses were managed by their

peers rather than bureaucrats, who now held the management positions with no nursing background. She felt that it was important to have executive positions held by nurses to ensure that nursing had relevant input and nursing was given value.

The mentoring of new staff, Karen felt, was really important, especially new graduates as she believed they were extremely idealistic and wanted to change the world but could not see the reality of what needed to be done and why the processes were done in any particular way. Karen discussed that the senior staff needed to support the new graduates by taking their "*patient stories to the meetings or the rounds*" (verbatim) thereby showing that they acknowledged and valued the contribution of the new graduate, understanding that such praise was critical in support of the new graduate. The next leader in providing her experiences of professionalism, is Katherine.

Katherine

Australian-born Katherine qualified as a registered nurse in 1993 from a Perth university with a Bachelor of Nursing degree. This 42-year-old Clinical Nurse Specialist currently works in nurse education in a large acute public hospital in metropolitan Perth. Katherine undertook a postgraduate Diploma in Clinical Nursing in 2000 and in 2009 completed a master's degree. She is responsible for nurse education in a full-time role in a high acuity area.

Katherine had agreed to meet me at the hospital reception area in the morning at 10:00 hours. I was standing at the reception area when approached by a tall blonde lady who asked my name. She was dressed in her hospital uniform and appeared to be in a hurry. She advised that she had booked a lecture room for us to speak in. We quickly wound our way through the ground floor of the hospital until reaching the lecture room where we set

ourselves up. Once we were settled in the chairs with the consent form signed and the tape recorder running, Katherine seemed to relax.

Katherine became a registered nurse through the Bachelor of Science (Nursing) course at a local university, Katherine, in the 1990s. Her recollection of initial demonstrations of respect centred around a medical consultant who used to have all of the nurses "*stand to attention pretty much when he walked onto a ward and be ready to take his orders, as he felt that was a sign of respect*" (verbatim). Katherine feels that staff are stressed about patients and bed flows. This stress results in occasionally the relationship between medical and nursing staff on the ward bordering on unprofessional. Nurses' communication with both medical staff and administrative staff, she feels can be considered as aggressive. She believes that all people in the team feel the same workload pressure due to the four-hour rule about patient movement. With the hospital administration advising nurses that they are accountable for the problem if the patients are not moved out of the unit within the time frame, their stress is increased. Katherine expressed that professionalism would be enhanced by removing the four-hour waiting rule, to which she added "*no joking*" (verbatim) then followed up with "*no, it really would make a difference"* (verbatim). Katherine added that on the weekend's staff did not have as much pressure; therefore, everyone had far more jovial relationships with their colleagues.

The hospital Katherine worked at was also undergoing reconfiguration and downsizing which added to staff pressure and led to added anxiety for nursing staff, as many staff were waiting to find out at which hospital they would be based. Katherine believed that in the future, a clear career structure, outlining the skills and attributes required for positions, would fulfil the expectations of nurses that different levels of professionalism were associated with the different levels of nurses. She explained that the move to map all positions from commencing graduate to senior nurse positions, to determine a set of skill requirements for

these positions, plus the leadership and management programs offered through the Health Department, would all support the skill development of nurses. Katherine described that there was an expectation that through the dissemination of the information and ideas to all staff, there would be a transfer of those learnt skills from the course attendees to others.

She believed that having staff who understood their job role and functioned at a high level in that role, was important in supporting the professionalism of the staff. She was concerned with the reality of nurses in senior roles who could not perform at the required higher level and hoped that the situation would improve. Katherine clarified that having an optimal number of staff with a suitable skill mix of junior and senior nurses, resulted in an increase in the level of professionalism and this needed to be implemented in the organisation. The next nurse leader to describe her experiences with nursing professionalism was Lee.

Lee

I met Lee at her office in the hospital; she was a middle-aged, well-presented woman in her hospital uniform. She advised me that she had put her phone on hold and told people that we were having a meeting so that we should not be interrupted. Lee was born on the East coast of Australia 53 years ago and was educated in a hospital-based Diploma of Nursing course in a local hospital. When Lee undertook her education, she reminisced, it was the apprenticeship system with nurses in white uniforms and a hat. Lee has been qualified as a registered nurse since 1982, then went on to gain a midwifery degree through a local university. Lee had also completed a Graduate Certificate in Management, together with other hospital-based management qualifications. Lee was a Clinical Nurse Specialist who managed a specialist ward in a private metropolitan hospital in Perth, Western Australia.

Having worked as a nurse for 34 years, Lee had undertaken a variety of roles whilst working in different speciality areas in both the public and private hospital sectors.

Lee had a very positive attitude towards both the hospital in which she worked and the nursing profession. She felt that on her ward she had a very stable workforce which she felt encouraged the development of professionalism, as people knew each other well, socialised together, and understood the behavioural expectations that Lee set for people working on the ward area. When there were instances of behaviour which did not measure up to Lee's expectations, a conversation with Lee gave the recipient a chance to tell their side of the story.

Lee always ensured that all new staff had a buddy nurse and that staff development also worked closely to support the new staff member in understanding the environment and the implicit requirements of being a registered nurse in that area. Lee explained how a person was supported, the way in which they were approached, the way they were made part of the team, and the role modelling of behaviours that were displayed by the rest of the team of expected attitudes and behaviours, all shaped the professionalism of new staff members. Lee believed that professionalism was not age or culture-related; rather, individual nurses were either professional or not in their manner. When somebody was not professional, she explained it was up to the manager to influence them and set them on the right path. In the organisation that Lee worked there was an organisational-based human resources system which presented the national organisational view of the expectations of how staff should behave. Considerable training was given to managers to assist them to deal with any difficult situations of errant staff behaviour. For example, on the day that I interviewed Lee, she had just come from a management meeting at which senior nursing staff had been discussing how information should be communicated to patients. The example given was that when discussing medications with the patient, a nurse would not guess what they did not know

about medication, rather they would go and look it up and make sure they gave the patients the correct information that they needed. So, the information was not presented to patients in an offhand approach; instead, the information was delivered in a professional manner.

When discussing how to improve professionalism in the workplace in the future, Lee discussed that the nurse manager of the ward area influenced the culture of the ward. The ward culture then resulted in a reputation for that ward, so when staff were sent to work on that ward, they know of the culture of the ward before they even got there. Our conversation was full of examples which were almost textbook in how to create a workplace environment in which all members felt respected and part of the team. Lee explained that any negative feedback about the team was an instance that could be used for all staff to learn about quality improvement. The highlighting of any issues, whilst ensuring the privacy of the individual concerned and turning it around to be a positive learning experience helped to develop and maintain professionalism for the whole team. The next nurse leader to be introduced is Louise.

Louise

Louise entered the nursing environment as an enrolled nurse in 1988 in Australia. She then completed a registered nursing degree through a local university in 2004. Louise recently completed her postgraduate Diploma of Nursing and was planning to do a master's degree. Louise was a clinical nurse, currently working as a research nurse, in a large public metropolitan hospital.

Louise had asked if we could meet at a local hotel in the outside restaurant area. When I arrived at the hotel, I searched the different outside eating areas and finally found Louise at a back table, drinking a cup of coffee. She was a middle-aged woman and appeared very keen to give her views on the current state of professionalism. During the interview,

there was very little discussion on her history or thoughts on how she had developed her sense of professionalism. She did, however, explain that for ten years her main concern had been nurses' ability to develop a therapeutic relationship with their patients, by introducing themselves to the patients and creating some form of relationship. Louise felt this skill had deteriorated, and nurses did not take the time or show patients the respect they had in the past. Louise debated that doctors are peer mentored as an essential part of their medical education on the wards and they "blossomed" (verbatim) but that nurse mentoring did not see the same outcomes. She discussed that doctors appeared professional and respectful to their colleagues and patients and believed that they must have been taught those elements at some time. However, she did feel that generally, nurses were caring and had a good level of knowledge which then resulted in the nurse being confident and calm when giving explanations to patients about their treatment and care.

Louise explained that she felt that the level of professionalism in the hospital in which she worked had been undermined by the Health Department's restructuring of the hospital. Senior staff were being "*poached"* (verbatim) with the opening of a new hospital and "*although leaders were trying to maintain a really good reputation of a good professional ward"* (verbatim) it was difficult to do so. She felt that this issue, when combined with work pressure and a lack of time, resulted in poorer patient outcomes and unhappy staff.

When discussing different aspects of professionalism, Louise had begun with nursing staff maintaining patient confidentiality. Patient confidentiality was high on Louise's agenda of current professionalism issues and related to keeping patients' details confidential through not discussing their care when in public places. She gave examples of nurses speaking about patients in the lift while she was also in the lift. Louise explained that she believed neither age nor gender were issues with nurses exhibiting appropriate communication. Louise felt that although some nurses were very good, others lacked the ability to temper their

conversation according to the situation and the patient; as well, some nurses were not self-aware of their manner and the tone of their speech with patients.

She explained there were some outstanding nurses on the wards with a high level of skill and competency, who followed through on their clinical findings, especially when medical interventions for patients were necessary. She gave the example of a patient who said that a nurse had saved his leg with her quick assessment, which was then followed by the nurse contacting the appropriate medical staff and organising the patient to have the correct diagnostic tests resulting in the detection of a clot in his leg. Louise described that the patient felt that the nurse's quick intervention had "saved his leg".

Louise discussed that the future of nursing professionalism was in jeopardy with the ever-increasing number of protocols and that decision aids were effectively "dumbing down" nurses' critical thinking skills. Such decision-making charts gave the nurse a series of protocols that they were to follow if the patient's vital signs fell within those limits. Louise believed that nurses should rely on their critical thinking and acquire new knowledge rather than be reliant on protocols and paperwork. She felt that nursing education for all nursing staff, on all shifts, on new protocols and new evidence-based practice was imperative to keep nurses up to date with changes in practice.

Louise identified the need for nurses to enhance and develop their research skills to enable them to develop interventions based on evidence as a means of increasing their clinical prowess and their professionalism. This was consistent with her role as a research nurse. Louise expressed her belief that new nurses need to work as change agents in hospitals because of ongoing resistance by nurses to changes in practice. The next leader to be introduced is Maureen.

Maureen

Maureen is a 46-year-old female, originally from the United Kingdom. Maureen commenced nursing at 18 years of age, undertaking a hospital-based Diploma of Nursing. She moved to Australia 20 years ago. Maureen had not undertaken any university-based qualifications as she preferred to embark on hospital-based courses that related to her clinical speciality of which she had completed four plus others on research. Maureen was currently employed in a large public hospital in metropolitan Perth. Her role was divided between working as a Clinical Nurse on the floor and leading clinical research in the area. She had vast experience with research having been a Clinical Nurse Researcher for 16 years.

Maureen completed her nurse education just outside London, where she received a Diploma of Nursing. Most of Maureen's time in this diploma course was spent on the wards with blocks of time in the nursing school for theoretical education. Maureen compared her diploma nursing course with nursing university degree courses. She professed that the degree courses had resulted in the current generation of nurses having more capacity and confidence to question and apply critical thinking.

When asked about professionalism, Maureen equated it with treating your colleagues, patients and visitors with respect and courtesy, as you would like to be treated yourself. Maureen believed that nurses who were her age were more professional than those nurses of a younger age. She always endeavoured to be respectful and mentioned that she would never address patients by their first name or answer back to patients or be less respectful of older people, as evidenced by the younger nurses. She went on to explain that she felt that new graduate nurses speak to all colleagues equally, in the same manner as they do with their friends, with no differentiation when the nurse they were speaking to was from upper levels of management or one who they worked with on the ward. Maureen believed that communication styles should change according to whether one was with peers or more senior

staff. She noted that nurses do not always speak in a courteous fashion to patients and colleagues. Sometimes when under stress, nurses have spoken in an unfortunate way, requiring them to go back and apologise afterwards. She believed that remaining calm during stressful times was an important aspect for nurses to demonstrate their level of professionalism. Maureen explained that she felt her role was to deal with clinical issues, not to teach professionalism to younger staff.

Maureen noted the need for consistency in management so that staff were able to work within the same set of guidelines. This was difficult as there were a lot of people in acting positions (due in part to the health department restructuring of the hospital sector) and they have been acting in those positions for some considerable time as the roles were never settled. This then resulted in people not taking ownership of the role which then filtered down to the behaviour of staff in the ward area. Maureen believed that nurses were required to have a high degree of professionalism. However, she was unsure if, at the grassroots level, nurses demonstrated professionalism working in a magnet hospital or not. She felt that some nurses were in the profession just to make a salary rather than feeling accountable and responsible for their actions. She had seen instances of nurses making mistakes who would just go home at the end of their shift and not even concern themselves the next day with the outcome of the mistake incurred. She perceived that elements of the nurses' role had not changed over time with nurses remaining as the go-between of the doctor and the patient.

Maureen felt those new graduate nurses who were taught to question and understand the theory behind their practice, were very good for future practice. However, she did feel that the capacity to develop therapeutic relationships was not second nature to new graduates as they had less time working in the clinical areas and this resulted in the new graduate not always providing holistic care. Experience taught a nurse that, within a holistic approach,

they would include asking the patients if they had any concerns, including if they had any pets at home that needed attention.

Maureen's main hope for the future regarding professionalism was that "the frequent flyers, the ones that were causing problems have consequences and are not just called into the office and given a ticking off" (verbatim). Where people were disrespectful, and the attitude was not satisfactory, they may have been spoken to, but nothing was documented due to the staff reluctance to put it in writing. It was important that the person who was doing the ticking off was not made to be unpopular just because they have held others to account. By having an open-door policy with the manager, it allowed nurses to discuss any issues that they had in the ward area. This helped with new staff, as orientation, did not necessarily advise of all the necessary policies and expected behaviours. Maureen observed that those responsible for performance management of staff have little time available for working on the wards and therefore often have little understanding of the extent of the problems. The next nurse leader to share her stories and experiences was Nicola.

Nicola

We had agreed that I would come to the hospital where Nicola worked and then go to the hospital cafeteria to talk. So, at 10:00 hours, I asked for Nicola at the nursing reception, and within a few minutes, a well-presented, middle-aged lady in a blue nursing uniform came out and introduced herself. We then walked to the hospital cafeteria and found a table at the back of the room, where we could speak more freely, and the taping would not be influenced by the background noise. Nicola was very enthusiastic about the study and eager to share her experiences over the years.

Nicola is a British-born 55-year-old who qualified with a Diploma of Nursing in the UK in 1977. She then attained a registered District Nurse qualification, having worked as a

district nurse before coming to Western Australia. Having completed her registered nurse training through a hospital-based training model, Nicola had nursed for 39 years and had undertaken a variety of roles in middle management and leadership. These roles included that of a nurse manager, clinical nurse, and education officer in different hospitals within Perth. Nicola was currently working as a Clinical Nurse Specialist on an Aged Care Assessment Team and loves the job and the people she works with. As part of a multi-disciplinary health-team, she is involved with the discharge of patients. Her clinical specialist role involves assessing and managing the patients in the home care environment.

Nicola began her training as an auxiliary nurse at the bottom of the nursing hierarchy. She recalls that when the matron came on, she checked that the sheets were turned down, and the wheels were in the right direction, and the pillows were turned. Although Nicola felt this was "*over the top and didn't have any impact on care"* (verbatim) she believed it made her sit up and take notice of how things were in the ward area and how the ward and patients looked. She felt that there was an emphasis on making people comfortable in bed, which included such things as the regular pressure area rounds by nurses. Charge Nurses were either supportive or "cranky", but everyone understood the system and where they fitted in the structure which gave continuity to the staff. In the past, Nicola felt there was a real sense of comradeship and support between nurses, which she thought was due in part to living together in the nursing home. She recalled that coming home to all the other nurses and talking about the day together, made a hard day seem not as bad.

Nicola talked about how, if you feel good in your environment, you feel more positive, and that the hospital in which she works now has very beautiful views and a very opulent feeling. Nicola then reminisced that in England she had worked in two hospitals, one built in the 1700s and the other in the 1800s. She thought that the environment of these hospitals was very old, so perhaps did not go "hand-in-hand" with good nursing care. Nicola

was surprised when she came to Australia at the amount of power that the medical services wielded which was different to that in England. Nicola described how doctors were treated as if they were Gods in Australia with the nurses running around, making sure that everything was ready for them. She described how nurses reinforced their subservience as "handmaidens to doctors," whereas she believed they were equals. Even the doctors recognised that some believed they were special as illustrated by the joke: "*I went to see an anaesthetist with one of the operations I had, and it was neurology. The specialist, the anaesthetist, said to me 'Do you know what the difference is between God and a neurologist?', and I said No, and he said, 'God doesn't think he's a neurologist".* Nicola felt that nurses played an important role in the training of the junior medical staff.

Recently it became evident to Nicola how important a professional manner was to patients. Nicola described her experience as a surgical patient in a hospital where she had ended in tears. Nicola shared the story of a nurse who told her off in a very stern, impersonal, sharp manner for not having drunk enough water during the day, which resulted in Nicola bursting into tears. Nicola believed that the registered nurse's behaviour was an extremely unprofessional way to deal with patients. Nicola did not believe that such poor communication was frequent; however, she had seen other similar examples on the wards.

Previously, Nicola was concerned about a lack of continuity in the ward's management, resulting in the younger staff not understanding where they fitted into the nursing structure. However, this situation has changed, with greater continuity of the ward coordinators; subsequently, there is more stability for staff. Nicola felt it was difficult for nurses to be professional when there was a lack of senior staff to provide support, particularly in an environment where patients present with a wide range of co-morbidities.

Nicola explained that in her workplace, they have a very professional multidisciplinary healthcare team that works well together. They have regular meetings

where all members share information and work within the organisational policies and standards. Through regular team meetings, any issues are worked out collectively, resulting in more of a team approach, rather than any team members taking things personally. All team members have equal input and ensure that the associated workloads are of an equal level. Understanding each other's professional role helps with understanding the workloads, for example, if one member of the team is unable to take on more patients or patient concerns, then the workload is allocated to someone else, where it fits into their role. Having a good understanding of people skills and personalities and using those skills in a positive way ensures that the team work in a professional manner.

A career structure which includes access to professional development opportunities, enabling nurses to develop the necessary skills and knowledge to progress up the career ladder was important. Progression within the career structure was not done well in the healthcare sector, according to Nicola, as current processes for job interviewing and promotions needed to consider people's knowledge, personality and fit into a team, as well as if they interview well. The next nurse leader to discuss her views and experiences was Page.

Page

Page is a 48-year-old woman, born in Australia, who registered with a Bachelor of Nursing in 1996. She has since attained a postgraduate certificate, a master's degree, and a Nurse Practitioner qualification. She had been nursing for 20 years and currently is the Clinical Nurse Specialist/Nurse Practitioner in a multidisciplinary medical team which also incorporates home visits. Page developed her specialist Nurse Practitioner at a large public hospital in Perth. When the organisation decided to create the nurse practitioner role for the multidisciplinary specialist team in which Page worked, she was asked to assist in

determining the level of autonomy required for the nurse practitioner role and to write a job description which determined the level of function of her position.

Page and I had agreed to meet in the café at the hospital where she worked in the late afternoon at the end of her shift. Moving to a table outside allowed for more privacy in case other customers arrived; it was also was very quiet and facilitated the recording of the interview. Page was a tall, dark-haired woman in a blue hospital uniform. She said that she was happy that someone was interested in the professionalism of nurses and was pleased that she could be part of the study.

Educated primarily as an enrolled nurse at aged 18, Page then went on to undertake a registered nurse training in Perth at a local University. This was followed by Page attaining a Critical Care postgraduate Certificate and then a Nurse Practitioner master's degree. Page now works as a clinical specialist in a small multidisciplinary team.

When describing people in her nursing career who have impacted her the most, she explained that there were only a few that really made the difference. She felt that the people who stood out for her were the ones who did that extra something for the patients; they did not race off for their lunch break but would stay with patients. She described these nurses as having a positive work ethic, being dedicated, caring, and very patient-focused. She explained that these people had vast knowledge and spoke with authority because they knew what they were talking about.

Page reminisced about an old matron with whom she worked in the Australian outback. When there were no patients, the nurses would go and have a cup of tea and sit down; however, when there were patients, they were the entire focus of the nursing staff. She felt that she tried to emulate those beliefs by role modelling the good behaviours and attitude, which showed nursing is about the patients, not just getting paid to do a job. She felt that these days there were nurses who were not actually interested in looking after the patient;

rather, they were just doing a task, without considering the patient. This meant that sometimes, they spoke to patients, perhaps not as nicely as they should, which she found extremely frustrating. In addition, these senior nurses sometimes spoke unkindly to junior medical staff, thereby destroying any collegial, interprofessional relationship. Generally, Page felt that a lack of respect between medical staff and nursing staff posed huge risks for patients because without respect for each other health staff did not communicate effectively, and that's when issues happened. Page stated, "*...instead of assuming let's just ask*" (verbatim).

Page believes that professionalism is taught, that people are fundamentally caring, but that parents and other role models teach respect. She believes that nursing role models are those nurses who can manage their patients in a quiet, calm manner, albeit senior or junior nurses. She believes that nurses are at work to do a job, and even if they have home stresses, nurses should leave their problems at the door as the patients are the focus. Page described that when she was diagnosed with breast cancer; she only took the day off, then went back to work and continued setting up the health service in which she currently works. Page believes that increasing knowledge through further education augments equality with different disciplines, thereby increasing peer respect. Page believes that to support professionalism in the clinical areas, one needs to manage poor staff behaviour, thereby perpetuating a culture of respect amongst colleagues. She believes that social events are important for team building as it develops bonds and encourages consideration of colleagues. The next nurse leader to share her experiences of professionalism was Wendy.

Wendy

Wendy had emailed me asking to be part of the study, having seen the study flyer at her hospital. Wendy asked if she could come to my office rather than meet me at the hospital

in which she worked. Wendy came to nursing reception to meet me at 10 am midweek. We went to my office and sat on either side of the desk with two tape recorders on the desk. Wendy seemed at ease, refusing a coffee, rather accepting the offer of a glass of water.

This Australian–born, 53-year-old woman, had qualified as a registered nurse 12 years ago with a Bachelor of Nursing through a Perth-based University. Since then, she had completed a postgraduate course in intensive care nursing and was currently undertaking a master's qualification in nurse education. Currently, Wendy worked in an acute care public hospital in Perth, in the dual role of a clinical nurse and nurse educator. In staff development, Wendy managed more junior staff development nurses who provided the support and education for the nurses on the ward.

Wendy was very prepared, having brought a set of notes with her on her thoughts about the topic of professionalism, and she referred to them throughout the interview. She did not discuss any history of her professional development or her understanding of professionalism, other than to say that professionalism was learned through good role models, *"where you see people, and you think that that's how you'd like to be"* (verbatim). Wendy's conversation was enthusiastically focused on discussing the current state of nursing professionalism.

Discussing professional standards, Wendy explained that standards are about nurses who are professionally competent in what they are doing and who have a high degree of skills, especially in basic nursing care. It was also about keeping patients safe and using evidence-based practice (EBP) for clinical care, and all nurses utilising EBP in their daily nursing care. However, she said that when she talks about EBP with nursing staff, *"you see people, the shutters come down over the eyes, and it's like now she's going to bore me with it"* (verbatim).

Wendy explained that currently, the hospital at which she worked was undergoing restructuring and that the new Chief Executive Officer (CEO) had regular forums where everyone was welcome to talk about the future goals for the hospital. All staff were encouraged to have their say about the new structure. The new CEO had instigated a plan to have medical and nursing sectors *"have more engagement across the two disciplines rather than work independently, which was what they've done for years*" (verbatim), she said. Wendy explained that at present, the hospital was under restructuring because there had been a new large public hospital opened, and a lot of the senior nursing staff had left to join the new hospital. This meant that the skill mix left on the wards was not as good as it could be, with a lot of junior staff "acting up" into more senior roles. As a junior staff member, they could not support the other nursing staff on the wards as they were also learning in the job, day by day. She felt that in time it would be all right, but at the time of the interview, everyone was really unsettled and needed a lot of support, due to all the changes.

As far as Wendy was concerned, she could not understand how nurses could say that their day was just the *"usual crap or they hate their job"* (verbatim). She reiterated that if you hated being a nurse, you are obviously on the wrong ward, implying "why wouldn't you want to try a new area of nursing?" Wendy felt that there was so much variety available, with so many different nursing areas to experience, but nurses had no self-incentive. The disgruntled staff had not used the staff development nurse who tried to push them and help them develop professionally. Wendy felt assistance also came from the senior nurses who could help guide more junior nurses toward different available, suitable opportunities, to broaden their scope of practice and make their work-life more interesting. She believed that having a negative attitude, especially from those acting in leader's positions, rubbed off to other members of the team. Wendy explained that when nurses applied for a promotional position, there were selection criteria which applicants had to demonstrate they could meet

through providing examples to case studies. This was demonstrating they had the skills and knowledge necessary to meet the selection criteria. The only problem that Wendy saw was that once an applicant got into the position, there was no trial period – for example, a three-month probation period – rather, than once they are in the position, *"you're stuck with them"* (verbatim).

Wendy described that a strong leader who was open, supportive, with regular meetings and good communication, who did not allow "Chinese whispers", and did not apply blame to an individual, influenced the professionalism of the ward culture and created a positive work environment. Wendy believed that there may be *"only pockets"* (verbatim) within an organisation with individuals or groups who were bullies, but that generally in her workplace, most staff were professional. She did mention that in some ward areas the workload, even with the allocated nurse-to-patient ratio, the ward work was physically demanding and extremely heavy. In these situations, when the clinical nurses tried to address any problem, they were bullied out of their position by more senior levels of management.

When discussing where to from here, Wendy believed that managers needed to work on the floor, even for one week every three months, as it would keep them in touch with the reality of the issues and the changes required. Wendy felt that talking and listening to the other nurses during their tea breaks would give the leaders information about the issues impacting on the nurses and the workplace. This would then allow management to understand better, how to improve the workplace and enhance the nurses' daily work life. Wendy was the final nurse leader to describe her experiences of professionalism.

All twelve of the nurse leaders have been introduced and their beginning, middle and end stories discussed at the varying levels of depth that they shared with the researcher.

Summary

Each of the leaders has been introduced and described, allowing for the development of a picture of the participant. Each leader gave a short synopsis; items included their age, where they undertook their nursing education, their current area of work and expertise, their experiences related to the beginning of their understanding of professionalism, their current views and experiences of professionalism and their thoughts on the future of professionalism. It was interesting to note that, when examining the interviews for the beginnings of the nurse leaders' experiences of professionalism, the hospital-based nurse leaders tended to want to share their more historical experiences of professionalism whereas the university-educated nurses did not. Hospital-based nurse leaders appeared to have more stories of their time in "training" which they were eager to share. This storytelling of early nurse education was not evident with the nurse leaders who were university educated. These descriptions from the nurse leaders of their experiences will assist the reader to hear the nurse leaders' voices when reading the following analysis and findings chapter. In the following chapter, the various experiences and verbatim excerpts of the nurse leaders are revealed and, when combined with the descriptions of leaders given in this chapter, a full image of the leaders can be made.

Chapter to follow

Chapter Six Analysis follows and identifies and discusses the themes which emerged from the nurse leaders' narratives. As each of the themes are described, examples from the nurse leaders' narratives are provided to give voice to their thoughts, ideas and opinions on the professionalism of the registered nurse.

Chapter Six: Analysis

Introduction

The previous chapter introduced the nurse leaders and the context in which they worked at the time of interview. The chapter outlined how the nurse leaders had developed their view of professionalism from their role models and mentors; their current workplace; the registered nurse within their workplace context; and what they saw as the future of professionalism.

The narratives of Andrew, Diane, Jerzy, Julie, Karen, Katherine, Lee, Louise, Maureen, Nicola, Page and Wendy provided valuable insight into the concept of professionalism in nursing through the telling of their experiences. An essential element of an interpretive research approach is that the researcher reveals not only the salient points which the nurse leader wishes to be known but also enables the researcher to recognise and interpret the more elusive elements contained in the narrative which underpin the fabric of the experience (Clandinin & Rosiek, 2006; Cohen et al., 2007; Creswell, 2009). Four themes were revealed from the nurse leaders' stories – professional presence, walk the walk, owning the problem, and bridge over troubled waters. Each theme and related sub-themes were presented in turn.

Theme One: Professional Presence

Nurse leaders identified "professional presence" as the first significant professional theme. Professional presence, in this study, encompassed the perceptions held by nurse leaders, formed through observation, of ward nurses. The professional nurse was a person who presented to the clinical environment as neat, clean, and when relevant, in uniform; and displayed a calm and confident demeanour. Confidence was described as an attitude of self-assurance and a belief that the nurse was able to do something well and succeed in providing nursing care.

Appearance: Being neat and clean

The appearance of the nurse as neat and clean in the workplace denoted a professional nurse. Louise described how a professional nurse should present at work: "She's confident, she's calm, she understands the patient, she's caring, and she's clean, neat and tidy". Here, as a part of professional presence, being neat and clean was a blend of pride, self-confidence, control, and character. The nurses' presentation denoted them as credible and competent to others. Nicola, who described herself as "old school", believed that the way nurses presented themselves demonstrated their professionalism. She contended that a nurse's professionalism was recognised by "the uniform is clean, your shoes are clean and whatever the policy says your shoes should be, as a nurse your hair's tied up, you don't wear lots of jewellery, but that might be old school". Several nurse leaders shared this sentiment. Katherine discussed:

> There is no way around the fact that people judge you by your appearance. So, nurses who are in clean scrubs, or whatever their uniform is, with tidy hair, off their faces, and who wear clean enclosed shoes, look groomed. This says, even before they speak that they care about themselves and because of this, they have the capacity to care for patients.

These same sentiments are mirrored by Julie:

> …. in all the basic things like appearance and things like that. People are just adhering to the uniform policy, which often isn't as good as it could be perhaps and just these kinds of appearance and things like that. Looking neat and tidy and things. I think from a patient's point of view, that's what they would anticipate professionalism within nursing to be.

Maureen also says:

> A professional nurse is not only calm and confident in the way they speak to others, but their uniforms are clean and ironed. They don't look like they just

> got out of bed.... When you are providing patient care, it is important to look professional and hygienic, so wearing clean and ironed clothes is a necessity. It shows that the nurse takes pride in how they look. This, I think, is important for patients. (Maureen)

Three nurse leaders also stated that nurses who wore nail polish to work showed a lack of self-respect and pride in the profession.

> I've seen older nurses come in with bright red nail varnish on and laughing when they get told to take it off. …They're not stupid people, I would have thought it's fairly obvious. I wouldn't say its defiance either; I don't know, it's probably that 'I don't care feeling'. (Maureen)

Katherine, who believes she is from the "old school", raised the issue of nail polish and adornments as not only being a poor reflection of professional self-respect but was an indication of the nurse's adherence to professional practice.

> I guess it's just the little things really. It's even like whether or not you see people doing their hand hygiene and maintaining aseptic technique. For example, the whole bare below the elbows thing and not wearing loads of jewellery. I just don't think that [sic] looks very professional when you see people out with loads of bracelets … you see them with all their arms full of bangles and rings on all their fingers and nail polish. (Katherine)

Nicola also referred to the "old school" when discussing appearance and said

> …skills, knowledge, your motivation, your education, your presentation. I might be old school, but I think professionalism is shown in how you present yourself.

Julie described how she believed patients felt about professionalism and appearance, saying:

> I think a lot of it goes down to professionalism in the way the nurse does basic things, like appearance and things like that, looking neat and tidy. I think from a patient's point of view, that's what they would anticipate professionalism to look like. (Julie)

Jerzy contended that some nurses do not consider how their appearance impacts on their professionalism:

> I mean there is a world-wide dress code, but the dress code is that you go into any ward dressed to meet the requirements, but I don't think it is as it used to be. I'm not saying put them in uniform or anything at all, but we all have to be smart, dressed casual, respectful but you see people with their shirt out and shorts and probably sometimes they will come with shoes that are not (gestures) so I think that kind of thing has changed. (Jerzy)

Diane and Katherine discussed their different viewpoints on this worldview. Diane began with:

> Not having the dangly earrings, the excessive amounts of tattoos or something, but then, that's me, that's my demography that's what I think. I certainly don't think my kids would even bat an eyelid at anything.
>
> ….I've got on the right shoes, I've got the right uniform on, I've got the right earrings on…You know some of the managers wear red shoes by the way (laughter) I know, it seems to be liked in our role (laughing). I haven't got a pair of red shoes, maybe I should (laughing).
>
> …I'm not anywhere near the patients, but that's how I function as a nurse because that's what I've always been, but that doesn't make it right, and I don't know, I honestly don't know whether the way she is you know with the stud in

> the lower lip and all that. Does anyone notice? I'm not sure that they do half the time. (Diane)

However, Katherine did not consider that nurses having tattoos or piercings were any less professional saying:

> I don't think it matters if somebody has got tattoos or anything, it is not what I mean by appearance (Katherine)

Lee presented a more practical approach to the subject of the appearance of a professional registered nurse:

> Appearance in general terms needs to be looking neat and tidy. No long hair, I can't say about the piercings and things like that because people do have those and as long as they don't interfere with their work (pause), we had one girl that had the web of her hand pierced, and that to me is interfering with her work and doesn't look very professional. So that was removed, infection control comes into play there. So, the look, the way they approach things, the way they interact with people does.

Manner: Calm Demeanour

Nurse leaders reported that the display of a calm and confident manner by nurses was a reflection of a nurse having an appropriate skill level and knowledge base, an attribute seen in a nurse that demonstrated professionalism. Five participants described calmness as an observable attribute, like an aura that a nurse radiates even when the ward is busy and in times of stress. Louise described this quality: "She's confident, she's calm, she understands the patient, she's caring, and she's clean, neat and tidy". Wendy continued with:

> …[they] have that lovely calm manner about them when they're working or when they are teaching they don't mind how many questions are asked …. they

> never treat them [others] as being stupid or taking up their time, no matter how busy it is. They are open, and people don't feel threatened in any way. (Wendy)

Lee described how a calm and confident manner portrays a nurse as a professional, and this demeanour can impact on the way others behave and work. She explained:

> I don't think it's something that somebody can sit down and teach you about professionalism.….when you don't have a good attitude, get stressed out, so others [then] feel stressed, that to me is very unprofessional. When you see a nurse that is calm, soft-spoken even when it is hectic, or when there is a patient who starts to bleed, or becomes really unwell, it makes all the difference. You can see how those around them seem to mimic, I don't know if that [is] the right word, but they settle and follow her lead.

Page went on to describe the nurse who can manage a stressful situation while demonstrating a calm manner:

> I don't necessarily think it has to be a senior nurse, could be a junior nurse. You know yourself if you're on [sic] a ward there will be someone who [sic] you will go to. They have got it together; they can manage their patients; they are calm; they are quietly speaking with people very nicely—their attitude to the patients and co-workers shows.

Katherine also discussed the value of having registered nurses who display a calm and confident manner:

> There is a way nurses can communicate when things are frantic on the wards, and everyone is busy…then something happens, a MET call happens. Everyone rushes in and starts trying to get to the patient. I have seen some nurses walk in and in a calm and quiet way, just take charge. They kinda [sic] just in a quiet way get the others to stop and think.…. I think with the pressures that are on

> the wards, a nurse that is able to settle the group by just getting on with the job quietly is what we need. No drama, maybe this way of acting is professional.

Maureen reiterated the importance of calm and confident nurses on the floor. She contended that:

> Nursing is the kind of job in which emotions can run high because every day a nurse comes to work and has to deal with patients and their families who are usually worried about being in [the] hospital. Along with this, most nurses work shift work, often with short turnover times, so often the nurse has to call upon all their reserves to get through the shift. Every shift is busy and what makes a difference often is the nurses on the shift, if they are confident with what they have to do, they make others feel calmer because they [the nurses] know they have someone around who knows what's going on. Particularly, in emergency situations when a calm, clear thinking nurse is needed, someone who can show, and [has] good judgment and show others how to manage.

Skills and knowledge: Competence

Nurse leaders also identified that in their experience, a nurse's calm and confident manner reflected the nurse's ability, and their skills and knowledge, and this demonstrated a professional presence. A calm and confident nurse was considered a competent nurse. Lee said:

> I think put professionalism as appearance, interaction, communication, knowledge, understanding and empathy. The nurse I am thinking about wraps all these attributes together, but being competent and being calm in a crisis is the key. No point in empathy if you aren't competent.

All leaders discussed knowledge and skills and the importance played by these attributes in the role of a nurse. Maureen described the need to be competent in practice as: "the nurse is

somebody who is caring, somebody who is knowledgeable about what they are doing and not just knowledgeable; but actually [sic] has the skills to know what they are doing". Maureen continued:

> So, competence with what the nurse is doing, the knowledge behind what she is doing, and her demeanour towards them [patients], and other staff on the ward, depends on the situation but staying positive and calm is important.

Wendy asserted that nurses:

> ….are professional when they are competent at what they are doing, and you can see that they've got a high degree of skills, especially in basic nursing care. So, it doesn't matter about all the bells and whistles. I mean they do matter, but I think a professional nurse seems to give a feeling that things will be OK and will always demonstrate good basic nursing care, no matter where she's working.

Page added to this, saying:

> People's confidence and skills are part of professionalism because at the end of the day if, if you can't do your job, or you don't have the knowledge to do your job, and if you don't recognise it [sic], then it is impossible to be professional.

Diane shared her belief that nurses who have the necessary knowledge and skills are able to use this knowledge to make sound clinical judgements. She added:

> A nurse's calmness and confidence are embedded in their nursing knowledge and skills. Knowledge, if I look at people who have impacted on, or have stood out to me, they tend to be people who have knowledge. So, they talk with authority because they actually know what they are talking about and because they are seen to have knowledge and skills, they act in a particular way, and others notice it. I thought being a professional, confidence would be quite high up; I would imagine.

Julie added to this by discussing the ability of a nurse to switch between personas, for example, when building rapport with the patient and having to undertake a nursing action. She asserted that the nurse must be knowledgeable and confident in their skills and be able to work at these two levels:

> I see professional nurses who can be friendly and talk to the patient about casual things, like for argument's sake, about grandad's party that they had. 'How did that go and who's making the jelly and blah blah blah" but then when it turns to their disease or nursing caring, the nurse switches persona to start talking or explaining to them [the patient], "you know your phosphate's high, so therefore, this is probably what you're doing or here is the plan" ….so competence with what they are doing, the knowledge and confidence to know how to talk to the patient and family and the nurse's demeanour towards them depending on the situation.

Wendy also discussed the persona of nurses and the need to be thoughtful of the situation, not only for patients but for the nurse's well-being as well, thus pointing out the importance of the nurse's attitude:

> To me where you have, swearing or [a] bad attitude, towards the patients and visitors and to the team. Attitudes and behaviours are the big thing for me, that does shape a profession when you don't have a good attitude that to me is very unprofessional. You are in control of your attitude, and a nurse can choose how to behave or feel at work. It's really important because your attitude can influence others and the ward.

Attitude

Lee continued by saying: "attitudes and behaviours of the individual is what helps with teamwork and professionalism, displaying a really positive attitude and positive behaviours is [sic] what makes one nurse different to another". Louise stated:

> …having an attitude of helping out others and making sure everyone is OK with their workload, not sitting at the desk flipping through a magazine when someone else is running around trying to look after their patients. Pitching in and helping without being asked.

Karen explained that being prepared for the workplace showed which nurses, who came to her specialty area, had the right attitude.

> … new nurses come down, and they get a day with us… you certainly can pick the ones that just like nursing because they come in and they are dressed appropriately, they haven't got the dangly bits, they haven't got their phones in their uniform pocket, that's in the bag, and it's turned off. They've got a biro, [sic] they just come ready to work and to learn, [to] be interested.

Nurse leaders agreed that it was often difficult to give examples of nurses exhibiting the right attitude to work by some of the behaviours that they had witnessed. However, when a nurse displayed professional presence, some of the characteristics included not backstabbing, not being sarcastic or looking for the negative in colleagues or others. Julie described a nurse with a professional attitude:

> A nurse with a professional attitude is supportive and encouraging with patients and other people in the ward. They don't bitch [sic] about other nurses behind their backs. They make sure everyone gets a break, and they help out others when it's busy. They seem to try and make the best of the situation, and it

> doesn't matter what's going on at home they get on with it. It's 'I am at work, and I have to do this well,' and they get on with it.

Katherine recounted a story of a nurse displaying a professional attitude when dealing with a member of the multidisciplinary team:

> I think with the pressures that everyone works, means that you have to have the attitude of being respectful and assertive to get the job done… when the nurse is collegial and has a plan to discuss with allied health so that both can prioritise the workload, it works better. They are showing a professional manner or attitude and using diplomacy to get the task done. You've got to work with them the next day so being stressed and rude isn't going to help. The nurse acts in a way to build the relationship.

Maureen explained that dealing with any staff member should reflect respect:

> Treating your colleagues as you would wish to be treated yourself, treating your patients as a person rather than a patient, respect, knowledge, courtesy, and I'd even include the visitors and relatives….So yeah, it's just treating people respectfully I think.

Lee, Louise and Julie raised the issue of a nurse's attitude as significant to how they fostered a professional presence, although most nurse leaders were only able to provide instances where situations impacted nurses from their home lives, or from the negativity of others, which hampered their attitudes and behaviours at work. These attitudes and behaviours, it was felt, prevented nurses from displaying a calm and professional manner. Wendy discussed having a negative attitude and how this attitude may blight another nurse's workday:

> Having a positive attitude, definitely, there are people out there that have a negative attitude. The other day I spoke to someone who is in an acting NCM

> [Nursing Clinical Manager] position, and she said she hates the job and she doesn't want to be in it. She is only in it because they couldn't find anyone else to do it, so they asked her to do it. She takes that negative attitude with her, to the people that she talks to and graduate nurses that come through, that negative attitude I think can rub off on people. So, I think a positive attitude is really important.

Katherine recognised the influence of home-related problems and how these influence a nurse's presence on the ward:

> Sometimes I find there is a difference between whether or not someone is struggling at home when they are busy. They react without thinking; they sometimes add to the issues on the ward. They are not able to be unruffled when things happen, and this flows on to others, and it's no fault of their own. I suppose that's a key if you are having a conversation with them about whether or not they need support in that area.

Moreover, Lee acknowledged that home stress interplays in how nurses acted while at work. However, the belief that personal stresses and home pressures should be *left at the door* and not brought into the work environment remained central to Lee's view of behaving professionally:

> I suppose workload of patients, and home stress can affect peoples' attitude at work; relationships with colleagues can affect peoples' attitude at work. My belief here is [that] you are there to do a job, and everyone has problems, but there needs to be a divide between home and work once you enter the ward.

Andrew explained that: "being able to leave home problems at the door demonstrates a positive attitude". Eight participants felt that a positive attitude at work was an integral part of

having a professional presence. Diane described its impact on patients, families and colleagues:

> I think it's about attitude and the right attitude brings the right actions …It's the way we act when we are around patients, families, colleagues, and it's the way we dress. I believe the way we present ourselves is part of professionalism.

Maureen and Wendy agreed that a part of being professional is about being able to have a presence, despite having issues at home or with others on the ward. Maureen described a scene in which she was dealing with a nurse who had recently had a death in the family:

> It was a busy shift, and like usual, it seemed like everything was happening at once. Mrs S was terminal and had her family around her. …It came time to go home, but this nurse didn't seem in a rush and stayed with the family a little longer and then went to write up her notes. What struck me was that she put the family's needs first and didn't rush off to do her notes. Later I learnt that she had a family member die, recently, but I would never have known because she just got on with it.

Page talked of a personal experience which cemented her position on having the right attitude at work.

> I had breast cancer a few years ago, and obviously, I took a day off when I found out about it, but I still managed to work because I had to, I was setting up a service, and if I didn't work then I didn't have anyone else to cover me. So, it's the attitude that you do; you can leave your stress behind because at the end of the day your focus should be on your patients and not yourself, that's my view.

Wendy talked about the attitude of nurses which enhanced professional behaviour which stemmed from having a calm, confident manner, particularly when dealing with confrontation on the ward.

> [A relative] was really angry and speaking loudly so the other patients and visitors could hear. [name] her mother's nurse, I could see, was also getting louder and defensive; it was like she was mirroring the upset relative. Then the shift coordinator joined the conversation and quietly apologised for what had happened. She offered to make the daughter a cup of tea and said that she would page the doctor for her. I think this calm way of dealing with the daughter and taking charge of the problem showed professionalism. It didn't matter what the issue was, or whether the nurse was to blame, it just worked. (Wendy)

Having a professional presence meant more than being able to remain calm; it also included being knowledgeable and displaying a professional attitude.

Caring qualities

Nurse leaders considered the skills of demonstrating caring qualities, along with competence, as integral to professional presence. Nurse leaders believed that the effect of these skills on colleagues, interdisciplinary team members, patients and families placed nurses firmly as professionals in the broader community. Ten nurse leaders emphasised the observable attribute of caring. Nurse leaders described caring as a nurse's understanding, supporting and assisting of an individual while being mindful of that person's feelings, concerns and experiences. Nicola described what caring meant: "Someone who is approachable, who uses the personal touch, understanding and empathy. A nurse who sees and hears the patient and responds to their needs. To me that shows what professionalism is". Lee discussed her experience with an uncaring nurse who did not demonstrate empathy for the patient.

> Empathy and what that means, putting yourself in that patient's point of view, and I don't think that this individual [nurse] did that. To recognise [that] if you are having bariatric surgery and you are one hundred and forty kilos, how that influences how you feel about yourself and how you think other people feel about you. Not everybody thinks along those lines, but to me that caring about the patient and showing empathy is part of being professional as well.

This example showed that as a professional, there was reinforcing of the expression of caring through the use of empathy. In this case, Lee highlighted how nurses often construe what is best for the patient without consideration of how the nurse's communications and actions influence the nurse-patient relationship. An empathetic and caring posture would have resulted in a different message being sent to the patient, a message that meant "I understand how you feel, and I want what is best for you". Another nurse leader who believed interactions between nurses and patients that were less than professional was from Louise, who said:

> ….they [nurses] really don't care, their attitude towards their patients is uncaring; they're rude and abrupt to their patients; they ignore some of the patients…. mostly, they don't show patients that they care about them and what happens.

Julie proffered an interesting opinion of why these non-caring behaviours may prevail. She said:

> ….in many places that they [students] work they're picking it [poor behaviour] up from where they work, and they don't get pulled up on it, and so it continues, and then it [the poor behaviour] continues on [sic] into their time as a nurse, and then they're mentoring other nurses.

Andrew, however, juxtaposed these examples with a description of an event that he witnessed as a junior nurse which captured the nurse's caring qualities, which he viewed as the essence of professionalism.

> I will never forget the night shift, where we had only one patient in our area. We normally have six, and it was about 4 o'clock in the morning, and we were both really tired. We had this one elderly lady from a nursing home who was quite demented, and she had cellulitis on her foot, so she had to be admitted. She kept on getting up, she was just 'busy' at that time of the morning, and we were very tired but Josephine [the nurse] sort of changed the bed around a little bit. She just, instead of having them in a nice neat row, she turned it on the angle away from the lights down the corridor, dimmed some other lights, pulled up a chair beside her and held her hand in the bed and just talked to her and sang her some songs and talked to her for a good 45 minutes, if not an hour. This lady eventually fell asleep. I said to her that really meant a lot to me, and it was when I first started at XX hospital as well. I thought, wow she is awesome, that's what I want to be like. I want to be that caring nurse; she knows everything. She's really smart as a nurse, but she still has that caring quality which I think sometimes is more important, people just want to be heard, and they just want to be cared for.

Josephine's caring behaviours had a lasting effect on how Andrew developed as a nurse and on how he was able to describe tangible caring as professional behaviour. Andrew expanded on this view, stating:

> All nurses need to be able to encourage and work from a humanistic approach, and that is being a professional. We need to ensure that our interpersonal skills are of a higher order and incorporate caring. If I, as a leader, can step out and

> demonstrate that [caring], amongst my peers, as opposed to just telling them 'you have to do it this way or that', then the message to people watching me is [sic] that I put the patients' needs first and care about them as individuals.

Page similarly shared her views that caring behaviours are an attribute of a nurse's professional repertoire and that these caring behaviours facilitate professional presence:

> I have seen caring where nurses have sat with patients after they [the nurse] are due to go home because the patient doesn't want to be left alone or sat with family members. I think that is really important as a nurse that we are caring.

Diane provided similar rhetoric:

> Just the way they [nurses] speak and present, talk to patients, their acceptance of different cultures and diversities….[it] doesn't matter who [sic] they are talking to, or what they are dealing with; they just present the same caring attitudes.

Lee says that a nurse's attitude of caring is simply shown when "Nurses who didn't race off for their lunch break but would sit with patients … it tends to be people who have put the extra time into the patients. I suppose that's what I see as being professional". Nurse leaders felt that the public expectation of nurses displaying a caring attitude or demeanour impacted how the profession was portrayed. Wendy stated: "I think they [the public] view us as caring and hardworking. I don't know whether they really view us professionals or not, I guess they do". Maureen added that the public sees a nurse as "somebody who is caring, somebody who is knowledgeable about what they are doing, and not just knowledgeable but actually has the skills to do that". Lee went on to say that she believed that the public hold nurses in high regard as "we always come out on that poll [Gallup Poll] where they go on about how much you can trust nurses". This sentiment was also voiced by Jerzy who said, "We know the public has a [sic] good regard for nursing; generally, we know that, with what

we hear and all that". However, although the public has a positive view of both doctors and nurses, Maureen felt that patients see differences in the type of support the nurse provided compared to that of the doctor:

> I like to think that nurses deal with patients and advocate at the end of the day for the person. I still think they [patients] see the nurse as the go-between; between them and the doctor and as the person that's going to fight their cause.

The narratives of the nurse leaders of caring and supporting patients were seen as part of a professional presence that should also include caring and supporting colleagues.

Support of colleagues

Leaders acknowledged that the healthcare environment placed many stressors on nurses. These stressors included completing nursing care often with a shortage of staff, rapid patient turnover and increased paperwork. Those nurses observed to be supportive of colleagues despite these conditions possessed an attribute of professional presence.

> There's a lot more support from hierarchy. There's not the old 'well I'm the Matron' or 'I'm the whatever,' 'this is what you're going to do.' There is [sic] a lot more respect and support of people [nurses] using people's [nurses] knowledge, skills and personality to fit them into the right area. (Louise).

Page contended that nurses needed to improve how they support and care for each other, which may be saying a simple thank you:

> I like to tell my staff each day thanks for coming in, thank you [for] doing a great job. I hope that by doing this, I am showing the practice of being supportive....It seems to have rubbed off on some of the staff. I see them thanking each other for helping out with patients or for getting a patient from theatre.

> While I don't expect nurses to bring their problems to work, it's important to take [an] interest in some aspects of their home lives. If they have a problem or can't get kids to school because they are a single parent, it's good to know this. If there are problems at home, and we understand this, it's easier to be supportive. I have seen the nurses discuss the roster and ask, 'what days do you need off', or 'do you need an early', 'do you need to work the weekend?' Really this is collegial support, and I think it sets an expectation that you're not just a nurse on this ward. (Jerzy)

Katherine said:

> I do expect people to leave their major stresses at the door, but if each person, and me, understand a little bit more of those you work with, it can make a difference. I think it is really important for team building as the actual team working on the ward needs to be supportive of each other. A couple of times a year the staff go out for dinner, they need to do a few social things throughout the year, that is really important because it does develop those bonds and gives [a] better understanding of your fellow people and supports them.

Karen gave an example of how acknowledging the efforts of less experienced nurses acted as a way of providing positive support. She explained that, through giving this support and emulating the qualities you want to see in other nurses, it encourages them to also behave in that way. In essence, nurses who acknowledge the knowledge, skills, and effort of others demonstrate a professional attribute:

> "Thanks kiddo, you've been a great help". I have never forgotten that and that was sort of a really good example for me when I was moving through the ranks… So, I think that if I'm being the example, and this is what I do, people will then think, "well that's how she does things, we might emulate that".

Lee said that junior or new nurses to the ward need support and reassurance:

> I try and reassure them that they have already learnt a lot in the first six months, be it in a medical ward, even a rehab [rehabilitation] ward. You know all the paperwork now, how to answer the phone, how the system works, how to deal with people, you have learnt about medication and what you are learning now is the surgical side of all of those things.

Likewise, Louise discussed the importance of supporting new or junior staff:

> Clinical nurses who accept new people to the ward, and let them grow by supporting them, and let them take on more responsibility, allowing them to take on more roles but in a supported way. They don't interfere, know what's going on, and if they [the new nurses] do get stuck or get busy they [clinical nurses] are the ones who [sic] you can shout out to 'I really could do with a hand'. This kind of nurse is supportive because they help, they stand by. It gives new and junior staff more confidence in themselves because they know there is someone to help who won't make them feel bad or stupid.

Katherine also discussed the importance that nurses, as part of their professional repertoire, support one another in the clinical context. She reminisced about a shift coordinator who was able to do this:

> There are some really supportive nurses on the ward, and often they act as the shift coordinator. One nurse said that [when] she is the coordinator, she is looking at the people that do the shift with her, so that when she allocates [nurses to patients], they feel well supported and that they [nurses] know she is there to help them sort out the issues on the shift. They feel confident then that the person who is leading the team is organised and knows what's happening. She tries to allocate based on their knowledge and skills and their experience.

> In this way, she can support those who are known to [be] completely disorganised when the ward is chaotic; and I can identify who needs support. Or I allocate an experienced calm nurse with a junior nurse who needs to know there is some [one] to ask questions or to double-check with. I guess this stops or tries to, cut down on me having to be worried all shift. Some people may call this mentoring; I just think it's being supportive.

Katherine went on to describe that each person on a shift, even those in other areas, could provide support for those at the bedside. She discusses the supportive role of the patient flow nurse and how it frees the load of the clinical nurse, which allows them to support the new staff:

> …you can't say that we can't accept a patient because our nurse is not skilled to be able to look after them. So, they need to have someone there to provide support; otherwise, they [new nurses] have a crash and burn shift.

Nurse leaders saw nurses who supported each other as essential when working as a team: "I guess when you are working together in a team, supporting each other and learning off each other, it is really important for professional practice, it's being collaborative, being part of a team" (Andrew).

Lee described how teamwork builds relationships on the ward:

> We had a phenomenal relationship; we worked as a team. I did her job; she did my job; it was teamwork all the way. We stood up for each other, and it made it easy to go on holiday, we shared the load, and the staff were incredibly happy. There was a lot of reward and recognition, a lot of building on the wonderful things that they were doing, and it was really good.

Wendy also described the importance of working as a collaborative team member in maintaining a professional presence.

> I think a positive attitude is really important. I think for professionalism in nursing, it's to make sure we work as a team rather than on our own. When you're a professional, it's important to make sure that you pull your team together. That people don't feel as if they are working in silos and you give credit where credit is due.

Nicola expanded the idea of teamwork to encompass the importance of a team providing structure for nurses in order to provide support for staff at all levels of expertise.

> I think one of the differences here is that up until very recently we had coordinators of wards, we went through that stage when there was nobody really coordinating wards. The younger staff didn't really know where they fitted in; there was no structure, and everyone just got on with it. I think that [it']s very difficult to be professional when you've got nobody to get support from.

The importance of working in a collaborative team extended to working as part of a multidisciplinary team. Julie and Louise described their experiences. Julie stressed the significance of working in a multidisciplinary team and being considered professional.

> People know what they have to do; they know what the standard is. We have regular meetings where we share information, we can also have a grumble, and you know if something's not right [then] we can say "there's an issue, how do we sort it out?" It's not as if there's an issue with you and [its] your problem. It's an issue of what's happened in the team, how are the team going to deal with it, where all the people have an input. We also look at people's workloads and make sure that it's at an equal level and that there's support with an open-door system. So, if there's any complaints, they can come and talk; keeping the team cohesive so that everybody knows what everybody else is doing. So

there's none of "well I don't know what they do", everyone knows each other's role, and how far you can step into another role before you say "OK I can't do that anymore, I'll have to give it to the next discipline". (Julie).

Louise commented:

The coordinator is very much into the multi-disciplinary team being supportive of each other. We have had other managers who haven't bothered with that, and it's become very factorised, [with] nurses do nursing, OT's do OT, social workers do social work, and you don't overlap whereas now we do a bit of overlapping. So nurses have input into the managing of patients and bring up nursing care issues. The team listens to our input, and we have to have a say. This means that they see us as equals with knowledge and skills that provide a different perspective. So teamwork is good, it raises our professional standing in the multidisciplinary team. (Louise)

The importance of supporting members of the healthcare team has been evidenced by the examples from the nurse leaders and demonstrates its importance as an essential attribute of the professional presence of the registered nurse.

Summary of professional presence

The professional presence of the registered nurse encompassed a combination of qualities which together delivered a professional first impression to those with whom the nurse interacted. The observable qualities reported were the confidence and calm demeanour of the nurse. The registered nurse demonstrated they were knowledgeable and competent through their calm, confident, positive attitude, which had a flow-on effect on the ward, with both patients and colleagues. Integral to the professional presence of the nurse was the demonstration of their caring qualities by the nurse with patients, their families and

colleagues. The attributes of professional presence are outlined in Figure 3 is a diagrammatic summary of professional presence and the related attributes, visible to nurse leaders.

Figure 3

Diagrammatic representation of Theme One Professional presence

Theme one	Respect	Professional presence	Appearance
			Manner
			Skills and knowledge
			Attitude
			Caring qualities
			Support of colleagues

The next theme discusses the importance of an environment where the identified professional presence traits were role modelled and supported by all staff.

Theme Two: Walk the walk

The second theme "walk the walk" examined additional traits which demonstrated professionalism in registered nurses. It contains the sub-themes of role models and mentors, collegiality and communication.

Role models and mentors

Nurse leaders identified the importance of having a role model to encourage and sustain professionalism in the clinical environment. A role model was a nurse who embodied the behaviours, attitudes and skills which other nurses admired and aspired to replicate in their practice. Nurse leaders identified role models as those nurses who were clinically competent and demonstrated personal qualities that other nurses wanted to duplicate. It was determined that nurses could learn to be professional by observing and following the behaviour of others who acted as role models.

Eleven of the 12 nurse leaders believed that acting as a role model provided an example to colleagues of how to demonstrate professional behaviour. A nursing role model took on a variety of forms when discussed by nurse leaders – ranging from a nurse they had known or worked with, to the importance of mentorship; concepts which were interlinked by nurse leaders. Nurse leaders purported that a mentor, through role modelling, not only offered an example for others to follow but also provided a resource to nurses about the professional and personal expectations of being a nurse. These expectations often pertained to areas such as communication, attitudes and emotional support as well as other general information relating to working in the healthcare environment. For example, Wendy expounded that nurses need to be cognizant of their behaviour and undertake safe clinical practice. She said: "I guess that for me it comes down to, as a professional person, you need to be a good role model for others, so you practice what you preach". Lee stated:

> It's done by [the] process of role modelling when they [students] do rotations on your ward. Those types of things you are educating them through them watching, learning, and exposure to what other people are doing. I think they learn all that from the role modelling by the nurse managers or their senior staff.

The experienced nurse was seen to provide guidance and support to others. Nurse leaders understood that these experienced nurses were role models because they provided an excellent example for other nurses to follow. They embodied the characteristics of responsibility and accountability and are discussed in theme three. Page attested to the importance of a role model, especially for junior staff: "I think what nurses hopefully do is find role models. Junior nurses need to find role models on the ward to know what is expected of them".

Nurse leaders explained that role models often became mentors to less experienced nurses. Here, mentoring appeared to be an informal relationship where nurses aided each other through the sharing of information. This happened spontaneously with junior nurses seeking out nurses with more experience and skills. Wendy explained that nurses gravitate towards someone who is approachable and able to help:

> …you know yourself if you go somewhere new to work, you would in your own [sic] mind work out who [sic] you would want as a role model and you know, perhaps push yourself more towards that person and seek their help.

Karen explained how a nurse was an informal mentor by just taking an interest in other staff members and supporting them through the structural and logistical maze of the healthcare setting:

> When new grads come in, they are very idealistic, and they want to change the world. If they are on the wards, they've just got to take a step back, look how

> the process works, find the people who [sic] they can talk to or who [sic] they can look up to and then use them as an example.
>
> I would hope that people who have been working in an area for any length of time would reflect and take on board their interest and what they're wanting to know and say, "Well, yep, you can do it this way, or this is the way to do it" or just sort of mentor them a bit.

Diane gave a detailed account of how a nurse demonstrated interpersonal support, via communication with mental health patients, for other staff members and students. This nurse was recognised and nominated for an industry award for the role modelling of exemplary daily patient care and provided the impetus for other nurses to follow suit.

> …she [role model] said, "I see their [new nurses] eyes and they're looking at me going, 'what do I do now,' because they don't know [how] to respond or what's the right thing to say and do. I just step in, and I do it, and then they continue". At those points when they [new nurses] don't know what to do, she [role model] does it, and they get to see how she does this communicating with patients with mental illness and what's expected of them. (Diane)

Nurse leaders shared stories about role models that had impacted their understanding of what it was to be a professional nurse. Karen proposed that behaviours modelled by past senior staff set the expectations of nursing behaviour and interaction on the ward.

> I must say that depending on where you worked and what ward you worked, you had living examples in the ward sister. She might have been a bit of a [sic] tartar, but she ran things and showed the expectations of the ward system, how she wanted her ward run; how she conducted herself when the consultants or people were doing rounds; and how she conducted herself with the junior medical staff and the junior nursing staff. So, they [the ward sister] might have

> been a bit of a tartar, but when sister says just do that, it was "yes sister, no sister, how high sister".

Nicola described that, in the past, senior nurses like the Matron and Charge Nurse actively engaged in overseeing the delivery of care to ensure a high standard of professionalism was maintained. This was evidenced by the role modelling of the expectations of the level of care demonstrated by the Matron and senior nurses. Nicola's transcript attests to this when she says, "It made you sit up and take notice of how things were, how things looked". Her example continued with:

> I actually started as an auxiliary nurse, so I was really at the bottom, and I started on the ward where Matron still came on and checked that the sheet was turned down and that the wheels went the right way and the pillows were turned. To me, that was totally over the top, and it doesn't have any impact on care; but it did make you sit up and take notice of how things were, how things looked.
>
> I know a lot of that's gone by the wayside, but it hasn't really made any difference to [patient] care. In my day, probably the same as yours, you know we did pressure area rounds, people were made comfortable in bed, I think times have really changed.

Nicola went on to describe how the quality of nursing care was dependent on the attitude of the nurse in-charge and how this impacted on a workday:

> If you knew your Charge Nurse supported you, you were going to get a lot more work done than if you had one that's cranky and difficult to get on with. I think one of the differences here is that up until very recently we've got coordinators of wards. We went through that stage when there was nobody coordinating wards. The younger staff didn't really know where they fitted in, there was no

> structure, and everyone just got on with it. I think that it's very difficult to be professional when you've got nobody to get support from.

Lee discussed the influence that team nursing had provided on role modelling for younger staff. Lee felt that team nursing developed a more positive ward culture compared to the culture of nurses looking after their patients in the patient allocation model:

> A graduate nurse starting on this ward will look at their peers as a role model; we try and encourage [that]. There are no silly questions because they feel like all they are doing is asking questions, just be there to support, help them develop their own professional presence. A few years ago, they would come to the ward, and they would be allocated patients and work by themselves; and "you didn't know what they don't know", and that was always a concern. I think team nursing is so much better and helps develop that professional presence, I think, and give[s] some guidance to that.

Jerzy contended that, in current practice, the importance of nurse managers, or senior staff, emulating professional behaviour through role modelling is how staff learn how to behave and professional behaviour is reinforced:

> I think they learn all that from role modelling by their nurse managers or their senior staff, they also learn from their peers who are professional, and they learn from other people or from a student coming from the tertiary institutions. I mean the learning is no different, like any other learning a change of attitude. I think the role modelling by the senior people is very important as well so they can model it.

Andrew described how, as a leader, it is important to role model the qualities that one wishes staff to demonstrate and that this is an expectation he has of nurses on the ward. He

contended that the demonstration of professional behaviour has more influence than just telling someone how to act:

> … how I interact with someone, speaks far louder than anything I could tell someone. I expect the experienced nurses to do this; it's a flow-on effect.

Diane explained the importance of role modelling in the mental health area:

> You know if organisations like the role models of the people who are excellent at their work have done post-grad [postgraduate] studies, and who [are] shining examples, of which I know quite a few; If these people were valued more, I think there would be a lot more people who would aspire to do more [postgraduate studies] in the workplace.
>
> A staff development nurse who is down to earth, who says about herself "I am not above being a nurse, I wipe bums [sic] as part of my role" because she gets alongside and then new nurses go "Wow the educators I knew before never, never did that sort of work". So, they're the people who can combine the clinical and role model (pause) and leadership and do it very well.

Katherine proposed that when professional behaviours are exemplified in practice, nurses should be able to recognise the difference between professional and non-professional behaviour and adjust their actions to encompass professional behaviour:

> So, I always say to people we are informal role models or informal mentors. You are looking at the good qualities in people, you are also looking at the bad qualities, so how do you identify which ones [are] right and wrong? If I am looking at being a Shift Coordinator, I am looking at the people that do shift coordinating really well, so on my shift, I feel well supported and then confident in the person who is leading the team. Or, when I am on a shift with a person, and it is completely disorganised, chaotic, I can't identify what is I need to do

> each shift, I am getting barked at constantly; then, pick the good qualities and bad.

Page considered that nurses who use timely positive feedback provided re-enforcement to staff on the professional expectations of nursing practice and behaviour. Page explained that although she provided positive feedback, generally the staff were getting on with the job:

> I thank them [nurses] for coming in, "thanks, you do a great job". I just think it's everyone getting on and working, so I don't think there is a lot of that "wow that is amazing" …. I am sure if you kept saying to me "wow that is a great job" then it stops meaning anything.

Lee added that the way in which feedback was provided, even though it may be negative in nature, the feedback still had the power to educate the nurse and provide a model for correct or improved practice.

> I was just thinking of the talk that we had today [at a workshop], some of the things that we could do on an individual ward basis. That it's not just that one person learns from any negative feedback, but rather everybody learns something that we're not doing right. Then you can highlight it and come up with ways of doing it better, so quality improvement activities will help with the professionalism addressing issues as they come up.

Whilst role modelling professional behaviours may be considered a palpable activity, respect – an underlying premise in all themes – was essential to professionalism as identified by nurse leaders and vital to developing a professional work environment. Within the positive work environment, respect underpinned a culture of collegiality demonstrated through nurses showing they valued the contribution of all team members, through their actions and words.

Collegiality

Leaders discussed that respect was a multifaceted concept made visible through consideration of other nurses' or patients' points of view, ideas and feelings. A professional nurse also acknowledged and respected other people's differing beliefs, attitudes, culture and personal needs. Respect of these differences within members of the healthcare team resulted in collegiality in the work environment. Collegiality ensured mutually respectful and meaningful relationships between team members, who collaborated to achieve common goals. Collegiality in the work environment differs from the notion of "supporting others" as discussed in theme one, due to its goal orientation. These goals underpin the professional encounters with nurses who were seen to demonstrate these collegial behaviours and were deemed to be professional. Nurse leaders described experiences of professionalism demonstrated by the collegial way in which nurses encouraged the sharing of ideas, discussed practice options and maintained a calm and confident manner (theme one). Page described how collegiality might work when each member is respectful:

> I think, if you are professional, then you respect others, and then they will respect you. I think that gets demonstrated in your relationships with medical staff as well as nursing staff. Working in critical care, you tend to develop quite close relationships with medical staff because there is that "this a specialised area", so your knowledge level should be a little bit higher. There's a belief that you know what you are doing to obtain a degree, and because of that then if you make a phone call, they will listen to you, and I think that's a really big thing.

Page also referred to her past experiences to discuss how respect was demonstrated in the hospital setting:

> I suppose if I look back at the people in my nursing career who have impacted me in their approach to nursing, there hasn't been a huge number, but there has

> been a few, so it has been around respect, respect for fellow workers, respect for patients. It has been around a calmness, a positive work ethic, the fact that they are there to do a job and they want to do the job of nursing and caring; so, they probably go a bit together (pause) and dedication. They tend to be people who do the extra steps, so if it is more study or whether it is staying back that extra ten minutes to help someone ….they are very patient-focused, I think that is the difference.

Page's experience related to critical care where she included and described relationships between medical staff and nursing staff. She believed that the shared knowledge in a specialised area creates an avenue for collegiality. Andrew also described how his experience in the critical care areas identified the importance of working in a collegial manner with interdisciplinary team members:

> I think particularly in critical care areas, where there is a lot more demand on collaborative practice, you can't get through a resuscitation, or you can't manage someone in ICU [intensive care unit], or you can't manage someone in coronary care or any of those critical care areas without collaborative practice. I think that respect for [other] professions comes out in those higher-demand areas.

Lee also found that collegiality was enhanced through acknowledgement of special events like team member's birthdays, Christmas and Easter. A cake and a card had the potential to facilitate team spirit and collegiality. Team members were encouraged to communicate with each other, to develop professional relationships, so enabling feedback on meeting outcomes and practice issues.

> I think it really helps bring everyone together and it helps communication. It makes it easier if you're able to communicate all together and interact well

> together; using the same language, and all those types of things. So, I think a team approach is really, really [sic] good, so there's support, not only in supporting you with your workload, if you find you've got an easier section, then go over and help somebody else. (Lee)

This inclusive approach was seen to value and create a workplace for all nurses, regardless of differences to achieve their potential at work. This meant that nurse leaders, valued nurses who not only worked collegially but listened to different perspectives, tried different approaches and worked to bring other nurses forward. Diane described how being inclusive makes the other team members feel part of a ward's culture, even though nurses may be working in the ward area as casual staff. This may also include acknowledging a colleague's skills and knowledge and including them as part of the ward dynamic; this represented collegial – professional behaviour on the ward. Diane described in her role that she would visit wards other than her own, and she saw the importance of collegiality being extended to persons other than those with whom you work daily:

> …so, it's about being friendly and people looking out from the desk and saying, "Hi, can I help you?" You know when you've asked for someone, and they take you there to show you, that sort of thing. Or [alternatively] they can point you down the corridor and say "yeah if you just keep walking down there, she's somewhere down there" and then you spend your time looking under curtains and it's embarrassing because I'm not going to go into a patient's room uninvited but when you're trying to find someone that you need to see.... (Diane)

Maintaining collegial relationships remains problematic in the clinical setting despite nurse leaders having identified it as an important and a professional attribute. Nurse leaders raised issues related to "in-fighting" amongst nurses, including personality clashes between

staff, so that they do not get along. These behaviours and actions permeated a culture of low morale where co-workers did not speak to each other. Nurse leaders described some work environments where they could "cut the tension" with a knife. Maureen described how some nurses did not work collegially. An example given was the behaviour of "talking behind people's backs" without seeking opportunities for open and frank, non-judgmental conversations around issues. Maureen explained:

> Look I think whatever group of people you get; you are always going to get some that don't treat others respectfully, and I don't think that is any different in the nursing profession, unfortunately. So, I'm not talking about bullying. I'm just talking about talking behind people's backs rather than approaching them. It's just the way people talk to you or the way their voice carries. You can say the same thing in many different ways, and there are always those that don't really care [how they speak]. You wonder why they are a nurse. I guess you wonder why they're in the profession in the first place because they seem to be doing it as a job and nothing more.

Wendy gave the example of the acceptance of an organisational culture of not questioning or advocating for others as the norm when you are a young graduate:

> I guess I felt I was bullied as a grad [new graduate nurse]. I think it does happen and I think sometimes it's probably in the perspective of particularly junior nurses 'cause [because] they don't, perhaps [know] how to communicate clearly enough and stand up for themselves, be assertive I suppose. So, there's some of that, but there is a level of bullying, and I think there probably always will be, especially in bigger organisations. I mean just the other day I spoke to someone that works for XX hospital, and apparently, there's a ward there, the surgical ward, [a] terrible amount of bullying goes on. So, it's across the board

> I think, and it's just cultural [organisational culture] and gets ingrained if you want to fit in, you follow the leader.

Wendy agrees that there are small groups that behave unprofessionally towards others on the ward: "there might be little pockets where people do have hiccups with one person perhaps on a ward that comes across as a bully, rather than a whole ward mentality". Diane expounded that nurses will leave an organisation rather than confront the problem of lack of collegial support from peers and managers and that sometimes a collegial person is seen not to rock the boat, or that a collegial environment is one in which nurses do not engage in decision making or question managers of leaders, thereby supporting prevailing attitudes and practices, to preserve the comfort level of colleagues. This was her experience, and Diane consequently esteems nurses who show collegial regard. She explains "…managers just side with managers, and you don't have a voice, and HR [human resources] does not support you at this level… that to me was big flashing signals; you're not welcome here".

Nurse leaders re-iterated that professional collegiality, as a component of professional practice, was reliant on how nurses communicated. Mutual respect through sharing ideas, knowledge, and problem solving was said to enable trust amongst colleagues in an open communication environment. This respect and trust amongst colleagues, collegiality, impacts the management and effectiveness of that unit/organisation.

Communication

There was explicit agreement that excellent communication skills were essential in the profession of nursing. In this study, communication was defined as the nurse's use of verbal and non-verbal means to share information. It related to how nurses communicated with colleagues, patients, and members of the public demonstrated their respect for other people's feelings and needs. Further, nurse leaders felt that how nursing staff communicated with colleagues, determined if the working environment was professional.

> I think a lot of it goes down to professionalism in the way you communicate. I think from a management point of view I guess we're thinking about how people communicate with each other, and patients, how they communicate with doctors and fellow professionals as well as the nurses and all the multidisciplinary teams. Also, about [sic] I guess how things are documented and things like that. So, it's not just about verbal communication; it's about all those kind of things as well. (Julie)

Julie pointed out that good communication methods are important in nursing, and Lee described how important it is to have effective communication within a team:

> We can't manage those 20 patients in, and 20 patients out, without having a good system that works for us and without having good communication. So that when we see that falling down, that communication, then you know, we need to do things to correct that so that we can work better as a team; we do have to face that every now and then between each other.

Wendy reasoned that nurses' communication is aided by collegial and inclusive interactions which support an inclusive work environment:

> Being accepting of each other's individuality, being supportive, inclusive and understanding produces and maintains a respectful, supportive nursing working environment where professional behaviour is the norm.

Maureen explained how positive communication methods falter in stressful situations, and that staff should recognise this and rectify their sometimes-unfortunate behaviour:

> People get stressed… if you're that kind of personality, then yes it could get to you, but then if something was said in a stressful moment, I would expect that person to come back and either apologise for it or at least say "you know this happened". If they didn't even realise it then perhaps after a while or if it

> happened two or three times, I would actually approach them and say, "I know you're stressed but do you realise you do this?"

Nurse leaders discussed keeping patient information confidential as a professional behaviour which was sometimes overlooked with nurses speaking loudly about patients within and outside the confines of the ward area or within the ward area including in the hallway or at patient handover. Louise says: "Confidentiality is number one, that's my biggest bugbear… it's quite interesting to see what happens and what conversations happen in the hallway. I have seen what gets discussed over the patient, in the lift, [it] was just abominable".

Nurses being overheard not only related to conversations with patients but also in those held between members of the health team, for example, an argument between a doctor and a nurse. Nurses do not always act in a professional manner or demonstrate responsible and accountable behaviour. Nurses displayed a variety of behaviours when acting unprofessionally, including speaking rudely with others or arguing in public areas; breaching confidentiality; and allowing home life to impact work life. Healthcare team members are accountable for their actions and have a responsibility to behave in a professional manner, screaming at each other in a public forum does not constitute responsible and accountable behaviour.

> This relates to medical staff and nursing staff and having discussions. I have seen where they've been screaming at one another at the nurse's desk, so a discussion has taken place, but it has actually turned out to be a screaming [match] between the two people concerned and yeah, and it was basically open for everyone to see. (Maureen)

> I suppose another one [communication issue] is with interpersonal relations, so two nurses having an argument in the corridor is viewed as unprofessional. (Katherine)

It was the experience of one of the leaders that sometimes people get stressed from their life outside of work and bring the stress that they are experiencing into the workplace with it influencing their behaviour with other health professionals:

> I think it depends on the content of the workplace or the dynamics of that workplace at that time because there is [sic] some influential people at XX that I have seen them lose their shit [sic] a bit when sometimes the going has got a bit too tough. Your personal life and what happens outside, you bring that to work with you as well. And you know, we are all human, and I think sometimes if you're having a bad day at home and then you come to work and even worse, you might just lash out or let fly at people. I think that plays a massive part in how we learn of [about] each other or how we are supported. (Andrew)

It was acknowledged that working within multi-disciplinary or inter-professional teams is an essential part of working in a healthcare environment; and that nurses needed to be able to communicate well with other health professionals as part of their professional repertoire.

> Yeah, so communication is a huge risk for patients, the lack of it, so unless you have respect, then people don't communicate effectively. So, nurses that treat junior doctors with perhaps, not the respect they deserve for different reasons. It means that the doctor won't necessarily go to the nurse or the nurse won't necessarily go with something to the doctor because he, they think, that they don't know and then the poor patient is left sitting there. (Maureen)

All healthcare professionals use communication as an essential part of their daily routines. However, nurse leaders felt that this did not mean that they are all cognizant of how

they spoke at all times. Julie explained, “I think that everyone knows how they should be talking and how they should be doing things, but I think people just need a reminder every so often”. The importance of open communication and listening to each other, accepting that each person is a knowledgeable professional, is an essential part of working in a multidisciplinary team as outlined by Page:

> Perhaps there is a miscommunication or poor communication; so, the nurse’s expectation is that the doctor should have done XYZ but hasn’t [done it] because he doesn’t actually realise, he should. You see a lot of that, probably more in critical care areas where you have nurses who have a lot of knowledge. So, they will often be a step ahead of the junior doctor, and sometimes I think it a little bit unfair as to the [their] expectation of the doctor. I have seen the opposite as well where you have doctors who think they know what they’re doing, trying to push and you know they are wrong.

Whilst communication between team members was considered a part of professional behaviour, Maureen and Julie raised the point of over-familiarity between staff, which often influenced the ways in which nurses interacted with another staff member. This idea meant that the more one gets to know another, a manager or other staff members, on a personal level, the more likely that one can find fault with them or accept their unprofessional communication and behaviour. Maureen believed that there is a lack of respect when staff do not address each other in a more formal manner yet, from her transcript, it appears that the younger nurses alluded to did not see this as problematic: “I would ask somebody, ‘What would you like me to call you, Mrs So and so or your first name?’ They [the younger nurses] will automatically call you your first name”. Julie expanded upon the issue of over-familiarity in communication with colleagues and peers, saying that the manner is far more relaxed than

in the past. Over-familiarity with colleagues and patients was believed to blur professional boundaries:

> It's society as a whole [that] has changed, we've become a lot more relaxed in a lot of our ways. You know, whereas before it [the registered nurse] was always referred to [as] the sister and you know, you always call[ed] the doctors, doctor whoever, but a lot of that's gone now, hasn't it? You know you're talking to them as Tom, Dick whoever and it's broken down those barriers, but I think particularly from the patient's point of view, particularly the older generation, I guess they actually see that as being not as professional.

Nurse leaders felt that the nurse should be self-aware enough to understand that the way in which communication occurs is significant; and that in a collegial environment, the professional nurse needs to consider the ways in which ideas and directions are given, the impact of the message sent, the respect of the patient's position, and the impact on the person to whom the message was directed. Clarifying the receiver's interpretation and rectifying misunderstandings are identified as professional behaviour.

Nurse and patient communication

Nurse leaders also discussed the ways in which the registered nurse's daily practice was influenced by the nurse's ability to communicate with the patients. The patient is a partner in the delivery of healthcare and therefore required nurses to demonstrate the capacity to communicate effectively with patients, developing and maintaining a positive relationship.

> Communication is really important. That's part of our core principals, [communication] is about relating or not so much about relating to the patient, interacting with the patient and really developing that empathy for the patient, that's really part of how we are as a profession. (Andrew)

Katherine described how patient-nurse communication demonstrated professionalism:

> So, if you have got [sic] someone walking into a room and taking [an] interest in the patients, even if a patient is talking absolute nonsense to you, it is actually being attentive to them and communicating back in a respectful way. Again, you have got to show respect.

Page explained how the ability to read nonverbal cues is as important as hearing what the patient has to say about their care: "By listening, active, not talking above someone; by getting a whole picture instead of half a picture; by reading the body language of the patient, which is really important". Communication skills are an element of nursing that has always been a part of the nursing role. Karen reminisced that in her time as a junior nurse "…it was very much a matter of listening, asking questions and somehow or other you then become sort of the filter for the patients".

Nurse leaders also identified the need for nurses to ensure privacy when communicating with patients. It was felt that patients trust that nurses will show respect for them by ensuring their privacy when communicating private information. Katherine described how something as simple as a handover in a shared room makes the patient feel you are disrespecting them by speaking about them in a nursing bed-to-bed handover:

> I think that when I sit with the patient, sometimes their perception is quite different of what professionalism is as well. The example would be if you are doing clinical handover to another nurse at the patient's bedside. Although we have not given private information out as such, some of the patients still feel affronted because the people in the room can hear, you even though from our point of view, we haven't spoken about anything private.
>
> …they might think that nurse is unprofessional in the way they're behaving [having bedside handover] because they are talking about them in front of other people, which is interesting. (Katherine)

Julie explained that she believes that nurses forget what it is like to be the patient in the bed:

> I think sometimes people can be very impatient with their patients. I think people forget actually how they talk, I suppose when you [are] rushed, and you're busy and things like that, you don't take the time to you know, explain things fully. I suppose because they're [nurses] doing the same things every day to them [patients], they know what they're doing and they know what the outcome is going to be, but for the poor patients sat there who's never been in that situation, that's really hard for them.

Nurse leaders also believed that it was important that nurses demonstrated their ability to show respect through effective individualised communication with patients. Andrew explained that in the emergency department, the importance of how words [information] are delivered makes a difference in developing a relationship with the patient and the way in which patients view staff:

> People that come to triage, if I just say, "What do you want?", or "Who's next?" and not really being mindful of the way my non-verbal communication as opposed to "Hello, my name is Andrew, how can I help you?" That, in itself, says a massive message to the person that is coming into emergency for help.

Similarly, Nicola says:

> …sometimes you just want to say to them, "You wouldn't like to be spoken to like that". You know, you try and be the person in the bed and when somebody comes up to you saying "What have you done this for? Why are you ringing the bell? What do you want?", instead of "Oh, hi, can I help you? What would you like?"

Nicola's experience accentuates the importance of respectful, individualised communication with patients in geriatric nursing. A further point from Nicola is:

> Sometimes you do have to pull some people up when they forget about how they're coming across or have totally no idea how they may have upset somebody, and you know them personally [so] you know that it wouldn't be their intention. Professional presence isn't something that you learn once; it's something that's always evolving.

Professional communication does not need to be face-to-face; it may also be demonstrated when communicating over the telephone.

> You don't know who you are talking to so it's important to ask who one is speaking to and also introduce yourself. Most phone calls are from relatives, and they are worried about their loved ones. So nurses need to stop and listen to what is being said, and the nurses should ask how they can help. Especially when you are talking to someone who has difficulty hearing, make sure you are heard, so speak clearly and be aware of your surroundings because you never know who's paying attention to your conversation. It shouldn't just be being polite because it is a doctor or specialist; everyone needs to be respected. (Jerzy)

Different contexts provide differing opportunities for communicating with patients. Nevertheless, professional communication – that is, respectful communication – is required to promote understanding of disease status, current situations, and addressing requests for service. Sometimes, even with the best of intention, the delivery of a message may not always be successful due to how it is communicated, as demonstrated in the examples below:

> She had quite a good relationship with the patient. They joked a lot, but the nurse continued her joke in the same manner with the patient's family around who thought it was a very callous comment, so she was viewed [as unprofessional], and the complaint was made in regard to her unprofessional behaviour. (Katherine)

> Sometimes she comes across abrupt in the way she speaks, but she doesn't necessarily mean it that way. By recognising that happens, then offering her some assistance with communication, which she found of huge benefit, that helped that person's learning and helped the team as well. (Lee)

Louise also gave an example of poor communication, and a lack of respect experienced when her family member was an inpatient: "….they [nurses] don't introduce themselves at the beginning of a shift… they don't respect the patients, and heaven forbid to touch a patient… No therapeutic touch whatsoever".

Nurse leaders indicated professionalism was essential and demonstrated through communication; that a lack of professionalism can lead to complaints as discussed previously. The nurses' approach to work is communicated to patients and colleagues by their presentation, as highlighted in the following narrative:

> The complaints go up higher if you have got someone that is coming in [nurse] and they are speaking rudely or abruptly to a patient, behaving inappropriately to a patient, or looking like they are scruffy and just rolled out of bed. I think that then the patient has no confidence in them for starters, and then they will notice and pay more attention to what is going on in that shift. I think that is when we mostly see a complaint written in that situation. (Katherine)

From the examples given, the visible elements of professionalism are used as a measure by both patients, family members and other staff as an indicator of a nurse's level of professionalism. Respectful two-way communication between healthcare staff, the patients, and their families is a multifaceted area and requires behavioural parameters and education for both to ensure that required care can be efficiently and safely administered.

Summary of walk the walk

"Walk the walk" describes the behavioural attributes, as identified by nurse leaders and demonstrated by registered nurses in the ward areas, that encompasses verbal, non-verbal, telephonic, digital and written communication. The role modelling of positive behaviours by informal mentors supported nurses in their daily routines, and with the acquisition of skills and knowledge pertinent to the area. Having mutually respectful and meaningful relationships between team members demonstrated by effective professional communication resulted in a positive work environment. Nurses being able to communicate freely because of this encouraging environment made dealing with any complicated and emotional situations much easier as discussed by leaders in the next theme "owning the problem". Figure 4 presents the diagrammatic summary of the attributes identified in the theme "walk the walk".

Figure 4

Diagrammatic representation of Theme Two Walk the walk

<table>
<tr><td rowspan="6">Theme two</td><td rowspan="6">Respect</td><td rowspan="6">Walk the walk</td><td>Role models</td></tr>
<tr><td>Mentoring</td></tr>
<tr><td>Collegiality</td></tr>
<tr><td>Communication</td></tr>
<tr><td>Nurse and patient communication</td></tr>
</table>

Theme Three: Owning the problem

"Owning the problem" was the third theme identified from the narratives of nurse leaders. Nurse leaders contended that nurses needed to "own the problems" in the workplace as part of their professional role and employee responsibility. Leaders espoused that a nurse's responsibility came from having both the ability to do something about a problem

encountered and oversight for the area or group in which the problem occurred. Leaders felt that a professional nurse, often the owner of a problem, took control of the situation initiating and following through to find a solution.

Notably, leaders acknowledged that Professional Codes of Conduct (NMBA, 2018) delineated accountability and responsibility as central to nursing practice but believed that nurses were sometimes remiss in behaving and acting in ways that reflected this fundamental professional tenet. Leaders reported instances of poor documentation and patient care as examples of the lack of professionalism; and complained that when issues or problems were identified by an individual, they were discounted as a problem that needed the identifier's action. It was someone else's problem or management's problem. Given this disposition, the nurse who took ownership of the issue and sought solutions was seen to be professional. The following discusses the personal responsibility and accountability of nurses as a professional attribute.

Personal accountability and responsibility

Resolving a situation

Personal accountability and responsibility, in this study, related to the nurse's willingness to be responsive, and liable for the direct consequences of nursing care, to which they were assigned. It involved taking ownership of the nursing actions, behaviours and the quality of care delivered. Nurse leaders talked about their experiences with accountability and responsibility of registered nurses, with one leader giving an example of how it has changed over time.

> A patient had arrived on the ward and was left waiting to be admitted. She was scheduled for surgery later in the morning. The ward was busy, and no one had admitted her or prepared her for surgery. The patient just sat there waiting. Finally, the nurse who was to look after her found her and commenced berating

her for not making her presence known to staff. The patient looked confused and alarmed as the nurse continued to scold her for being late and now having to rush to be prepared. The nurse was speaking loudly, and it was obvious that the patient was embarrassed. This all took place in front of other people in the ward and really was unprofessional.

After the patient was taken to her bed and given instructions, and the nurse left the room, at which time another nurse pulled her aside and spoke to her about the way in which she had spoken to the patient. She said that it was inappropriate to have spoken to the patient in an aggressive tone in front of others, and that was not the way in which patients were spoken to on this ward. The nurse was reminded that the patient had been on time and that the problem lay with the orderly who had left her [sitting] there without informing the staff. This nurse then wrote in the ward diary to remind nurses to check the waiting area for patients and said she would follow this problem up at the ward meeting. (Nicola)

This doctor was saying she (the nurse) had not done the obs [observations] and that the dressing wasn't taken down when he arrived. He was angry and thought it was OK to speak to the nurse like that. The nurse was a new graduate and just stood there. She looked like she was going to cry. That was when the shift coordinator stepped in and quietly spoke to the doctor about his behaviour. I wasn't a manager then, and I remember thinking how I [was] just trying to look busy and didn't intervene, [or] do anything to stop the doctor yelling at the grad [graduate]. She did, and I thought that was good to see. (Karen)

Now it is expected that nurses' question everything, and nurses are mindful of their responsibility for patient care. So, I think that those kinds of components have changed, but the profession, the professionalism is mostly changed over time. I think the patients would expect us to question and we [nurse leaders] need to be responsible for our nursing staff now as well, and we expect them to question everything, so it has all kind of changed. So, when a nurse questions treatment, offers options for their patient, they are acting within professional boundaries. (Katherine)

A further example of this was provided by Karen:

We have nurses who are able to take responsibility for questioning doctors about this [pain]. They (the nurse) go to the doctor and say, "This patient's got pain, with a pain score of eight, what are you going to do about it?" And then if the resident says "Well, have they had their Panadol?" The nurse will say "Panadol isn't appropriate; they need something stronger like Oxycodone because I have assessed their pain".

Other nurses see this, and know it is their responsibility to ensure that their patients are not in pain and to ask the patient questions like "Well, how long have you had the pain? What makes it worse? What makes it better? How would you describe it?" To look at the charts to make sure they have proper and alternative pain meds ordered. This means they are being accountable for their nursing care and taking responsibility for ensuring that patient outcomes are good. (Karen)

Errors and omissions

The leaders recounted their experiences of registered nurses making errors and omissions and the professionalism of those registered nurses who were accountable for these errors. The nurses who took ownership and responsibility of these errors and omissions reflected honesty and integrity; with a lack of professionalism demonstrated by those who did not.

> Accepting that you made an error (nurse) or forgot to give a drug may not seem important at the time but knowing you missed something is an issue. So, being responsible for what you did or didn't do is part of being professional, so I think it really important. (Diane)

Professionalism is also demonstrated by taking responsibility for errors and omissions and demonstrating accountability through apologising to the patient.

> We have a lot of angry patients who are left waiting around, don't get help with their showers, or are waiting for a long time for a nurse to answer their bell. So, if you make a mistake, or take a long time answering the bell or getting them to the shower, the nurse needs to say "look, I'm really sorry. I apologise". (Karen)

> For instance, when I made or make a mistake, I worry about it. I check up on it. I go through all the motions to make sure that the mistake, if not undone, then that the best it [outcome] is possibly made from it. Nurses will worry and follow through rather than going home without a concern. They make sure the patient is OK, or the drug count is OK because it happened on their shift. I don't want them to take blame or whatever but to see it through. If I have one of those kinds of nurses working with me, I know that they are honest and accountable about their nursing care. (Maureen)

Not all nurses report every mistake or error; rather, they decide which errors to report based on potential outcomes.

> Things like integrity, you know being honest, being up-front when you've made a mistake. I reckon that's an interesting one, where you know, it's quite common to find that if the mistake or the patient error is perceived to not affect the patient, it doesn't get disclosed, or documented, or spoken about. (Diane)

Supporting and supervising registered nurses provides opportunities to pre-empt errors as well as to use these occasions to promote accountability and responsibility; that is, opportunities to learn about these aspects of professionalism.

> I have been involved with that [errors] a lot of times, and sometimes when I approach it, my immediate thought is the safety aspect. If someone is about to give a drug that they haven't really checked or haven't paid any attention to, I'll step in straight away and say, "what are [you] doing explain to me?" Try and turn it into an educational opportunity but highlight the fact of how I think it was dangerous what they were doing. (Andrew)

A further example is given as:

> I was in the treatment room on a ward when a new grad [graduate] came in crying. Asking what the matter was, she said that she had made a medication error and had just told the shift coordinator. The grad [graduate nurse] was very upset and reluctant to give meds [medications]. We talked about it, and I reminded her of her courage of owning her mistake, and how I had felt years ago when I had given too much pethidine to a patient. I asked her what she had learnt from the mistake, and she said not to dispense more than one patient's medication at a time and not to get distracted by other things. She learnt a lot

> that day about accountability and being courageous enough to report her mistake. This grad [graduate nurse] has since become a good nurse. (Andrew)

Increased responsibility

Nurse leaders believed that personal accountability within the role of the registered nurse had expanded, resulting in more responsibilities for the registered nurse. This resulted in a higher expectation that nurses are now accountable for delivering a higher level of patient care. The following examples evidenced this viewpoint.

Karen explained that, in the current work environment, nurses were more responsible for their actions: "…these day's nurses are more professional because they are more responsible for their own actions and how they work".

> Yes, the nurse's responsibility has increased; it [responsibility] has definitely increased. So, whether nurses take responsibility for their patients or not, there is a professional expectation that they are responsible and accountable for their patients while on shift. So, it's good from our [nurse leader's] perspective when you see a nurse taking responsibility for their actions. (Nicola)

Juxtaposed the behaviour of acting professionally

Three nurse leaders discussed registered nurses who worked without consideration of personal responsibility and accountability. This disregard described by the nurse leaders of nurses not taking a responsible view of their own actions and how they worked was juxtaposed with the behaviour of registered nurses acting professionally. For example, how nurses do not always provide the nursing care but complete documentation as if they had.

> So that consists of just the basics for patients, making sure you brush their teeth each shift rather than signing to say you've done it. You know things like that. Making sure that "you dot all your I's and cross all your T's", I suppose, so that everything on your nursing care plan that needs to be done, is done.

> I've been around before and had people sign off to say that they've cleaned patient's teeth and then you see the toothbrush sitting on the side in the packet and brand-new toothpaste unopened. So, do you think I don't quite know how that works, how do they brush their teeth; this is in ICU [intensive care unit], so patients are dependent on you to do those things for them. (Wendy)
>
> I don't know if it's just that they have had a really busy shift. There would be varying reasons for that. So maybe they've just had a busy shift, and so at the end of the day, they've just gone through and ticked all the boxes. Signed their life away on the nursing care plan, not looked at it properly and haven't had time to do the basics [basic patient care]. I think personally the basics are just as important as everything else. (Wendy).

Nurses being accountable related to more than just the completion of accurate and authentic documentation as an essential component of personal accountability and responsibility. Unprofessional behaviours demonstrated by nursing staff included dishonestly recording care that was not provided, as having been provided; not identifying errors in care; or not taking responsibility for errors or omissions.

Potential reasons for lack of responsibility & accountability

Following the reported experiences regarding issues of responsibility and accountability by registered nurses, nurse leaders reasoned that perhaps a lack of ability to reflect on their practice was a possible cause. Without personal reflection on visible changes in the patient's condition, or observations, the recognition of potential complications or deterioration of patients was not possible. This inability to reflect is described below as possibly hindering clinical reasoning. Louise describes the use of patient documentation which is colour coded and has instructions to follow if the patient's observations fall into any of the different sections.

> There are weekly observations. They've got the normal white, and they have got different gradients of yellow and oranges, so if your obs [sic] go outside of those white ones, you are to ring somebody; nursing staff or doctors, are meant to act upon it. They have had to create our forms now that are colour coded so that if you go into that [colour] area, you call somebody. This is professionalism? How can this be showing responsibility or accountability? That's just not there anymore.

Additionally, nurse leaders raised the issue that nurses felt that it was "not down to them" so they did not take on a responsible and an accountable role concerning poor care – whether their own or that of another; nor intervening when poor behaviour was shown by other staff.

Reflection

Nurse leaders contended that nurses who appeared to be reflective in their practice delivered good nursing care because they were able to mesh the complexity of patient problems with nursing knowledge. Reflection, for nurse leaders, was considered as the nurse's ability to consider their personal feelings, beliefs and interpersonal interactions; and how these influenced the scope of practice, clinical practice, and the nurse's subsequent clinical judgments and actions. Within the transcripts, there was no discussion on self-awareness as the terminology appeared to be related only to self-reflection. The capacity to be self-reflective was considered to facilitate the recognition of situations in which nursing care or personal reactions had not been conducive to team dynamics or impacted poorly on patient care. For example, Page stated that nurses who can: "look upon these situations through personal self-reflection have an opportunity to grow and improve their professional understanding".

> They'll learn through experiences; they will talk to their support person that they might have of instances or situations that haven't gone too well. So that's an opportunity for them to reflect on that practice. As part of that, I am sure there is an element of professionalism which they may not recognise, but I think that will help them to deal with similar situations in the future and so enhance their professionalism in the future. (Julie)

Somebody's capability to be able to reflect on their abilities influences being able to use scope of practice appropriately in their workplace. Nurse leaders identified the importance of understanding the concept of the scope of practice and applying it to their clinical practice.

> So, being aware of your scope of practice, I guess that is a bit of the skill in itself, particularly for newer staff, but that really demonstrates to the public that we are safe, trustworthy and honest with what we do, or what we do. That's part of being a professional. (Andrew)

The importance of nurses to self-reflect and have an understanding of their level of skills and knowledge was considered essential for a nurse's professionalism.

> … but I think if you can't recognise yourself [your skills and knowledge], then you have got no insight … (Katherine)

> If I am not able to improve my own behaviour or improve my skill and ability in my workplace, then I haven't reflected if I have got any faults that need to be improved, not faults, but areas that I can actually continue to develop in. I think that does show that they are unprofessional. (Katherine)

Lee explained that in her work environment nurses appeared to have a good understanding of reflection, saying "No, I don't see that [reflection] as one of the problems for my area, yeah. Which is probably why I do have a stable workforce, yeah we've worked

on that you know". The importance of reflection to the registered nurse practice was considered as an essential attribute of professionalism.

Summary of owning the problem

The third theme of "owning the problem" revealed the attributes of professionalism as described by nurse leaders. The attributes identified by nursing leaders were personal accountability and responsibility and reflection. These qualities encompassed the underpinning philosophy of the nursing role. These tenets may, at times, have been visible because of the actions they underpinned. These attributes observed how nurses dealt with and resolved a situation handled errors and omissions and examined a potential reason for the lack of accountability and responsibility by nurses. Figure 5 presents the diagrammatic summary of the attributes identified in the theme "owning the problem".

Figure 5

Diagrammatic representation of Theme Three Owning the problem

<table>
<tr><td rowspan="2">Theme three</td><td rowspan="2">Respect</td><td rowspan="2">Owning the problem</td><td>Personal accountability and responsibility</td></tr>
<tr><td>Reflection</td></tr>
</table>

The discussion by nurse leaders of accountability and responsibility shown by nurses in the work environment looked at areas in which nurses were influenced through their own actions. However, the next theme introduces elements which nurses may not be able to influence but rather within which they need to work.

Theme Four: Bridge over troubled waters

Influences on professionalism

The final theme addresses the second research question: that is, "What do nurse leaders identify as the influences on the professionalism of registered nurses?" These may be environmental, organisational or personal factors, perceived by the nurse leader, to influence professionalism and thus the professional behaviour and actions of nurses. The narratives of nurse leaders show that often these influences were out of the nurse's locus of control yet still had an impact on their ability to work within the confines of professionalism, articulated by leaders in the preceding themes.

These influences were predominantly organisational and environmental. The organisational factors encompassed the hospital leadership team and lack of acknowledgment by senior staff of "a job well done", ensuring that the right person was in the job (qualifications, continuing professional development) and performance management. The environmental factors included: the restructuring of healthcare, workload, facilities for staff, and the patriarchy of the medical system.

Organisational Influences

Hospital leadership team and lack of acknowledgment

A potential influence on the professional behaviour of direct care nurses was identified by nurse leaders as the leadership shown by the hospital management team. Nurses did not know, nor had met, their senior nurse leaders because the Directors of Nursing rarely visited the wards and were considered "invisible". In spite of this, there were varying opinions about the need for the nursing executive to be visible. The lack of presence of senior nursing executive in the ward setting seemed to therefore denote that they (nurses) were not valued and by association, their work was also not valued.

> The nurses on the wards probably don't see enough of the Director of Nursing [DON]; I think they probably very well know who the DON is, but they don't see them actually in the wards. They [the DON] do go to the general nurses' meeting and talk to them three or four of those a year, and that's open to any nurse. They come to the senior nurse meeting and the nurse managers meeting; god knows how they [the DON] find all the time. (Karen)
>
> They used to come to the wards you could not do anything without running it by the nursing executive. They knew everything on the wards. I think these days the economics of the just running the health service is such that (pause). You don't know what it's like, managing all these dollars and you could say that nursing exec [executive] doesn't have time to worry about nurses and whether [they] need to be seen by them, even though we know everyone like to see their manager. (Karen)

> A visible Director of Nursing would be good. The previous Director of Nursing was far more visible in coming around on the wards and being friendly, a little over-friendly probably. A little over-friendly at times but would be visible and being visible is important to show that they're interested in what nurses are doing. I think that only now happens when you've got accreditation. When big things like accreditation come up suddenly, you're warned to be aware of any stranger or person because they're probably from [nursing] executive (Nicola).

Wendy explained the disconnect she felt was present between the hospital nursing hierarchy and those on the coalface. She held strong views regarding how senior nurses could reconnect with direct care nurses, explaining that the nursing executive should not only be

visible to staff but engage in direct care nursing to keep them abreast of the nursing environment, although this may be difficult to do.

> I think that they should get back on the floor, at least you know, if they can once every three months, even if it was just for a week once every three months. I know that realistically, probably as far as their workload goes, they probably just can't find the time to do that. I think by working out on the floor it keeps them in touch with reality [sic]of what the real issues are, what the changes are and even just the little things like the type of new equipment that comes in; that works, and the stuff that they're bringing in that's useless and doesn't work. Where money is wasted, they would actually see that from the ground, working out on the floor. (Wendy)

Karen, however, noted that nursing executives were process-driven and that the pressures of meeting budget and reporting to the Chief Executive Officer detracted from the value attributed to developing connections with direct care nurses. The flow on from this lack of interaction between the nursing executive and the direct care nurses was detrimental. The direct care nurses felt that they were not recognised as an important part of the organisation, and their work was not valued, in particular, the impact of nursing care practices on patient outcomes. In turn, nurse leaders believed this was attributable to nurses not taking pride in their work and acting, at times, in unprofessional ways.

> Nurses are very good at managing the process, but the danger is that because we manage the processes that they don't value that clinical input and that's just because it's all bureaucrats and economists talking now, you know KPI's and outcomes, budget bottom lines. (Karen)

> I think probably one of the things that does that for us as professionals is, when you've got leaders at the top there that are just spouting off all this stuff that they want to do and how grand everything is and yet do they really implement any changes? They don't make things happen for the people working on the ground floor. I think that is quite harmful when you see your leaders just all patting themselves on the back and not really doing anything for the workforce. (Wendy)

One nurse leader stated that the nursing executive did not often visit the ward and that she tackled this by personally inviting them to visit the ward and introducing them to the staff:

> We've have had exec [executive] members [who] have been up to the ward [be]'cause I think one of the things we see here is that we don't see them very often. I mean over the last, well, 13 years I've probably had 3,4,5,6,7, about 7 or 8 different [bosses], my bosses, so I try and bring them up to the ward to be part of that so that there is that exposure from the exec [executive] level. (Lee)

An extension of not seeing the hospital nursing leadership team on the ward was reflected in the ways in which nurse leaders operate. The following example outlines Page's opinion on receiving acknowledgment for her work. She says:

> I think if my medical director came and saw me every week and said "ah you are doing a great job", then I would fall over but I would go "Oh something is not right", so I think if you troop along and you are not getting any negative feedback, and then you assume you are doing a good job.

Diane also discussed the lack of acknowledgment by senior managers and the consequence of staff not feeling valued:

> The nurse who is working at the bedside or if you're middle-lower management doesn't come with much recognition and certainly [for] the nurses on the floor it depends on the manager. The manager here in mental health she is another one of these leaders, managers, wonderful. I mean pizzas keep turning up for the staff, and you know little things like pizzas don't cost a lot to make staff feel they are valued, that they are appreciated. When there are particularly hard times, or just because, they give out chocolate frogs here, now that's really important, again not a big thing but it just says we care about you, here have a chocolate frog, thanks for doing that. So that occurs here, doesn't occur on a lot of wards and I know there is a lot of burnt-out people who never felt that valued and being valued. (Diane)

Wendy raised an instance where she felt the senior nursing leadership could have given acknowledgment of the many hours and extra work nurses were putting in:

> We've got accreditation looming, it's just weeks away now, and we're hammering away like mad, with trying to get the doctors through basic life support [be]cause prior to this they just hadn't done it. So we're really under the pump trying to get extra training through, we're working back extra hours, and the nursing director has walked into our office and said "Oh good you're all here I've got a question for you" asked her question and then left and not even said by the way thank you.

Acknowledgement for doing a good job was seen to encourage nurses to "go the extra yard". Lee described incidences when a good job is recognised by organisational leaders but claimed that these acknowledgments alone were inadequate for the direct care nurse to feel valued. Lee stated:

> There are sometimes thank you or reward barbecues that the hospital puts on at Christmas free lunches. We have reward ceremonies for how long you have worked at the hospital, I've had my ten years and my fifteen years. It's another time all the staff at that level come together in the year to be rewarded. On the day-to-day stuff, you don't really see or hear from the top. So probably, on the whole, there are no other ways of them being able to be recognised by the organisation and the executive.

Sending a message of support is not only important by leaders working with staff; Wendy explains the importance to the staff on the floor of nursing executive acknowledging when staff are really putting in an effort.

> I don't necessarily think they would come down face to face and acknowledge [staff], but they do occasionally send out emails to perhaps the staff development nurses and say we know you're working really hard. "We know you've got all your new grads [graduates] at the moment and we appreciate that, and we're asking you to do extra. You know this is really important, and that's why we are having to get you to do it, but we do acknowledge that you are working very hard out there". So that's probably about the best that they'll get.

Katherine explains that role modelling by nursing leaders, acknowledging that staff are doing a good job is important as the behaviour filters down to the nurse on the floor:

> Where the manager or that shift coordinator is actually sitting and acknowledging and thanking everyone for coming today, that "we couldn't have actually done our work if you hadn't all been here". They [managers] learned that behaviour from a person above them. I do leadership talks for the grads [graduates] all the time, so I am hoping that it [acknowledgment] does happen more frequently now than when I first came because it didn't happen

> much. As far as the people above the Nurse Directors and all of that, I am not sure if they get thanked ever and that is generally why in research isn't it, they say people don't actually thank other people because they don't get thanked themselves. (Katherine)

Louise gave an explanation of why it was so difficult for a leader to build up a workplace culture that was positive and professional. Her explanation follows:

> It comes down from the leadership if they get new members, they either join the pack, or they get tossed. I wouldn't say in all wards, but in that ward, you could just see the whole staff mentality was like that. In other situations, the leaders are trying so hard to build up a good reputation of a good professional ward, but then you've got people undercutting them. (Louise)

Andrew gave another example of how an individual leader can affect the culture of an area. He outlined two different styles of running an ED (Emergency Department):

> I was at XX hospital ED, for example, for four years and the leaders of that ED when it got busy, they would ramp the patients. [leaving patients in ambulances with paramedical staff looking after them, rather than being admitted through ED] If it started to get a bit unsafe in the department, they would come out and take over the role of co-ordinating where staff were working, and say what patient would come in next and who was coming in on the next shift and how we are going to manage all these patients.
>
> It was very different how it's managed at YYY hospital when the exact same situation arises; we are ramping, we are full, and it's getting unsafe. The senior staff or the leaders, the Clinical Nurse Specialist, would come out, and go up to the shift coordinator and say "where do you want me to work, where do you

> want me to help" and the shift coordinator also knew that if they started to get a bit difficult, they could speak to the Clinical Nurse Specialist.
>
> The Clinical Nurse Specialist also had that awareness that "look I think the shift co-ordinator here is struggling, I'll help them, but I'm not going to take over". That is a massive difference, I have noticed in leadership between the two tertiary hospitals in the metro [metropolitan] area. The staff sees the leader not coming in as a dictator. It's really important to able to say, "I'm here to support you, and I want you to come with me" as opposed to saying, "you're going to do it my way or else". (Andrew)

Julie also described that a manager who helps out when they are busy is a positive role model for others:

> I think we need to have professionalism in our work but also if you've got someone that you would class as being professional, setting a good example. It's very "old school", but if you do everything right or you think you're handling the situations right, then hopefully the staff are going to see that as being a positive way and think OK maybe we should follow suit.
>
> I wouldn't interfere, but I just like to know what's going on so that if they do get stuck or get busy, when they do shout and say "oh you know we're really really busy now, we can really do with a hand", I can just go straight to that ward and just pick up and help them out if I can.
>
> I remember having managers like that, as well as people who just sat [sic] in an office; I could do my job sat [sic] in an office, but you know that's not really supporting them and setting a good example is it?

Lee, as a manager, also described times that she had gone onto the floor and helped staff when they were busy:

> I got in there and showered somebody, and I don't know if many of the other managers do that. It does give you good recognition from your staff that you are not asking them to do anything that you wouldn't do yourself.

Being supportive of members of the multi-disciplinary team was evidenced by Maureen, who explained how a manager ensured inclusiveness which had a positive influence on the ward culture:

> …our coordinator is very much into the multi-disciplinary team being supportive of each other. We have had other managers who haven't bothered with that, and it's become very factorised, nurses do nursing, OT's do OT [occupational therapist], social workers do social work, and you don't overlap, whereas now we do a bit of overlapping.

Performance management

Despite a supportive environment sometimes a staff member appears as not suitable to the area, or even perhaps to nursing, as described by Wendy who discusses the difficulties as a manager dealing with underperforming nursing staff and the difficulty of removing them from the ward area.

> It happens at all the levels, so you can have graduate nurses even that come through that you really know are not suited to your area. You'll help them with performance management issues. You'll put objectives in place to try and help them improve so that they are very well aware of what their issues are. You really try and help with their professional development and if at the end of it they still are a safety issue, a risk, and you don't feel they're suited to the area you could sit down, and you could talk to them about it. Ask them if there would be another area that they would be interested in but unless there has been [an]

> incident that has put patients at risk you'd be very hard-pressed to get rid of them out of your area.

Wendy went on to discuss that dealing with performance issues is the same as the more senior nursing staff:

> It's very hard to get rid of them is what I'm saying. You must have so much documented evidence; you have to have support from higher up people, and there's really not that much support. Once you get to that level, who are you going to go to? So, if you've got a nurse manager that's a bully, the whole culture of your unit is going to end up being depressed.

Nicola recounts the difficulty experienced on the ward when nurse leaders (Nurse Managers, Clinical Nurse Specialists) were unhappy or in disagreement with each other and the impact of this on direct care nurses. She explains:

> We don't have the best culture now in our unit at the moment. You occasionally get one in the mix that stirs things up. We've got a few more than one, and unfortunately, that caused bad feelings on the ward; and, it's because we have unsettled management. I'm not saying there is anything wrong with the management, but it's very unsettled at the moment, they had different opinions which is filtering on down. So, staff pick up on this, and it creates more tension. So, when you talk about being a professional, no one is. And the nursing exec [executive] don't help really because they don't know or care really. There are complaints about the management people and vice versa, I hear, I know the names although I don't actually work with them, I know the names of the people that are unprofessional, and I know why.

Louise continued with examples of a nurse-to-nurse interaction which constituted a form of horizontal violence:

> You've got your personalities of course with certain staff. They tend to be in one particular ward at one of the hospitals; there is a cohort of, I call it "high school-ism", as they have all reverted back to whispering behind each other's back and setting each other up.

In some cases, the leaders felt that they were unable to do anything about the problem. Being unable to easily remove staff demonstrating poor behaviour is due to the processes which are required to be followed to ensure that the individual's rights are also being protected. Part of this process is the documentation of any incidents; however, as Maureen explains, nurses don't always want to document the poor behaviour by their colleagues:

> They [nurses] do get pulled aside and spoken to about it [poor behaviour]; however; it takes an awful lot of it to go beyond that point. So they're [Nurse Managers] quite happy to bring them in and have a discussion about it, but when it comes to actually starting [sic] to put things down in writing there is a reluctance to do that because then it's in black and white and you can't pull it, I assume, I think that's what it's about. I would like the frequent flyers, the ones that were causing the problems, to actually have consequences not just called into the office and given a ticking off. I think if it happens x number of times and they are told off the same thing, or they are reminded about the same thing. It needs to go in writing, and unfortunately, the person that does that is going to be awfully unpopular, and that's why people don't do it, but I think it has to happen or how are we going to change it, nothing is going to change.

Katherine explained there are a set of protocols that have been commenced in her hospital to deal with this sort of behaviour and help create a supportive work environment:

> A supportive work environment is actually being able to identify what those behaviours are that people display and what we have done is "above the line

> and below the line" behaviours. So, it is obviously trying to get areas [wards] to identify what their good qualities are, what they expect of people. So some of them might be things like, you are not allowed to yell at other people, or you can't raise your voice loudly, you have got to speak quietly in a different room; in regards to these types of [below the line] behaviours. So that we expect these are things that are completely unacceptable. We have actually started writing them down and having them laminated as posters. It is for what we expect in anyone that comes into the ward area.

It is imperative to reduce poor behaviour; as Diane recounted, people left an organisation rather than stay and put up with poor behaviour:

> I can only talk about my own experience and what I've seen happening to other people, but I think people vote with their feet, people leave and get other jobs. When there's positions that fill up.…they are happy places where there's teamwork, and people are aware of people's feelings and work hard to engender that sort of teamwork that's when people stay.

Jerzy describes how concerns from the staff on the floor can be ignored by the more senior management team and resulted in staff leaving the hospital:

> I remember very well a number of nurses came from the UK to work here and they wanted to change it [the ward system]. They were trying to not complain [sic] but still make their concerns known, I don't think that was taken on board by management, and I think eventually they got so fed up that they all left.

This dissent at the middle management level, nurse leaders reported, contributed to the potential for unprofessional behaviours at the nursing coalface. It was proposed that often it was the case of the "wrong person" getting the job and due to the large number of staff who were in acting roles. Maureen described how the organisational processes of not employing

into a position instead of filling the position with a person who is acting in that role were not necessarily the best way to manage a ward demonstrating poor professionalism.

> I think you need an open-door policy with your manager, which I'm not sure that we have. We also have not so much a high turnover, but there are people acting in positions and have been acting in that position for x number of years, and nothing is ever settled. I think that's problematic because people babysit the role; they don't take ownership of it. So, they are existing rather than leading and role modelling.
>
> I think you probably need your senior staff to be on the same page so that it filters down. If you've got two people at the top that are at loggerheads and then the CNs [clinical nurses] don't particularly agree with one of them or both of them then that's going to filter down. What the hell, even if I do try, it's going to filter down, and I think you need consistency with whatever you do. You can't say well were doing it all this way this week and then it might be another supervisor the next week. (Maureen)

Having the right people in the job influences the culture of the ward. Page describes the influence that the senior staff can have on this:

> You know if your staff don't respect your senior leader, then it does have an influence because they are leading. They are meant to be the role model overall, so you got [sic] to have respect for that. I think that is one of the reasons why it is really important to put the right person in the right job because if you don't, it can destroy a team.

This was also discussed by Wendy, who said:

> The other day I spoke to someone who is in an acting CNM [Clinical Nurse Manager] position, and she said she hates the job, and she doesn't want to be in

> it, she is only in it because they couldn't find anyone else to do it, they asked her to do it. She takes that negative attitude with her. So, the people that she talks to and graduate nurses that come through and that sort of thing and that negative attitude can rub off on people.

Right person for the job

So as described above, taking on a nursing leader role when they have been placed into the position is one way to obtain a promotional position. Nurse leaders believed that even when a position was advertised, it did not necessarily follow that the new incumbent met the requirements for the role despite the use of a position selection criteria. Wendy explained:

> So, I think for the most part it [organisational promotion] is transparent but having said that there is [sic] some underhanded things that go on, where it's just a tap on the shoulder; there is still some of that, unfortunately, but for the most part, even if it is an acting position it has to be advertised.
>
> Diane explains how promotional positions are filled within her private hospital:
>
> Here particularly, it's through recommendation and knowing the person that they've been in other roles. You know the thing where they advertise and even though outside people may show interest some are not encouraged because there is an internal person that they have in mind, but it isn't a lot about qualifications. It's a lot more about fit, I think and possibly being this organisation [private hospital], it's a lot more about fit and working with people than qualification.

She went on to explain that once they were in the management position, even if they did not get on with everyone, the staff member would not be moved "Oh they'll stay, they'll stay here forever" (Diane). Nicola explained the job selection process within the public hospital system:

> I think it's more knowledge-based, so when you go from a level 1 to a level 2 [Registered Nurse], its experience in the ward. You probably would have had some opportunity to act up in that position and have peer support from somebody who's in that position, but there are no set criteria that says OK to go from level 1 to level 2 you have to do this, this and this course. Then going from level 2 to level 3, it's only done on knowledge and experience. Whereas for the management or if you're going to be a clinical nurse manager or a clinical nurse specialist, some type of education course would be good. I've been lucky I suppose in the positions when I've changed, that I've had the opportunity to do those courses, but I like doing courses, so I do a lot of training and up-skilling, some people wouldn't do it. So, there's nothing specific, but then I suppose people that move from level 2 to level 3 are only going to get that position if they have the knowledge and the ability and the skills to be able to do that. You don't automatically get it you have to pass an interview where they're going to ask those questions that are related to that level 3 position and the courses that you would have done that are related to that position they are going to give you more support in doing that new role. (Nicola)

Louise describes her view of applying for a promotional position, again in a public hospital system:

> There's no progression planning in any of the hospitals although they say there is, there is no progression planning to move a CN [clinical nurse position] to a CNS [clinical nurse specialist position]. There is no one taking on that person; no senior is taking on [mentoring] a CN saying this is what you need to do these are the avenues you need to go down, no CN is going to an RN saying this is what you need to do. I mean, they can tell you go to University, you need to go

> down this stream or this particular speciality, you need to take those sorts of things and allow them to take on more roles but in a supported way. The nurse just applies when it comes up. Usually, I have seen the exception a few times, but usually, they need five years post-registration experience, but that doesn't happen at the times when there are no other applicants. It's still in many cases who you know or if you're their buddy. (Louise)

Preparation and qualifications

Education, as discussed by leaders, was any form of learning which enhanced knowledge, either undertaken in the hospital or through a university. Diane commented that those in management and/or leadership roles should possess appropriate educational qualifications and relevant experience to undertake the job but that this is not her experience.

> My experience here is that most people in management and above don't have the qualifications that I would expect, which might be a master's or a post-graduate certificate, or [postgraduate] diploma in anything. Some of the managers will have business administration certificates.

The broader benefits of education relating to improving both critical thinking, as well as developing a broader knowledge base, was explained by Jerzy. Despite the identified link in increasing critical thinking and problem solving and professionalism, further education was not always encouraged. Jerzy was concerned that the newly graduated registered nurses, replete with their critical thinking skills, entered the ward culture where nurses did not consider further education was important:

> I think basically, in anything, education is very important in any person's life, and I think being educated in different areas makes you think differently as well. What happens is that we have a graduate coming, graduating from the

> university, coming in with that kind of mind, and then they get stuck with those people [without further education] with those ideas, and it is very difficult.

Wendy felt that further education led to clinical practice that was current and based on scientific research.

> Having a tertiary education improves your practice, it's really important because it says to the world that I'm about a set of standards and examples. I'm not just learning from the next person along here, and we are just going to go because that's how we always do our work. We are educationally or university trained, and we try and better ourselves through evidence of scientific research, and I think that's in essence [sic] defines professional practice, particularly in healthcare.

Support of staff, an investment of time, money and energy by the organisation into staff education is not always supported by the organisation, as discussed by Andrew, from the public sector. He explained that within the public hospital sector in his work area, additional time for the educators to support staff was not supported sufficiently by his organisation.

> Well, I think there needs to be a lot more focus on support off the clinical floor, for education. We are expected to do or participate in education and clinical audits when you are on the floor working, yet you have got to try and find that time during your clinical hours.

He continues saying:

> I mean we aren't going to be who we are without being professional about what we do, and that's from saying hello, being nice to the person, through evidence-based practice, through doing a set educational course, to furthering our studies, to working on our non-verbal and verbal communication styles and

> collaborative practice, through constantly being reassessing all that again and continually trying to improve what we do. (Andrew)

Diane felt that organisational support for further education was lacking for staff members undertaking higher qualifications. She believes that education enhances the individual's ability not only with the academic style skills learned from doing a higher qualification, but she feels it also translates into improved practice through having a more analytical thinking process.

> I think there's a difference with more education than just the qualification; it increases someone's ability. I think discernment, understanding, using these critical thinking processes when you're writing and thinking about things, and you can translate to practice, and why people do what they do. I think definitely the more study you do you have a greater ability to read and understand people, so I think any postgraduate qualifications are beneficial to the organisation, but I don't think they're encouraged. (Diane)

Louise explains that within the hospital, there needs to be a system where all staff receive face-to-face education rather than emails or daytime sessions:

> I think there needs to be more education at ground level, renewing protocols not just throwing them out there in cyber world 'cause [because] I would get at least three emails a week. 'Did the new protocols come out?' I'm not going to read them.... it's more time consuming to take it back down to ward level, but it's going to lift the professionalism.

Understanding and utilising new protocols within the hospital system is an important up-skilling of staff. New protocols are based on best practice methods identified from the latest scientific research in the clinical area. Nursing staff need to appreciate the value of evidence-based practice application and its importance in improving patient outcomes. Diane

affirms that “my experience here is that most people in management and above don’t have the qualifications that I would expect, which might be a master’s or a postgraduate certificate, or diploma in anything”. Nicola also discusses the importance of qualifications as an influence on how well a nurse can lead or manage. Nicola states, “In the same way, if you’re good on the ward as a nurse, it doesn’t mean to say you’ll make a good nurse manager, just because you’ve had some experience on the ward. It’s all about education”. Jerzy agrees that those in promotional positions have inadequate preparation and qualifications:

> I think people are not well prepared and then they are put into a nurse managerial position. Fortunately, I mean, my experience in England was quite different. I mean, to become a person in charge you needed to have done some kind of management course…in the current climate by what I can see they are not, they are put into a position of seniority without that preparation to go with it. I think that is what the problem is now.

Andrew explained that there are nurses who are not interested in furthering their education, and he gave his explanation of why education is so important to a nurse:

> You can just sort of sit in your box. Unfortunately, I know there are [a] lot of nurses that like to try and do that, but I think that is really important that you try and improve yourself, better yourself and broaden your horizon because that makes you a better person and it also makes it better for the people around because you run off each other.

Jerzy suggests that the monetary recompense may play a role in the lack of uptake of qualifications as staff don’t feel it’s necessary to attain further qualifications if they can end getting the position without the added effort. He continues:

> I think some people can get the certification allowance, which is fine, but it’s not huge. Therefore, their intention is “well I don’t have to do any study; I’ll

> only get minimum money anyway for a certificate. I can get promoted easily without doing it, so why should I?"

Diane has similar reasons why educational qualifications are not being emphasised with job selection:

> …. the upper echelons don't have that [university qualifications] themselves so why would they enforce [nurses] doing something? Interesting I heard recently people going for jobs at a higher level without the qualifications, use a little trick. Enrol in university to do your qualification, then get the job and then don't do the qualification and apparently that's OK. To me, talking about professionalism that is appalling, and these people continue to get it [the job]. It seems to me you get to a certain level; it doesn't seem to matter what you have or how much lack of integrity you have, the promotions keep coming.
>
> Most people I know look at these people and go, "you know they're not people that you want close by; so, they might as well be at that [higher] level because they're appallingly bad managers".
>
> I think, going back to the organisation, the management don't have them [university qualifications] themselves, so they don't see the need, they don't see that difference. They are there because of what they do, right place, right time; somebody has to do the job. I say to the graduates as they are here doing their grad cert [postgraduate certificate] in clinical nursing through university XX, after their first --year that they are more qualified than most people on the ward. That's why I always wonder why the [staff development] educators are not going "Gosh they've got a postgrad cert [certificate] I've got a [vocational sector] certificate four" and not go "Perhaps I should be doing something about it," but they don't even see that connection. (Diane)

Leaders explained that learning does not end upon the completion of the registered nurse qualification and registration; it needs to continue throughout the nurses' time as a registered nurse. They discussed lifelong learning as associated with skills and competencies acquisition, and it also consisted of the attitude which encompassed learning for learning's sake, having a curiosity to find out more about the world in which we live. Jerzy was quite impassioned about this subject:

> Life-long learning has to be the core of professionalism. I think life-long learning brings the person up to date with what has to be done and not done, and development of that attitude. Otherwise, you sit in a corner and live in the past. You've got to move, and you've got to change, and the change has to be evidence-based as well. You can't have evidence-based [practice] without that life-long learning, so I think that has to be very important, I mean in any area, education has to be the cornerstone of anything. (Jerzy)

Diane also mirrored the above sentiment saying:

> It's a seeking of knowledge in terms of curiosity about why we do what we do. If you're presented with a nursing patient diagnosis, it's the ability to go and look it up and be interested in finding out more information; I think that is really important. To be up to date, relevant, use best practice, know where to go, know other resources, how to find out, how to ask the questions, and the interest in finding out more about what you do. Again that's being I think more up to date, recognising that your nursing knowledge needs to continue and to grow along with the time spent in the job; as opposed to just knowing what you know and you just carry on and never look for anymore. I guess it's lifelong learning, continuing professional development.

> …You know it's that critical thinking, clinical reasoning, looking for more than what is in front of you at times. (Diane)

Remaining up to date with information and maintaining their standards of practice is evidenced by Wendy, who discusses the different aspects of skill acquisition including being a member of nursing professional bodies as a means of keeping up to date:

> So I guess they have to maintain their standards of practice, then be evidence-based in what they're doing, keep up to date with all the literature, whether they join professional bodies to help them do that or however they want to do that I guess, but make sure they're always upskilling, make sure they've got good communication skills if they haven't, then do courses. There's plenty of stuff out there that you can do to help improve that.
>
> ….be supportive of others, continual awareness of patient safety, staff safety, the skill mix that's out there. I guess with the reporting, you know if you've got any issues with things, make sure you are just reporting, and it's not just been swept under the carpet, that issues are being brought to light and discussed within the team. (Wendy)

She expanded upon this saying: "I think belonging to professional organisations helps make you more professional". Wendy continued that nurses would rather join an organisation that was specifically related to their job; an example being a theatre nurse joining the Australian College of Operating Room Nurses not the Australian College of Nursing. However, Jerzy felt that even with the more job-related organisations such as the Mental Health Nurses Association there was only a very small number of nurses joining and he doubted if there were many nurses joining the larger organisations. Jerzy suggested that joining a professional organisation should be part of their JDF [Job description form], to encourage nurses to join their professional associations. He stated:

> It's a very small number, very, very small number and that's representative of the total population [of nurses]. There's no encouragement; there's nothing, they will not have to join. It's just, why should I bother about all that when I can just come and do my bits here and there and go home. I think all should join a professional association this should be part of your JDF or you're sculpturing somebody without any professional standing.

The organisational influences shared by nurse leaders related to the hospital leadership team and their lack of visibility and involvement at the ward level; also noted was the lack of acknowledgement of a job well done not only by the leadership team but it flowed on down to those working on the floor. Standing up for a high level of quality care meant that sometimes difficult conversations needed to be undertaken where care was not being delivered as it should. However, at times this proved very difficult as support from others on the ward – which may include the leadership team – was not always forthcoming. Nursing leaders discussed that it was important to have the right person in the job, someone who had the right attitude as well as the right qualifications and experience. They felt that it was important to have an actual incumbent in the job rather than having people acting up into the role as they didn't necessarily have either the experience or knowledge or fully take on the responsibility that came with the role.

At the time of the interviews, there were a lot of nurses in "acting up" roles as there was a restructuring of the healthcare sector with the building and opening of a new hospital and expansion of many of the other metropolitan hospitals. This resulted in the movement of staff, especially of senior staff to new positions, thereby leaving the other hospitals having to fill those senior positions with more junior staff. This health sector disruption and resultant stress are evident in some of the interviews.

Within this section, we have discussed the organisational influences as discussed by nurse leaders. Generally, the organisational factors appear to be beyond the level of control of the registered nurse with most areas being related to that of the health department or the organisation for which they worked. These influences related to the hospital team and their lack of acknowledgment of the work that nursing staff undertook; performance management of errant staff where staff were to be held accountable for their poor behaviour; the employment of the right person for the job with relevant qualifications and experience for the job. The next area to be examined is that of environmental influences. These areas are more difficult for the individual nurse to influence.

Environmental influences

The second research question examined the workplace and environmental factors which influenced professionalism. The environmental influences identified by nurse leaders related to the infrastructure of the health system. Some of these excerpts of the environmental influences may also have been used in other areas within the first three themes where they were discussed in relation to the different sub-themes.

Restructure of healthcare

In Western Australia, at the time the interviews with nurse leaders were taking place, there was a large restructuring of the healthcare system. There was a new 783-bed acute care metropolitan hospital being commissioned, with staff being moved from the hospitals in which they were currently working to the new establishment. Nurse leaders from both the private and public sector discussed the influence of this restructure. Due to the restructure, staff from all areas of health were applying for new positions or many experienced retrenchments from their jobs, and these factors impacted staff morale, skill mix and leadership. The influence of the restructure impacted all hospitals in Perth as the new hospital

struggled to fill their staff vacancies, this resulting in staff moving from their current positions in other hospitals to take up positions in the new hospital. Karen says:

> The feeling that I get from a lot of staff, because they are trying to suss out who is going to go over [to the new hospital], a lot of people are just hedging their bets and sitting on their jobs at the moment and seeing how the lie of the land pans out I think. (Karen)

Wendy, working in a different public hospital, also was feeling pressured by the changes and had this to say:

> At the moment there is quite a bit of dissatisfaction at XX Hospital because we've got lots of people in acting up positions. There is a lot of our senior nursing that went off to YYY [the new hospital] or have even gone to other hospitals. So, we're left with the workforce where we've got lots of senior people who are only acting up [in the roles], and they're actually junior people. So, we don't have that nice skill mix and that level of support because they don't know how to support other people ….they've had no training, so they're going to have to try and fumble their way through. I mean in ICU [the intensive care unit] at the moment they've got three acting up staff development nurses, and they've just combined their high dependency unit into the ICU. So those high dependency nurses are trying, have to be, upskilled to ICU. They've got three acting SCNs [senior clinical nurses] in there, two of which don't want to be in the role anyway, they're only in it because they know they couldn't get anyone else to do it and said: "Oh god, OK we will do it for a while". Plus they've got two acting CNSs [Clinical nurse specialists] who are really quite junior and a CNS that's ready to retire. (Wendy)

The researcher joked "So now is not the time to go to hospital?" to which Wendy replied:

> No, not ICU anyway, not anywhere really because a lot of the wards are like that and what happened is because they closed ZZZ Hospital, and they moved some of those SDNs [staff development nurses] over into the other wards, some of our wards closed and went, and the whole ward disappeared off to YYY [the new hospital]... a respiratory ward has been moved to become an orthopaedic ward, so they [staff] have no skills in orthopaedic themselves. They don't know which end screws up and which end is down [laughs]. So, it is really difficult; they really need lots of support at the moment. The whole hospital feels quite crazy at the moment, quite unsettled; there are lots of good things I think that they want to bring in but getting there is going to be hard work, really hard work. (Wendy)

Katherine, who worked in the same hospital as Wendy, also felt that the skill mix was impacted by the new hospital opening and said:

> …with some of our staff transitioning to YYY [the new hospital], we are trying to develop a lot of junior people up to a role to the shift coordinator; also, a lot of the clinical nurses. At the moment, we are mostly not taking the shift coordinator role because we are trying to role develop everyone else.

Louise, from yet a different hospital to those previously mentioned, was more emotive in her description of the current state of staffing within the hospital in which she worked:

> The leaders are trying so hard to build up a really good reputation of a good professional ward, but then you've got people undercutting them, you've got staff getting transferred to YYY [the new hospital]. All the cream off the top are being stolen, the senior staff that have got all the years' experience getting taken to YYY [the new hospital], you've got other hospital staff coming in that

> don't have the experience, so it's a real rough and tumble world out there at the moment.

Katherine also expressed that these added pressures resulted in anxiety for staff members with, "Quite often, especially at this point in time, we are going through reconfiguration and downsizing, so I think those added pressures must lead to the added anxiety".

Workload

One example of workload issues is given by Karen, who explains that although patient numbers had increased, this was not reflected in an increase in staffing numbers for both nursing staff and support staff:

> We now see 1,200 new cases a year, and that includes inpatients plus outpatients. We are mainly outpatient ambulatory care. We fit them [new patients] in, and we do what we do. But it's like that for admin [administration] staff too, admin staff in an area like us are really, really important. If they cut back on admin staff that [work] will fall on the nurses.

Julie explained that when staff were pressurised, there was a lower level of care provided as patients did not have all the information explained to them thoroughly: "I think people forget actually how they do talk and I suppose when you rushed, and you're busy and things like that you don't take the time to explain things fully".

Andrew continues in the same vein with:

> If you have got more patients to look after and if they are really sick as well, the way you interact with patients will be impacted. You can't just spend that extra time, to provide that extra educational support [with staff] because there is someone that needs you to help them to the toilet. They or you have got a

> new patient to assess who could be having a heart attack, so you can't just stop and spend that quality time like you would.

Andrew also discusses that staff development is unable to undertake elements of their role such as education and clinical audits as they have been pulled back onto the floor to work as a clinical nurse due to workload issues, so they aren't fulfilling their role. Andrew says, "I think perhaps there could be more done [to support staff], but that would have to come out of finances and budget to allow for that". Wendy felt that the health budget was resulting in the downsizing and trimming of staff numbers, which increased dissatisfaction of the nursing staff, due to the increasingly heavy workload:

> I think often it's that they're overworked and underpaid. So, it's that ratio of nurse to patients, I mean for example on the ward at XX Hospital they used to have one nurse to 5 or 6 patients, and that's a really heavy workload, it was really hard-working there, and the dissatisfaction was huge. The CNS [clinical nurse specialist] on that ward tried to say, "this is the issue, [the staff-patient ratio] we need to change this" and she pretty much got shafted, she got bullied out of her position. Someone else is now in the position and guess what; they have changed the ratio from 1:3 or 1:2 in some cases. Staff satisfaction has improved hugely, but that other person [CNS] wouldn't get any recognition for all the effort that she put in trying to change it.
>
> I think that [the] nursing to patient ratio is a huge problem and especially now because it seems like we are trying to downsize and trim wherever we can, financially off the health budget, and you can see that that's going to happen again. At the moment, there is quite a bit of dissatisfaction at XX Hospital. (Wendy)

Page did not feel that patient ratio should make a difference with workloads, and she expected that people should then work as a team to get the job done so that workloads should not be an issue. Page stated:

> I think if people are frantic, obviously there is going to be stress which affects respect but if you are working together and there is respect for your colleagues, then you work together. If you have finished your workload, you are going to your colleague's "can I give you a hand" so the workload is equal, so that should be the standard.

The issue of workloads is really beyond the nexus of control of the registered nurse, and it falls to the nurse manager to ensure that if numbers and the situation changes, correct staffing is organised. As can be seen, the nurse leaders appear to feel that they have no control over this area as it is a financial issue-based either with the hospital or the Health Department. The issue of budget and finances also relates to the area of infrastructure within the hospital environment.

Facilities for staff

One of the nurse leaders, Andrew, discussed how infrastructure impacted on nursing staff. He related it to the level of respect that the organisation had for the nurse, where infrastructure was not supplied, he suggested that because of that staff felt disrespected. Andrew began with:

> I think XXX Hospital is a very run-down hospital, so the geographic of where we work really makes it hard to sometimes feel [sic] like you are looked after and loved by the Health Department. Our tearoom sits right on top of the female and male toilets in this cramped little area where you have nowhere really to relax and take yourself off the floor for that cup of tea break; you know those aspects are really important for feeling supported. I don't have really any say, I

> mean I can make complaints, and I can write letters and try and get my colleagues to sign a petition to say we want better facilities for staff, but that's hard to do.
>
> So, facilities for staff, ramp it up [sic] make it the best ever, and I'm talking about a 50-metre lap pool as well and a really big gym that type of stuff it all should be "part and parcel". There is a 25-metre lap pool here [at hospital XXX], and the gym, but it's all like really run down, and it's away from the main hospital, a bit dodgy [sic] over there. They don't like you going 24/7[to use the facilities], they only like it open during the daylight hours, but it should be open. If I finish work at 2 o'clock in the morning, I should be able to go to the gym because I am a shift worker and they should support me in that. I think that is really important.

Andrew changed his discussion from the hospital in which he was working to discuss the new hospital being built in the Perth metropolitan area:

> They YYY [the new hospital] doesn't have a pool; I did a mini-tour. They don't have a gym for staff, their end of shift facilities which is basically for bike [bicycle] riders are absolutely shit [sic]. They have got just a couple of communal showers and bugger [sic] all lockers. The bike block area is just under where the car park is, it looks like it should be a storage area, but they have quickly put in bike racks instead, and all these people are hanging up their suits or their uniforms on the concrete wall, on piping and stuff. They've got nothing, and this a 2.8-billion-dollar hospital and they have not thought one iota about how they are going to look after their staff, and they can't get staff either can they? The next six months is going to be interesting.

Interestingly other nurse leaders had commented on these points. Another area which appeared to have an influence on the professionalism of nursing staff was the patriarchy of the medical system.

Patriarchy of the medical system

There was evidence in the transcripts of what appeared to be a power differential between that of medical staff and nursing staff. Karen and Julie appeared grateful that the medical staff will listen to the registered nurse rather than an acceptance that it is normal practice to listen to them. Karen goes on to explain that she does feel the system is changing and gives the following example: "hopefully the training is a bit more enlightened for the doctors as well as the med [medical] students so that they are seeing that nursing does have a role and they can give you information that you don't get". Julie explains that respect has to be earned in the doctors' eyes rather than there being an expectation that registered nurses have a high level of knowledge:

> You know the private sector is very different and I think you have to earn respect. …. it's interesting, some of the doctors will actually say to me "now what do you think" which is quite nice.

As discussed previously by Wendy, the patients continue to revere the doctors and not understand the role of the nurse:

> I think they like doctors, as they always look up and revere the doctors, but I do think patients are more aware now. You do hear a lot more comments from people in public saying, "you nurses work so hard and you don't get enough recognition for what you do and that sort of thing". I hear quite a bit of that, so I think that's a good thing maybe people are becoming more aware, but I don't think that patients realise how much training goes into nursing.

Wendy goes on to discuss the image of nurses in the media which continues to be about the medical team more than the nurses: “I’m thinking there are shows that are always about the doctors and how good the doctors are; the nurses are always just in the background aren’t they?” Jerzy also commented about the lack of nurses in the media. However, he was referring to nursing champions for nurse leaders who were in the spotlight, rather than television shows.

> …the last few years I haven’t seen our leaders going and saying something about nursing, we have doctors saying [things], not nurses…there hasn’t been that exposure publicly and that’s professionalism, that’s important. We know the public has good regard for nursing, we know that. We hear all that, but I feel that in the same way, we haven’t got that champion and leaders going in and making some points.

Page working in a team of specialists felt that she was really lucky with the doctors that they had, as they were willing to discuss matters with nursing staff:

> …doctors are a mixed bag; most of them are good. Most of them all talk on a level with you, there is the occasional upstart [laughing], but that doesn’t happen very often. We’re very lucky our senior doctors are really good and really willing to talk things through rather than dictate, but they’re younger, I say younger, their 40ish, so I can class that as a different generation.

Nicola voiced her surprise of the power of the medical system in Western Australia that she had experienced when she first came from the UK: “One of the things I found coming from the UK to here is that nursing here is very medical or has been very medically controlled; in the UK it’s not so much”. Researcher: “Do you think that’s just Perth or Australia-wide?”

> I can't tell you I've never been anywhere else, so I can't tell you, but I just think that doctors have been given a lot of power here and it's very medical based which is really sad ….the consultants here seem to be this big thing.
>
> ...on the ward they were frantic, "oh got to get this, got to get that", and I said hold on, what's happening, "oh the consultant's coming". OK, so we need to make sure the notes are up [on the ward], and we need to make sure people have had their showers and whatever so he can see them all.
>
> ...I couldn't believe the "oh my god he's coming" they used to call him "god" and I said OK, but you've created him like that you've given him that power. He's here to do a job same as you're here doing a job; as long as your job's done well and he's got what he needs to do his job well, he'll be fine, and he was. (Nicola)

Katherine explained that some of the older medical staff expected nursing staff to act in a particular way, as she explained below:

> I think that [nurse-doctor interaction] has evolved over-time since I have been nursing. We still have one consultant, who is in a very high-level position within health at the moment, who even up until his started in that position, expected us to stand at attention, pretty much when he walked on the ward. For him, that was a sign of respect; a professional nurse was to stand there and take his orders, so he was still very much like that, even in this current day.

Nursing leaders did appear to feel that relationships between medical staff and nurses were improving; however, it appeared slowly.

Within this section, we have examined the environmental factors which have included: restructuring of healthcare, workload, facilities for staff, and patriarchy of the medical system. Generally, the environmental factors appear to be beyond the level of control

of the registered nurse with most areas being related to financial and budgetary areas, which in many cases was not only based within the organisation but also determined by the West Australian Health Department as a state-based organisation overseeing the budgets of the hospitals. These areas are more difficult for the individual nurse to influence.

Summary of the influences

The theme "bridge over troubled waters" has discussed two influences on the ability of the registered nurse to demonstrate professionalism, that of the organisational and environmental influences. Organisational influence as identified by the nurse leaders discussed the hospital leadership and the leadership teams' lack of acknowledgement of staff, performance management of staff, employing the right person for the job with leaders having the necessary preparation and qualifications. The second influence related to the environmental influences, as identified by nurse leaders, comprising of the restructuring of the healthcare environment, workload, facilities for staff and the patriarchy of the medical system.

The first element of organisational influence was evidenced by nurse leaders' discussion on the lack of acknowledgment by staff, either by the nurse leadership team or the nursing executive. This lack of acknowledgment related to an absence of communication to acknowledge either a job well done or the level of work being undertaken by staff members in the sometimes difficult circumstances of a hospital restructure. The conditions involved in the restructure resulted in insufficient time to perform their roles to the level required for quality care, a lack of staff of the correct skill mix or with staff experiencing an increase in their job role when they were already working to capacity. The second element within the organisational influence to be discussed was the performance management of staff demonstrating negative behaviour, needing to be dealt with expediently by the nursing leadership team, but that this was not always addressed. Nurse leaders described that the

culture of an organisation should be managed at all times to be harassment-free, and all reported instances should be considered equally and investigated with a no-blame policy for the staff who have reported the instance. The third element within the organisational influence to be discussed was employing the right person for the job, with leaders appointed to their position and not acting up in the role for any length of time was another issue raised. The leaders selected for those roles also needed to have the correct qualities, experience and qualifications for the role. There needed to be transparency of selection and promotion for all positions with equal opportunity for all staff to apply for a position through a transparent process which is equitable for all applicants so there can be no calls of bias or nepotism. The person for the job should have met a set of identified criteria, including experience and qualifications, which is the same for each applicant. Nursing leaders believed that there needed to be a trial period during which the person could be removed from the position if they did not fulfil the role adequately. Adequate preparation, experience and educational qualifications commensurate with the job also needed to form part of the job description form. Leaders discussed that staff should be actively encouraged and supported by their organisations to seek further educational qualifications and improve their qualifications. The job descriptions should be available on the hospital human resources site for all potential applicants, both internal and external, to view. For all leadership roles, there should be a requirement to demonstrate further qualifications commensurate to the role, as well as research and publications or presentations at conferences. Membership of nursing professional bodies should be mandatory for any promotional leadership positions. With performance appraisals for all staff, leaders included, which demonstrated that they were undertaking their mandatory training, as well as further education related to their role to remain up-to-date with the latest evidence-based findings.

The study found a number of environmental influences impacting professionalism which related to the state-wide health reforms and restructuring, hospital infrastructure, facilities of the staff, workload issues, and finally, the patriarchy of the medical system. The first environmental influence was that of the restructuring of the healthcare sector in Western Australia. The restructuring related to staffing, workloads, levels of anxiety of staff, skill mix and staff-patient ratios, with resultant disgruntlement and angst towards both the health organisations and the broader health department. The second environmental influence was workload issues, also influenced by the restructuring of the healthcare infrastructure. Staff complained they were too busy, had too little time, managed extended job roles in their already full role, these then influenced their ability to deliver a high level of care, rather than patient-staff ratios. The third environmental influence identified facilities for the staff. Although not mentioned by most nurse leaders, it was an area bought up by one nurse leader, who felt that the level of respect by the organisation and the state health department towards staff was demonstrated through the provision of adequate infrastructure and facilities provided for staff. The fourth environmental influence discussed was the patriarchy of the medical system evident in some of the nurse leaders' discussion, although they felt it was improving slowly. It appeared from the nurse leaders' discussions that some leaders believed there remained the patriarchal attitude of the past. That medical staff were of a higher level and nurses, and it appeared that nurses should be happy if asked to offer an opinion on issues relating to patient care. Nurse leaders discussed that this attitude did appear to be changing with the newer generation of medical staff.

The two influences, organisational and environmental, determine the healthcare setting, the working environment and conditions of the registered nurse and their ability to demonstrate professionalism in their daily practice. Figure 6 presents the diagrammatic

summary of the influences on the professionalism of the registered nurse as identified by the nursing leaders in the theme “bridge over troubled waters”.

Figure 6

Diagrammatic representation of theme four Bridge over troubled waters

<table>
<tr><td rowspan="5">Theme four</td><td rowspan="5">Respect</td><td rowspan="5">Bridge over troubled waters</td><td>Leadership presence and acknowledgment</td></tr>
<tr><td>The right person for the job</td></tr>
<tr><td>Lifelong learning</td></tr>
<tr><td>Standing up</td></tr>
<tr><td>Educational qualifications</td></tr>
</table>

Summary of the chapter

This chapter has discussed the themes and associated sub-themes arising from the analysis of the leaders’ discussion on professionalism. The first three themes identified in this chapter all fall under the control of the registered nurse, with the final theme, the organisational and environmental influences being beyond the realms of the individual registered nurse’s control. These themes have been described and examples provided from the nurse leaders’ narratives, that highlight the different aspects of the attributes of the professionalism of the registered nurse.

To summarise, the main idea of each theme is: Theme one – Professional presence related to the personal qualities of the registered nurse; Theme two – Walk the walk discussed the interpersonal behaviours of the nurse with others in the healthcare environment; Theme three – Owning the problem outlined the registered nurses’ facility to demonstrate their individual professionalism and accountability within the workplace; Theme four – Bridge over troubled waters related to the organisational motivators and inhibitors and the

influence on the nurses' level of professionalism, consisting of some areas over which the nurse did not have any level of control. Within this study, the attributes of professionalism, as identified by the nurse leaders, were not ranked in order of significance; rather, it was identified that all the attributes were intertwined. Figure 7 provides an overview summary table of each of the themes and the attributes they identified and discussed.

Figure 7

Summary of themes

Theme	Attributes		
One	Respect	Professional presence	Appearance
			Manner
			Skills and knowledge
			Attitude
			Caring qualities
			Support of colleagues
Two		Walk the walk	Role models
			Mentoring
			Collegiality
			Communication
			Nurse and patient communication
Three		Owning the problem	Personal accountability and responsibility
			Reflection
Four		Bridge over trouble waters	Leadership presence and acknowledgment
			The right person for the job
			Lifelong learning
			Standing up
			Educational qualifications

Returning to the iterative process

The emergence of themes from the analysis facilitated an extension in the iterative process, whereby the researcher became re-immersed in the themes. This re-immersion, although not intentional, illuminated the beginnings of a framework which added value to the

interpretation of the data. The continuous iterative process and concurrent data condensation resulted in the researcher's further interpretation of the nurse leader's narratives. These narratives provided the culmination where individual stories became the one "story of everyone" (Ennals & Howie, 2017). Throughout the study, the use of data has provided the simplification and visualisation of the data condensation process. This process of data displayed also assisted with the process of conclusion drawing and verification resulting in the subsequent renaming of themes, together with some movement and merging of sub-themes (Miles et al., 2014). Respect, for instance, was identified in each of the themes in the analysis chapter and due to its importance in every area of the analysis, this then became the underlying attribute of the study. Further refinement resulted in support of colleagues moved to fall within collegiality, as it was felt that it was an essential part of the collegial role of the registered nurse. Communication, although an important area within all aspects of the analysis, when given due consideration, was termed "respectful communication" and became part of the underpinning attribute of respect. Theme Four in the analysis chapter became the influences on the demonstration of the attributes of professionalism by the registered nurse. The broad areas of the theme "bridge over troubled waters", which examined the organisational and environmental aspects influencing professionalism, were redefined with the composition becoming more focused and renamed as influences. Figure 8 is a diagrammatic representation of the findings of the further analysis reworking the themes representing the framework which describes the professional attributes of the registered nurse.

Figure 8

Framework of professionalism with attributes and influences

<table>
<tr><td rowspan="3">Respect</td><td>Professional presence</td><td>Appearance
A calm and confident demeanour
Skills, knowledge and competence
To care</td><td rowspan="3">Influence of a stable environment
Stability of the healthcare structures
▪ Instability of healthcare structure
▪ Dissolution of teams
▪ Non-transparent organisational processes
Credible leadership</td></tr>
<tr><td>Accountability</td><td>Owning the problem
Seeking solutions
Self-reflection</td></tr>
<tr><td>Collegiality</td><td>Working relationships
Work-home dynamics
Role modelling</td></tr>
</table>

Chapter to follow

The findings chapter presents the framework of professionalism developed from the iterative process of conclusion drawing and verification of the analysis chapter. The findings are provided, both diagrammatically and in comparison, with the current literature on this subject. The themes presented are the four focused attributes of professionalism of respect, professional presence, accountability and collegiality, with the influence on the demonstration of professionalism by the registered nurse also identified.

Chapter Seven: Findings and Discussion

Introduction

The previous chapter presented an analysis of the nurse leaders' narratives, illustrating the professionalism of registered nurses. The key findings identified through examination of the narratives provided by nursing leaders delivered a new and different insight into the fundamental qualities of professionalism. The use of narrative inquiry to examine nursing leaders' views of professionalism is innovative in its use in researching this topic. This storytelling methodology allowed participants the freedom to discuss both the negatives and positives of professionalism as encountered in a variety of clinical areas. Within the narratives, examples of professional behaviours by registered nurses were provided by the nurse leaders in their attempts to describe how nurses can demonstrate professionalism within their daily clinical practice.

As previously discussed, the process of conclusion drawing and verification resulted in some movement and assimilation of sub-themes. The resultant four attributes of professionalism were identified as respect, professional presence, personal accountability and collegiality. This combination of attributes has not previously been identified when discussing professionalism (Bimray et al., 2019; Diede, 2018; Keeling & Templeman, 2013; Zibrik, 2019). The diagrammatic representation below of the consolidation and "drawing down" of the themes described at the end of Chapter Six provides an overview of the findings for discussion in this chapter. It is evident when comparing Figure 9 with Table 8 that this narrative inquiry study from nurse leaders has provided a new combination of attributes of professionalism, providing a fresh and clinically functional viewpoint.

Figure 9

Framework of professionalism with attributes and influences

<table>
<tr><td rowspan="3">Respect</td><td>Professional presence</td><td>Appearance
A calm and confident demeanour
Skills, knowledge and competence
To care</td><td rowspan="3">Influence of a stable environment
Stability of the healthcare structures
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Seeking solutions
Self-reflection</td></tr>
<tr><td>Collegiality</td><td>Working relationships
Work-home dynamics
Role modelling</td></tr>
</table>

Table 8

Comparison of six professionalism models with this study

Flexner (1910)	Hall (1968)	Kramer (1974)	Miller (1988); Miller, Adams and Beck (1993)	Baumann and Kolotylo (2009)	NMC (UK) (2017)	Richards, Hendricks, Churchouse and Shaw (2020)
Specialised knowledge		Continuing education	Educational background	Knowledge	Being a leader	Professional presence
Intellectual and individual responsibility	Commitment to practice	Subscribing and reading journals	Continuing education and competency	Competence	Being competent	Respect
		Participating in research	Theory use, development and evaluation and research involvement	Collaborative practice and commitment		
Altruism	Belief in public service	Public speaking and committee work	Community service	Profession hood	Being an advocate	Collegiality
Self-government	Self-regulation		Adherence to the code of ethics	Accountability	Being accountable	Accountability
	Autonomy		Communication and publication, autonomy and self-regulation	Autonomy		
	Professional organisation	Professional organisation	Participation in the professional organisation			

This study differs from many research studies into professionalism (Hall, 1968; Miller, 1988) because the aim was to identify the behavioural attributes of professionalism and the influences that impact the use of professional behaviour, not to measure professionalism, and the focus was not the use or implementation of models or instruments related to professional behaviour. This current study is in keeping with the resurgence of professional endeavours to describe and understand the attributes of the registered nurse's professional behaviours (NMC, 2017; Reed & Dix, 2018). Thus, the understanding of what nurse leaders consider as the attributes of professionalism, adds to the knowledge base of nursing and its application in the workplace.

This chapter discusses the attributes of professionalism in terms of their functional applicability by identifying behaviours which encompass the attributes to enable a shared perspective of what it means to be a "professional". This chapter also identifies the influences on professional behaviours in the clinical setting. The chapter ends with an illustration and discussion of the framework which encompassed the findings of this study.

Key findings

The key findings in this study were the identification of the professional attributes of respect, professional presence, personal accountability, collegiality and the influences on the professionalism of the registered nurse. The first of these attributes identified in this study was respect as it is the attribute that underpins all other professional attributes. Although the importance of respect has been discussed in the literature (Adams, 2011; Goff, 2018) it is the coupling of this underpinning concept with the attributes which is new to the understanding of being professional.

Respect

Respect was evident in most narrations by nursing leaders when describing the different professional interactions with patients and others, that underpin all nursing practice. Magri (2019, p. 332) claims that the concept of respect relates to "acknowledging another's autonomous standpoint". Further, respect was described as an attitude held by one person towards another person and underpinned by the premise that all humans are mutually accountable equals (Darwell, 2006). In this study, respect was conceptualised as appraisal respect and recognition respect (Darwell, 1977). Appraisal respect related to holding someone in high esteem for their perceived merit, values and character. Recognition respect is crucial because it allowed the consideration of a more comprehensive view of respect, where value is applied to others due to the dignity of humanity with an expectation of "mutual accountability" (Darwell, 2006, p. 126). Respect was found to relate to the registered nurse's self-respect, their respect of others and their respect of the profession. This expansion of the concept of respect differs in its construct to other studies (Beach et al., 2017; Koskenniemi et al., 2019; Snellman et al., 2012).

Professional presence is representative of appraisal respect or the self-respect of the registered nurse. The yardstick provided by appraisal respect often underpins the impression held by patients and others of the registered nurse's professionalism (Hatfield et al., 2013; Porr et al., 2014; Roach & Maykut, 2010). Snellman et al. (2012) stated patients felt it was important for a caregiver to be "kind, calm and understanding", have "courage" (p. 3) and "demonstrate respect" (p. 6).

Respect of others or, more definitively, of patients, colleagues and members of the multidisciplinary team, occurs within the framework of recognition respect. Therefore, the dignity and the autonomy of each person is considered as equal and mutually important. This perception of individual respect is supported by Goff (2018, p. 7) who described a registered

nurse's response when asked the meaning of professionalism as it " means [to] respect, to communicate and respect me as an equal". Respect, as described by Magri (2019, p. 333), "involves no evaluation or appraisal of excellence, because it entails valuing someone intrinsically". A principle which was also identified by Beach et al. (2017) where patients described respect by healthcare professionals as treating each person as an individual and an equal. Further aspects of recognition respect are discussed under the attribute of collegiality.

Another aspect of recognition respect is that of respectful communication with others. Where workplace communication was mutually respectful, collegiality between members of the healthcare team improved resulting in better teamwork, and a reduction in stress as concord in the workplace ensues (Kaiser, 2017; O'Leary et al., 2012; Padgett, 2013; Spence Laschinger, 2010). Positive patient outcomes were enhanced, when all members of the healthcare team efficiently communicated with a willingness to respect and listen to other's opinions and the attribute of collegiality was demonstrated (Chadwick, 2010; Johnstone, 2012). It is the registered nurse's professional obligation to communicate clearly and respectfully in an individualised manner, both with patients and inter-professionally, as part of their professional advocacy role (Ellison, 2015; Robinson et al., 2010). Wilkes et al. (2014) and Law and Chan (2015) attest that the ability to speak out as a patient advocate requires not only courage but the skills to articulate professional opinion, clinical judgments, and the needs of the patient to the team. The respectful manner of the interactions by registered nurses is both an aural and visual representation of the professionalism of the nurse (Nelsey & Brownie, 2012) thereby reinforcing the importance of respectful communication as an underpinning of the professional attributes identified in this study.

Interestingly, as an element of recognition respect and respect of the profession, the subject of membership of professional nursing organisations was not identified by nurse leaders as necessary, despite the general understanding that the aim of these organisations

was to improve practice and scholarship across the profession (Kim-Godwin et al., 2010; Matthews, 2012; Tanaka et al., 2016). Many studies identified the importance of registered nurses participating in professional nursing organisations as key to increasing the level of professionalism (Adams, 2011; Frenn, 2007; Nutall, 2010).

The broader application of respect of the profession related to recognition respect within the study, which determined respect was more than a moral attitude and related to the deliberations on how a person should act as well as to the law (Darwell, 1977). This is evidenced under the attribute of personal accountability, by the expectation that the registered nurse will abide by the law and work within the boundaries of the codes and standards of their regulatory authorities (ICN, 2012; NMBA, 2016; NMBA, 2018). Adherence to the codes and standards by the registered nurse was identified in this study as demonstrating professionalism and respect of the profession, with the codes and standards containing elements which related to both appraisal and recognition respect. When nurses demonstrated professional presence, personal accountability, collegiality, and worked within their scope of practice, this was seen as a respect of the profession. The second attribute to be discussed of professional presence relates to appraisal respect and the nurse's self-respect evidenced by their appearance; demeanour; caring attitude and demonstrating confidence in their skills and knowledge.

Professional presence

Presence is a term used in the nursing literature from the 1990s (Doona et al., 1997; Zyblock, 2010). The term has been used to discuss presence as a concept within the professional nursing practice environment. Paterson and Zderad (1976) linked presence to the nurse-patient experience. They emphasised the humanistic qualities of presence, its nature as reciprocal between the nurse and the patient and the value it adds to this relationship. Furthermore, nursing presence is a personal connection between a nurse and a patient where

the nurse views the patient as unique with individual needs (Doona et al., 1997; Zyblock, 2010). This concept of nursing presence is patient-focused rather than the identification of attributes of the nurse's role that facilitates professional presence.

In this study, a professional presence was identified as a significant finding. Finfgeld-Connett (2006, p. 708) has expressed concern that the concept of presence "has been fragmented into numerous types and used indiscriminately". This study considers professional presence as a standalone concept, as an extension of the historical connotation of the term. One such historical discussion was that of Paterson and Zderad (1976), who described a broader sense of presence incorporating skills, knowledge and clinical judgment as well as a regard for others and helping. This study further expands on the claim of Paterson and Zderad (1976) and, as such, is new to the nursing domain.

Professional presence in this study is an attribute of the nurse's professionalism and consists of several vital components. The vital components consist of the registered nurse's appearance; the display of a calm and confident manner; having an appropriate level of skill, knowledge and competence; and displaying a caring attitude towards their patients and colleagues. These components place professionalism within the registered nurse's scope of practice rather than merely with their interaction with patients. Here "presence", refers to the personal nursing behaviours which signify nursing professionalism and takes on physical and observable characteristics which determine a professional nurse. The following is a discussion of these components.

Appearance

Professional presence is the "first impression" of the nurse formed by patients and colleagues (Aquino-Russell, 2013; Kostrovich 2012; Kostrovich & Clementi, 2014; Priest, 2011). Fundamentally, being neat and clean was essential to be seen as a professional (Clavelle et al., 2013). Hatfield et al. (2013), Wocial et al. (2014) and Albert et al. (2008)

purported that a patient's confidence in the nurse's ability was improved when the nurse appeared neat and clean. Still, it was, however, not discussed as an attribute of professionalism. This current study found that the registered nurse's appearance was a central construct to being professional, and this demonstrated the registered nurse's level of self-respect through a clean and neat professional appearance. Interestingly, tattoos and piercings on the person of the RN were not raised as an issue in professional presence by the study cohort. This finding is juxtaposed to the studies by Thomas et al. (2010) and Wittman-Price et al. (2012) who warned that tattoos or piercings worn by a registered nurse might negatively impact on nursing relationships. However, this study found that professional presence encompassed more than appearance or image; it also included the demeanour of the nurse.

A calm, confident demeanour

The clinical environment in which nursing is conducted is stressful, often unpredictable, unplanned and challenging (Hamaideh & Ammouri, 2011; Cleary et al., 2012). In this study, a nurse's demeanour which was calm and confident in times of high workload and patient turnover demonstrated another component of professional presence. Notably, while studies have identified an inner sense of composure, or calm in the workplace, during times of stress as having a positive influence on others, demeanour has not been linked previously with a professional presence (Bostsrom et al., 2012; Ennis et al., 2015). Similarly, a nurse's knowledge, attitude and behaviours formed part of their demeanour and how they presented as a professional, which allowed them to feel confident in their interactions and decisions commensurate with their area and level of expertise. The perception held by others of the registered nurse appearing knowledgeable and competent form another component of professional presence (Billings & Kowalski, 2016; Clavelle et al., 2013).

Skills, knowledge and competence

This study, in keeping with Palos (2014) and Skela-Savic et al. (2017), asserts that there is a paucity of research which examines the relationship of the registered nurse's skills, knowledge and competence with their level of professionalism. It is through the application of knowledge, not "merely its possession" (Pennbrant et al., 2013, p. 740) that another component of professional presence is recognised. Tonnessen et al. (2020) support the finding of this study, discussing that professional, ethical conduct forms part of the delivery of safe and competent care. When delivering competent care, or when dealing with issues relating to patient care, the confidence of the registered nurse is a product of their knowledge and skills. However, the care demonstrated by the nurse in these human interactions with the patient is of a personal quality.

To care

In this study, it was determined that "to care" is a fundamental quality of the professional presence of a registered nurse when interacting with others. Caring is not mentioned in the nursing codes and standards; instead, empathy is listed (ICN, 2012; NMBA, 2016). Caring as a term, in the current study, was used interchangeably by nurse leaders to denote empathy and compassion. This meant demonstrating a positive, compassionate attitude within interactions. The use of the term care was different from its traditional use in nursing care where "care" is the provision of interpersonal and technical nursing interventions (Bramley & Matiti, 2014; Drahosova & Jarosova, 2016; Lachman, 2012). In this study, when care was discussed, it was in relation to interactions with other staff and members of the multidisciplinary team. Nurses who were seen to be caring as part of professional presence acted in respectful, empathetic and supportive ways with other staff. To care here was seen to be behaving in a civil and respectful manner. While in the literature, caring is considered as an essential element within the role of the nurse and described as a

universal human characteristic (Adams, 2016; Sargent, 2012; Shields, 2014), the literature has not previously identified care as a potential solution to poor professional behaviour. Care as a potential solution to uncivil behaviour was shown by understanding, supporting and assisting others while being mindful of that person's feelings, concerns and experiences. This point will be discussed under the theme collegiality.

Summary of professional presence

In summary, the attribute of professional presence is a complex phenomenon. It is comprised of the physical appearance of the nurse and the way in which the nurse portrays themselves. This portrayal of a professional presence includes the nurse demonstrating a calm and confident demeanour, through being knowledgeable and competent, and is seen to care for others in the workplace. When these actions or behaviours meld together in an individual registered nurse, they were identified as having a professional presence. In addition to demonstrating a professional presence, a registered nurse takes responsibility for clinical judgements based on their knowledge and skills, and this demonstrates personal accountability.

Personal accountability

Personal accountability was identified as another key attribute of professional behaviour by nurse leaders. Accountability is multifaceted as it applies to the registered nurse and outlined by Krautscheid (2014, p. 46):

> Professional nursing accountability will be defined as taking responsibility for one's nursing judgments, actions, and omissions as they relate to lifelong learning, maintaining competency, and upholding both quality patient care outcomes and standards of the profession while being answerable to those who are influenced by one's nursing practice.

The policies, professional standards, guidelines, position statements and frameworks under which registered nurses work are cloaked in the tenets of accountability (Milton, 2008). Plant, Pitt and Troke (2010, p. 718) and Drach-Zahavy and Srulovici (2019) contend that "accountability is a fundamental component of healthcare practice" and, as such, nurses are both responsible and accountable for excellent nursing practice. Overall, nurses in the current study were found to be accountable for their practice. However, the finding of this current study related to two dimensions of personal accountability. The first of these in keeping with the literature, related to patient care; the second, taking accountability in actively seeking a solution when problems and conflicting issues arose on the ward. These dimensions will be discussed in turn.

Patient care

The first of these findings within the attribute of personal accountability was associated with the errors and omissions related to patient care. In instances where negative patient outcomes were identified, some nurse's undertook self-protection measures by either shifting the responsibility to others or documenting that the missed intervention had been attended, rather than accepting culpability. One nurse leader explained that members of the leadership team remained silent at times about staff members' poor performance for fear of being unpopular. This issue of employee silence and fear of workplace ostracism can influence patient safety (Gkorezis et al., 2016; Hutchinson et al., 2010; Mannion & Davies, 2015; Yurdakul et al., 2016). Thus, perpetrators were not held accountable even though the issues were acknowledged as occurring. This lack of responsibility, transparency and admission of errors has also been reported in the literature (Bryan-Brown & Dracup, 2003; Cole et al., 2019; Leonenko & Drach-Zahavy, 2016).

In the current study, the errors and omissions which nursing leaders identified as not reported by nurses, related to medication administration, daily care such as showers,

documentation, answering of bells or the taking of vital signs. The literature supports this finding, discussing omissions or missed care items such as handwashing, glucose monitoring, ambulation, timely medication administration, bathing, discharge planning, assessment, and assistance with toileting (Kalisch, Landstrom & Williams, 2009; Kalisch & Lee, 2012; McMullen et al., 2017; Tonnessen et al., 2020). So, when nurses were observed to be personally accountable for patient care by undertaking core nursing business and reporting errors and omissions, this was recognised as an attribute of being a professional nurse. However, it was also found that where the error was not considered as important or did not affect a patient's outcomes, then registered nurses were not concerned about missing the care or omitting medication.

Seeking solutions

A second important aspect of the attribute of personal accountability identified in the current study was actively engaged in seeking solutions when poor behaviour was exhibited by others, or in situations of conflict. Nurses with this component of the attribute were seen to deal with issues of interpersonal conflict and poor practice on the ward. Unfortunately, there is no consensual recognition and acceptance of any one solution for managing poor workplace relationships (Clark, 2017; Hoffman & Chunta, 2015; Kangasniemi et al., 2017; McNamara, 2012; Spence Laschinger, 2010; Spence Laschinger et al., 2009).

The International Council of Nurses' Code of Ethics (ICN, 2012) discusses that each professional nurse has an ethical duty to resolve workplace conflicts and that it forms part of their responsibility. The NMBA Code of Conduct (NMBA, 2018, p. 10) contends that "nurses must never engage in, ignore or excuse such behaviour". Despite the personal accountability of the registered nurse being embedded in the codes and standards, nurses were seen to be fearful to "call out" another nurse. The lack of involvement due to fear of retribution, or of not being liked by other staff, left registered nurses appearing accepting of

poor behaviour in the work setting. Thus, when a nurse actively engaged in addressing transgressions in poor behaviour or poor practice, it was seen as exemplary nursing. If each nurse was professional in the way they dealt with patients and their colleagues, there might not be the level of incivility and bullying that is reported in the literature (Birks et al., 2018; Clark, 2017). Education, role modelling, self-reflection and mentoring (Clark, 2015b; Felstead & Springett, 2016; Gazaway et al., 2016; Purpora & Blegen, 2015), plus each nurse ensuring accountability through peer regulation in a collegial manner (Mannion & Davies, 2015; Padgett, 2013; Yurdakul et al., 2016), are the keys to changing the work environment.

Self-reflection

The capacity to be self-reflective facilitates the recognition of situations in which nursing care or personal actions and reactions have not been conducive to team dynamics or have impacted poorly on patient care. Taylor (2001) described that although nursing relationships are complex in nature when reflection is used to examine dysfunctional nurse–nurse relationships, there has been an improvement in understanding and acceptance. Furthermore, the nurse's capacity to consider their personal feelings, beliefs and interpersonal interactions, and how these feelings, beliefs and interactions influenced the behaviour of others and impacted the practice environment, were significant to their ability to be personally accountable. Self-reflection is a critical professional behaviour because it provides an opportunity for professional growth. The Nursing and Midwifery Board of Australia (NMBA, 2016, 2018) and the Nursing and Midwifery Council of the UK (NMC, 2017) encourage reflection as a way to shape professional practice and promote positive relationships. The development of a positive work culture through self-reflection and the demonstration of respect can influence collegial working relationships (Gallagher, 2004; Henriksen, 2008; Kupperschmidt, 2006; Mickan & Rodger, 2000; Nouri et al., 2019; Spence Laschinger et al., 2009).

Summary of personal accountability

The personal accountability attribute is made up two dimensions: the first dimension is the registered nurse and patient care; the second is the registered nurse accepting their personal accountability and actively participating in seeking solutions for difficulties and issues encountered within the ward. This view of the two dimensions of personal accountability has not been identified previously as an attribute of professionalism.

Collegiality

Collegiality was found to be a professional attribute of registered nurses; this construct is different from those previously proffered because it requires facilitation through role modelling within the work environment. Role modelling supports collegial behaviours because these behaviours may become the norms in the workplace. Furthermore, collegiality is enhanced in the workplace when home life dynamics are taken into consideration as potential interference to workplace professionalism. Each of these will be discussed in turn, to develop a different way to consider the term collegiality. Collegiality has not been identified in past models of professionalism.

Working relationships and the environment

Collegiality, here, is a professional action, which supports the work environment. Cowin and Eager (2013), contend that collegial nurses work together, defend and support each other, and intervene if a nurse's actions are not to an appropriate level. It incorporates respecting and trusting colleagues as well as demonstrating fair and equivocal treatment. Notably, while collegiality was identified as a significant professional attribute, this study highlighted that personal accountability was not always representative of nurses being collegial.

A collegial environment facilitates open discussion without fear of "ridicule, contempt, or fear of their views being dismissed and ignored" (Cowin & Eagar, 2013, p.

120). The literature explains that collegial environments enable nurses to provide the quality of care necessary for optimal patient well-being (Chadwick, 2010; Kalisch & Lee, 2012; Kalisch et al., 2010; O'Leary et al., 2012). Hayward et al. (2016, p. 1340) concurred that the degree of collegiality, "collaboration and cohesiveness among team members contributes to a positive workplace".

Collegial relationships ensure that team members are valued and supported in the work environment, which leads to a positive work ethic (Burr et al., 2017). Padgett (2013, 2015) contends that this work ethic allows for having respectful disagreements when peers and colleagues speak openly with each other in the clinical practice environment; there is the potential for a community of practice. Interestingly, the importance of being able to have respectful disagreements or forming communities of practice in the ward setting is rarely discussed in the literature. The tenets of a community of practice are applicable in the clinical setting because when a nurse works collegially, their practice encompasses their commitment to professionalism and achievement of excellent patient care. This ethos is underpinned by collegiality and is more than working together as a group with interests in patient care. If viewed in this way, nurses consider themselves accountable for their practice. Padgett (2013, 2015) and Law and Chan (2015) assert that collegial relationships are the first line of professional self-regulation and patient safety. This is due to nurses being respectful and comfortable in communicating concerns which relate to patient care standards and performance without fear of retribution. In this study, nurses who supported each other fostered a sense of openness and collegiality within the team; where gossip and criticism were not allowed, and open discussion was encouraged, it resulted in increased team confidence in discussing patient care issues (Hastings et al., 2016; Mickan & Roger, 2000; Polis et al., 2017; Sherman, 2013).

Supportive, collaborative and cohesive relationships between staff have been found to be paramount to a healthy work environment, with the existence of these relationships impacting positively on decisions to remain in the workforce (Hayward et al., 2016; Sherman, 2013). Furthermore, studies explain that collegial relationships improve patient outcomes and reduce absenteeism and separation from the organisation (Chadwick, 2010; Kalisch & Lee, 2012; Kalisch et al., 2010).

Impact of work home dynamics

If home life dynamics are taken into consideration and management provides support where needed for a stressed staff member, the nurse's ability to be collegial is enhanced. In juxtaposition, it was clear from this study that nurses expected nurses to separate the stressors present in home life dynamics from the work environment and to maintain a respectful, positive attitude, regardless of their situation. The current study found that poor attitudes and unsupportive behaviour, in many cases, was found to be related to external factors such as family life or work-life balance which were impacting on the nurses' ability to maintain a professional presence and collegiality at work. This supports the work by Dawson et al. (2014), which identified that when home life and the welfare of the household becomes the nurse's priority, the nurse's approach to work may be compromised. Akintayo (2010) also argues that unresolved work-life role conflict impacts the employee's ability to commit to organisational goals and impacts job performance. Additional stressors such as hours worked, workload, overtime and shift work have a strong association with work-life interference increasing the likelihood of absenteeism, physical problems and emotional exhaustion (Boamah & Laschinger, 2016; Dawson et al., 2014; Hayward et al., 2016; Lembrechts et al., 2015; Ng et al., 2017; Van Bogaert et al., 2014). To this end, management should consider different approaches to assisting staff with work–life balance. Agosti et al. (2015) proposed that employers should be flexible in managing workplace compounders to assist nurses in

meeting their work-life needs. Dawson et al. (2014) contend management should focus on the daily workplace stress of nurses which create these "experiences of daily wear and tear" (Lim & Lee, 2011, p. 96) rather than on work-life balance dogma which is often reflective of management's focus on meeting organisational demands. Thus, management as representatives of the organisation should, as identified by Carter and Tourangeau (2012), acknowledge the local needs of staff through employee engagement to address work-life interference/balance issues. When this is achieved the potential for creating collegial relationships are enhanced.

This study asserts that in the work environment, unresolved work-life interference may be a precursor for the registered nurse not displaying collegiality, respect and support of others. Instead, demonstrating poor behaviours such as rude and discourteous language, or an attitude displaying a lack of respect or regard for others is commonplace. Hickson (2012) asserted that if negative behaviour is accepted as the norm within a ward area or the profession, then it provides an informal consent to continue these behaviours. Laschinger et al. (2014, p. 13) asserted that incivility in the workplace was reported to have been experienced by as many as "28% to 53%" of nurses. When incivility is unchecked, because nurses do not take personal accountability for addressing same, Clark (2017), Birks et al. (2018) and Terry et al. (2015) claim bullying and horizontal violence occur. This point is raised to highlight the absence of personal accountability and collegiality, as key attributes of professionalism.

Importance of role modelling in the development of collegiality

Where positive role modelling is actively undertaken by a staff member, collegiality of other staff is supported. Within the context of a collegial workplace, the professional nurse modelled clinical competence, sound clinical reasoning, and communicated well with patients and staff (Manojlovich, 2005; Padget, 2015). Role modelling as a positive collegial system of

mentoring focuses on developing positive workplace behaviour, increasing professional knowledge and performance (Clark, 2015a; Clark, 2015b; Jakubik, 2008; Jakubik et al., 2017). A person who is a role model serves as an example of the values, attitudes, and behaviours associated with a role (Clark, 2015b; Jakubik et al., 2017). Further, collegiality and role modelling have a reciprocal influence, whereby positive role modelling creates a collegial environment, and a collegial environment encourages role modelling, where registered nurses often act as informal mentors and are seen to "practice what they preached". Role models embody the characteristics of responsibility and accountability in the work environment. Notably, this study found that role modelling was not age-related. Instead, it was dependent on the values and skills of the individual nurse. This is divergent from other studies, where age and experience were found to be related to the role modelling of more experienced mentors (Gazaway et al., 2018; Hunter & Cook, 2018).

Good nursing role models worked alongside others, and acted as a learning resource, reinforcing the expectation of professional behaviours and assisting those who are new to the ward or profession to understand their role as a registered nurse. Assisting those who are new to the ward area is vital as Gazaway et al. (2016) aptly articulated the potential relationship between poor socialisation processes in the workplace that result in the flow-on effect of disillusioned and unmotivated nurses (Eliades et al., 2017; Fleming, 2017; Johnson et al., 2011). O'Rourke and White (2011) and Vinales (2015) assert that understanding professional practice requires clarity of the obligations and expectations of the role, and this understanding is best achieved through the assistance of role modelling. Thus far, the literature around role modelling is associated with the acquisition of skills and clinical competence rather than the development of professionalism. Similarly, where informal mentoring occurred, it was generally undertaken voluntarily by these role models altruistically, with no acknowledgment

or recognition by the organisation of the workload involved. The altruistic nature of informal mentoring has not previously been considered as part of professionalism.

Summary of collegiality

Collegiality is comprised of three points, as identified within this current study: that of working relationships and the environment; the impact of work-home dynamics on collegiality; and finally the importance of role modelling professional behaviours that support the development of a workplace conducive to professional behaviour. Collegiality has not been discussed as an attribute of professionalism in previous research in this way.

Summary of the four attributes

This study identified the four attributes of respect, professional presence, personal accountability and collegiality, which, in combination, demonstrated a registered nurse's professionalism. The first attribute of respect was woven through the tapestry of the final three attributes. As the attribute of respect was embodied in all aspects of a registered nurse's professional behaviour, it was considered essential to professionalism and underpinned the three other attributes. The second attribute of professional presence included the presentation of the registered nurse encompassing a calm and confident demeanour, nursing knowledge, skills and competence, and demonstrated care for others in the workplace. The third attribute of personal accountability incorporated two dimensions: the first related to the accountability of the registered nurse as it applied to patient care; the second dimension related to the registered nurse being an active team member trying to assist in finding solutions for any issues within the ward. The fourth attribute of collegiality comprised three points: that of working relationships; the impact of work–home dynamics on the registered nurse in the workplace; and the importance of role modelling professional behaviours. These were the four attributes of professionalism of the registered nurse. Next follows the discussion relating to the influences that impact the registered nurse's ability to demonstrate professionalism.

Influences

A stable work environment

Nurse leaders in this study identified a number of influences, couched under the umbrella term of a stable work environment, believed to impact on the ability of the registered nurse to demonstrate the attributes of professionalism. A stable work environment encompassed the stability of healthcare structures and credible leadership.

The stability of the healthcare structures contained a number of issues. These issues consisted of a supportive hospital structure; the instability due to the healthcare restructuring; the dissolution of the healthcare team; and non-transparent organisational processes. The influence of credible leadership comprised issues relating to the credibility of the leader in the management of ward issues. Each of these influences will now be addressed.

Influence One Stability of healthcare structures

Three issues were identified as necessary for the stability of the work environment: the instability due to the restructuring of the health system; the dissolution of healthcare teams; and non-transparent organisational processes.

The restructuring of the Western Australian healthcare system, at the time of the study, was undertaken, affected the stability of the work environment. The restructuring necessitated not only the building of new hospitals but the movement and merging of staff into new roles, locations and departments. The structure of the physical environment of the hospital can either support or hinder nurses in their job of patient care delivery (Fay et al., 2018). Moreover, restructuring was unsettling and chaotic. This restructuring resulted in instability for the staff in their job roles with possible redeployment, as the restructuring of existing health facilities and the opening of new hospitals required reassignment of health specialities to different hospitals. This impacted senior nurses and the nursing leadership team, resulting in new and often less experienced staff undertaking roles for which they were

unprepared. This spilling of roles had an undermining flow-on influence on all staff from the dissolution of established healthcare teams. Studies by Burke et al. (2015) and Sora et al. (2013) claimed that hospital restructuring resulted in negative work attitudes and a reduction in the well-being of the nurse, which had a consequent impact on patient health outcomes and hospital functioning. In the current study, nurse leaders explained that a lack of consideration of nursing needs when restructuring or with new hospital developments, left nurses' feeling disconnected from the organisation with reduced organisational commitment and this may have influenced the registered nurse staff professionalism.

Organisational restructuring led to widespread staff stress, due to the uncertainty of staff movement, potential job losses, and team dissolution**.** The increase of the acting up roles in the work environment, and these elements proved to be a potential negative influence on the professionalism of registered nurses. The spilling of roles had a destabilising flow-on impact on all staff with the movement of experienced senior nurses to different roles in new or different hospitals. The movement of staff to fill workforce gaps resulted in decreased job satisfaction, as registered nurses were left bereft of their role models and informal mentors and the loss of their historical context and corporate knowledge (Duffield et al., 2015).

Within the healthcare teams, the presence of experienced staff in management roles was paramount to ensure the continuation of quality patient care delivery (Duffield et al., 2019; Grunbagh & Flynn, 2018). However, the restructuring and staff movement caused another problem of the creation of numerous acting up positions. It may be postulated that such positions are best suited to times when there is sufficient senior staff to mentor the acting person in their new role (Blythe et al., 2001). Blythe et al. (2001) found that when nurses are relocated, they often feel incompetent because they are situated in new roles with not enough time to develop sufficient expertise. Thus, when junior nurses acted in senior roles, they may not have had the experience and expertise to deal with issues like uncivil behaviour, poor nursing

practices or performance issues and this may have had an influence on the professionalism of registered nurses (Blackstock et al., 2015; Hutchinson et al., 2010). Seconding a staff member to an "acting" position was seen as a practical short-term measure while the organisation advertised for permanent replacements (Ballinger & Marcel, 2010; Duffield, Roche, Blay, Thoms et al., 2011; Ondercin, 2009). It resulted in a domino effect on other staff in the ward area when the incumbent of the acting up position was not able to perform in that role while they were trying to master their new role. Duffield, Roche, Blay et al. (2011) claim that the lack of experienced leadership has a domino effect which leads to instability.

The second issue related to the work environment was the dissolution of well established interprofessional health care teams through the movement of senior nurses, which left gaps of experience and knowledge with reduced productivity and effectiveness (Forsyth & Mason, 2017; Kaiser & Westers, 2018). It was interesting to note that nurse leaders discussed reduced productivity and care due to the restructuring, but did not discuss workload as a significant influence on maintaining professional behaviours. Although, the professional attribute of personal accountability and collegiality indicated that working effectively in teams enhanced professionalism.

The restructuring process dissolved teams incorporating high levels of cohesion, respect and familiarity, with members working with consideration of each other's strengths and weaknesses for a common purpose (Collette et al., 2017; Rochon et al., 2015; Tourangeau et al., 2010). It is no wonder that the dissolution of teams acted as an influence on maintaining professional behaviours. The worrying trend of a lack of team cohesion and a lack of concern for other team members may be representative of Kaiser and Westers' (2018) findings which described an individualistic attitude where registered nurses, rather than collaborating in teams, focused on their work only.

The third issue related to maintaining a stable work environment was the influence of non-transparent organisational processes. It was felt that inexperienced and less qualified staff were being promoted to positions that they were ill-equipped to perform, although the organisation deemed suitable preparation and qualifications for senior clinical and management roles as essential. The deployment of positions within the existing staff produced feelings that "the best person for the job" was not always employed. Instead, it was a case of "who knew who", "who was available", and staff "being tapped on the shoulder" instead of decisions utilising a fair, equitable and transparent employment process for all promotions. Some nursing leaders felt they were "passed by" with the employment of less experienced people taking the roles which nursing leaders felt they should have been given. This lack of transparency appeared to have an element of nepotism and caused upset in staff because fair process principles and accountability were not evident in organisational decisions.

When fair process principles, transparency and accountability are evident in organisational decisions, it results in a workforce who are supportive and respect managerial and organisational decisions (Blackstock et al., 2015; Hoffman & Chunta, 2015; Laschinger et al., 2014). In this case, nurse leaders were frustrated and angered, and they felt this lack of process demonstrated a lack of professionalism on the part of the healthcare facilities. Cutcliffe and Cleary (2015) discuss the "elephant in the room" (p. 820) as the lack of transparency of promotional positions, the power structure of the organisation, promotion of "those persons who best work the system and play the game" (p. 822) being promoted rather than the best leader. Filling senior nursing positions without appropriate training in clinical and organisational processes increases the potential for damaging work environments and practices to occur (Blackstock et al., 2015; Hutchinson et al., 2010; Tourangeau et al., 2010; Twigg & McCullough, 2014).

Within this discussion, the stability of the healthcare structures and its influence on the ability of the registered nurse to demonstrate professionalism have been considered. The identification and discussion of the related issues identified followed. These issues were: the instability in the work environment due to healthcare restructuring, the subsequent dissolution of established health care teams and the impact of organisational processes when they are not considered as equitable and transparent. The next area examined was that of the influence of leadership on the professionalism of the registered nurse.

Influence Two Credible leadership

The second identified influence on the demonstration of the attributes of professionalism of the registered nurse is credible leadership and involves the different aspects of leadership credibility. It is evidenced that clinical leadership influences the creation of a safe environment for patients and staff (Al-Yami et al., 2018; Cummings et al., 2018; Eneh et al., 2012; Laschinger et al., 2013; Tanaka et al., 2016). However, the role of credible leadership in times of change and restructure is not well addressed in the research. The perception of the credibility of the leader to undertake the role was found to influence the ability of the registered nurse to work professionally in the work environment.

In this study, the Director of Nursing and Divisional Nursing Heads are called the senior executive. The leadership team refers to clinical nurses, unit managers, nurse managers and clinical nurse specialists, as senior nurses with considerable clinical experience and qualifications. This leadership team were generally sourced from skilled clinicians who had the expertise of the expert bedside nurse resulting in management staff who may not be well prepared or are conflicted with the ward managers' priorities. The management skills needed for the daily operational requirements of the healthcare environment requires task-focused leadership (Townsend et al., 2015). When a manager demonstrates good management and

strong nursing leadership, there is a resultant team and unit stability. This leadership team reported to the senior nursing executive that oversee organisational nursing functions.

There appears, however a lack of consensus in the literature on the role and expectation of staff as leaders. Nurses consider employment into formal promotional positions as the point of delineation of those nurses who are considered leaders and those who are not; in practice, this may not be the case (Cope & Murray, 2017; Daly et al., 2015; Grossman & Valiga, 2013). When leadership is constructed in this way, personal accountability, a professional attribute, may be negated by the registered nurse who does not see their role in creating a stable work environment and expects those in formal leadership roles, the leadership team, to take this mantle. Similarily the leadership team was seen to defer to the senior executive team, to take on the creation of a stable work environment.

When personal accountability for leadership and managing the workplace is not seen as a responsibility of all nurses, there may be resultant feelings of insecurity and a discordant nursing environment (Al-Yami et al., 2018; Cummings et al., 2018; Roche et al., 2016; Townsend et al., 2015). This may impact on the level of professionalism of the registered nurse. Interestingly, once again, the conversation by nurse leaders focused on “the others” in their organisation, not themselves. This tendency to separate themselves from the situation under discussion may be a self-protective mechanism, a lack of ownership or, worse, may indicate that the nurse leaders genuinely did not recognise themselves as part of the organisation’s strong leadership.

Restructuring meant, as previously discussed that in many instances leaders were moved from their permanent wards to other areas which left the “acting up” leaders to take their places. The acting up leaders, often in the leadership team, in many instances assumed a “caretaker attitude” with long-term decisions being delayed while awaiting the appointment of a permanent incumbent; this then affects the functioning in ward areas and the organisation

(Ballinger & Marcel, 2010; Duffield, Roche, Blay et al., 2011). The notion of "caretaker mode" may be extrapolated to other leadership features, for instance, the unwillingness to lead actively.

Being a credible leader required supporting collegiality in the work environment through role modelling. Rondeau and Wagar (2003) report that following organisational restructuring, there is an increase in the frustration of staff and greater conflict with co-workers. However, due in part to not fully understanding the characteristics of leadership within an incumbent's role, undertaking the management of instances of professional transgression by nurses in the clinical setting was often not addressed (Clark & Kenski, 2017). Thus, staff exhibiting poor behaviours and not acting with respect appeared to be more prevalent. The inability to manage transgressions on the ward appeared to lead to what was described as a "them and me" mentality between the registered nurse, the leadership team, and senior executive where performance issues were someone else's problem. Blackstock et al. (2015) and Hutchinson et al. (2010) discuss that organisational pressures, restructuring and workload issues can encourage uncivil and dysfunctional acts. This study identified that those in the nursing leadership team, such as those in nurse manager positions, need to have the experience, education and preparation to assist them to complete their job efficiently. Yurdakul et al. (2016) and Mannion and Davies (2015) found inexperience, a lack of trust in the system and leaders, together with a fear of ridicule resulted in nurses keeping silent about the poor performance of their colleagues. With appropriate training and a culture of open communication in keeping with the professional attribute of collegiality, the voicing of concerns of both clinical and behavioural issues becomes more likely (Mannion & Davies, 2015; O'Leary et al., 2012; Yurdakul et al., 2016).

Neither the ward nurses nor the leadership team appeared to take the view of their professional accountability and responsibility for the other members of staff as identified and

required in the Nursing and Midwifery Board of Australia Code of Conduct (NMBA, 2018). There appeared an expectation by nursing leaders in the study that registered nurses on the floor show accountability for patient care and of the management of other staff's performance while failing to own the problem themselves. One nurse leader explained that their nurse leader colleagues remained silent at times about staff members' poor performance or incivility, for fear of being unpopular. This may be related to caretaker mode and the new leaders' lack of experience. Inexperience, a lack of trust in the system and a fear of ridicule were determined as reasons for keeping silent about the poor performance of their colleagues (Mannion & Davies, 2015; Yurdakul et al., 2016). This issue of employee silence (Hutchinson, Vickers, Wilkes et al., 2010; Mannion & Davies, 2015; Yurdakul et al., 2016) and fear of workplace ostracism reduces organisational loyalty (Gkorezis et al., 2016) and influences patient safety. Thus, the perpetrators of transgressions were not held accountable even though the issues were acknowledged as occurring.

The identification and management of poor behaviour need to be supported by organisational policies to deal with transgressions which are undertaken by all staff, not just passed over to the leadership team to handle (Hoffman & Chunta, 2015). If inexperienced acting up replacements and nurse leaders are fearful of repercussions and so do not manage staff members' poor performance well, this impacts professionalism and the enabling of positive work culture. The influence of credible leaders on professionalism can be profound. With appropriate training and a culture of open communication and a culture of collegiality, the voicing of concerns of both clinical and behavioural issues become more likely (Mannion & Davies, 2015; Yurdakul et al., 2016). The self-development attained through further qualifications and experience has been shown to have a strong influence on professionalism for those in senior executive management or leadership positions (Tanaka et al., 2014).

In this study, nursing leaders described their perceived belief that senior nursing executive lacked relevant postgraduate qualifications. Nursing leaders compared the executive lack of qualifications against their personal acquisition of relevant qualifications for leadership and subsequently did not always appear to value or support staff who were striving to attain further qualifications. Yet, the conflicted nurse leaders failed to extrapolate the deliberation of unsupportive leadership to their own support of further education by the registered nurses with whom they worked. Draper et al. (2016) discuss that the leadership team are central in creating a culture which encouraged and supported learning, for the nurses to have the skills, knowledge and competence they need to be current in their practice relevant to their position. In this study, discussion by the nurse leaders centred on the learning required for the nurse's preparation for promotional roles. Leadership prowess develops through experiences, interactions and purposeful self-improvement and is not necessarily "tied to a position of authority" (Grossman & Valiga, 2013, p. 4; Tanaka et al., 2014). Many nurses chose to remain in the profession with the aim of career progression, particularly Gen Y nurses, through the attainment of further nursing qualifications and specialisation (Lavoie-Tremblay et al., 2010; Stevanin et al., 2018). Therefore, support for registered nurses in their future aspirations and career pathways by senior nurse leaders is critical as a retention issue (Leiter et al., 2010).

Nurse leaders discussed feeling dissatisfied that their hard work, qualifications and expertise were not always appreciated or respected by the senior leadership team. They discussed the lack of acknowledgement for the effort put into "the job" as a concern for both nurse leaders and the nurses on the floor. Maurits et al. (2015) and Kvist et al. (2019) discuss that when staff believe their work was appreciated by senior executive staff, it increased their job satisfaction resulting in increased staff retention, with staff choosing to remain in their current job, which led to the demonstration of professional behaviours.

There was seen to be, by the nursing leadership, a disconnect from the reality of the work environment by the nursing executive and this was believed to have a detrimental effect on the registered nurses' professional behaviour on the floor. The solution offered by a nurse leader to increase nurse executives' credibility in the leadership role was "…they should get back on the floor at least once every three months, even if it were for a week to keep them in touch with the reality of the real issues". There appears little research on the issue of "the disconnect" of the senior nursing executive with nurses, either on the floor or of senior executives returning to undertake regular clinical practice.

Upenieks (2003) and Duffield, Roche, Blay et al. (2011) reported that the most valued traits of senior nurse leaders and nursing executives were visibility and approachability, both of which were interpreted as essential support mechanisms. Nurse leaders felt that to be acknowledged by a senior nursing executive for the job which they and the nurses on the ward were doing, would make nursing staff feel that their work was respected and valued (Choi et al., 2013; Nouri et al., 2019). Duffield, Roche, Blay et al. (2011) and Gess et al. (2008) discuss that recognition and acknowledgement for the contribution by staff are related to staff satisfaction. This finding is supported by Maurits et al. (2015) who established that where staff believed that their work was appreciated by senior nursing executive staff, it increased their job satisfaction and resulted in staff retention with staff choosing to remain in their current job, a point supported by the nurse leaders' discussion. Furthermore, the influence of effective leadership, both at the line management and senior nursing executive level, and stable healthcare teams have a positive influence on professionalism (Tanaka et al., 2014).

Having credible leadership influenced the professionalism of the registered nurse through their perception that their leaders did not always have sufficient experience and qualifications to undertake their leadership role. The inability of members of the leadership

team in dealing with any conflicting ward issues further reduced their credibility and the trust in their management decisions by registered nurses. This lack of trust and respect also included the senior executive team who were not visible leaders to the "team on the floor". This lack of credible leadership had an effect on the professional behaviours of registered nurses.

Summary of the influences

The section on influences identified the stability of the healthcare structures and credible leadership as influences on the demonstration of professionalism by the registered nurse at ward level. The stability of the work environment, the impact of restructuring on the same, including the dissolution of established health care teams, resulted in a flow-on effect leading to organisational processes not being equitable and transparent. This instability was seen to lead to incivility by nurses and to episodes of poor care. These transgressions were seen to not be addressed due to the caretaker mode assumed by many of the leadership team.

Credible leadership was also identified as an influencer on the registered nurses' ability to demonstrate professionalism in the clinical setting. The registered nurse perception of credible leadership in the leadership team and their ability to effectively manage conflicting ward issues had either a positive or negative effect on professional behaviours. This contention was expanded by the leadership team to include the senior executive team. The senior executive team were viewed as absent from the ward settings, and some were perceived to be poorly qualified for their role. In combination, these influences were theorised to have a role in effecting professional behaviours of the registered nurse. The instability of the environment and the caretaker mode of the leadership team may have caused registered nurses to feel undervalued with the belief that they were not given respect commensurate with their experience.

Conclusion to the chapter

Within this chapter, the findings of the four attributes of the professionalism of the registered nurse have been determined as respect, professional presence, personal accountability and collegiality. This was followed by the discussion of the influences on the demonstration of professionalism by the registered nurse. The overall term to describe the influences was a stable work environment. This consisted of the stability of the healthcare structures and credible leadership as those influences affecting the ability of the registered nurse to demonstrate professionalism.

The researcher using narrative inquiry not only listens to and reads the participants' narratives for what they are saying, the researcher just as importantly seeks the unsaid – the gaps and silences in the stories before them. When asked, many of the nurse leaders positively rated the professionalism of their clinical area. However, they highlighted that it was easier to remember and discuss episodes of poor professional behaviours than describe exemplary qualities. In this study, nurse leaders predominantly spoke about their experiences and views of professionalism in the third person. This suggests to the researcher that in speaking about "the other", the participants tended to divorce themselves from the context of the professional work environment and their involvement in, or need to be involved in, the display of the attributes of registered nurse professionalism.

The use of narrative inquiry provides a continuous iterative process during which the researcher takes responsibility for the interpretation of the narratives of participants. Through the telling and the retelling of the nurse leaders' narratives, the attributes of professionalism emerged from the data. It was through this method of interpretation and continuous iteration that the researcher gleaned the four attributes of professionalism as respect, professional presence, personal accountability, and collegiality. The framework of the attributes of professionalism of the registered nurse and the influences follow in the data display below as

Figure 10

Framework of professionalism with attributes and influences

<table>
<tr><td rowspan="3">Respect</td><td>Professional presence</td><td>Appearance
A calm and confident demeanour
Skills, knowledge and competence
To care</td><td rowspan="3">Influence of a stable environment

Stability of the healthcare structures
▪ Instability of healthcare structure
▪ Dissolution of teams
▪ Non-transparent organisational processes

Credible leadership</td></tr>
<tr><td>Accountability</td><td>Owning the problem
Seeking solutions
Self-reflection</td></tr>
<tr><td>Collegiality</td><td>Working relationships
Work–home dynamics
Role modelling</td></tr>
</table>

Chapter to follow

The final chapter of this thesis is that of the conclusion. The conclusion revisits narrative inquiry and the influences that mitigate the demonstration of professionalism in the clinical setting. The findings of this thesis are presented in a new way. Last, the strengths of the thesis, the recommendations for future practice and limitations to the study are discussed.

Chapter Eight: Conclusion

Introduction

The intent of this thesis was to explore nurse leaders' perceptions of the professional attributes of the registered nurse. This chapter returns to the original research questions posed in Chapter One. First, what do nurse leaders perceive to be the key professional attributes evident in registered nurses? Second, what are the influences that may have precluded registered nurses from behaving professionally in the clinical environment? The knowledge generated from this study is innovative and the approach used gave voice to nurse leaders. This voice of nurse leaders presents a new way of understanding and conceptualising what it means to be a professional registered nurse at the coalface.

This chapter concludes this thesis; it will revisit narrative inquiry as the most appropriate method for nurse leaders to relate their stories of professionalism and the influences that may mitigate the demonstration of professionalism in the clinical setting. Next, the findings from this thesis will present a new way of conceiving professionalism. This new functional perspective assists nurses to identify how to be professional in their practice. Last, the strengths of the thesis, the recommendations for future practice and limitations to the study are discussed.

The process of narrative inquiry

Narrative inquiry is based in the interpretive and constructionist paradigms, which contends that each person has a different view of reality and that reality is subjective (Guba & Lincoln, 1994; Scotland, 2012). It is an approach which is based in everyday experience and constructed by the person's interaction between their subjective consciousness and the world in which they live. This study method was chosen to enable the nurses to voice their viewpoint and then to develop from their stories a narrative which combined their views

(Clandinin & Connelly, 2000). Thus, the concept of what it means to be a professional nurse stems from the need to understand the phenomena from the participant's viewpoint and the environment that forms their experiences (Crotty, 1998; Creswell, 2009). The examination of the participants' narratives allowed the underlying unseen forces and interplays of the phenomena of professionalism of the registered nurse to be identified.

It was expected that nurse leaders stories of professionalism changed through discussion with others and with the addition of new experiences (Morse, 1991). The researcher was cognizant that every participant's perception/story/interpretation of reality was correct for them at the time of the research and represented their view of their experience at the time of research (Heikkinen, 2002). Nurse leaders, as members of a discipline, are likely to have formed their understanding of the meaning of professionalism through their interactions with, and observations of, others in social and work settings.

Moreover, this understanding provided the basis of how one understood oneself in relation to others. It created a shared world through the use of language. In the current study, it was dependent upon the individual's capacity to use language to describe professionalism. Thus, the understanding of nurse professionalism reflects both the universal and individual's experience of the phenomena through contextualising and validating behaviours of what it means to be a professional nurse. The interaction of the participants' and the researcher's voices is decentered, reality becomes a play of language, where neither the voice of the participant or the researcher determines absolute truth.

In capturing the narratives of Andrew, Diane, Jerzy, Julie, Karen, Katherine, Lee, Louise, Maureen, Nicola, Page and Wendy through storytelling, their views, experiences and perspectives are voiced. Listening carefully to their stories gave voice to their perspective within a relevant context and timeline (Clandinin, 2007). Through the telling and retelling of those experiences, a vibrant picture and understanding were constructed. The process of

writing narrative inquiry research is a unique process; Clandinin and Connelly (2000, p. 167) describe the "back-and-forthing" nature to the narrative inquiry process.

In this study, the steps to undertake analysis were based on those proposed by Ennals and Howie (2017). In this two-stage approach, the first related to story creation for each participant, then in the second phase, each participant's story was analysed. Through thematic analysis of the narratives, the experiences of professionalism and the attributes that made this experience observable were identified. The influences on the demonstration of professionalism were also determined.

Findings

The context and timing of this study resulted in the development of a framework of the attributes of professionalism of the registered nurse influenced by a work environment in flux. Here in the context of the unstable healthcare setting, this study in keeping with narrative inquiry identified the stories of the registered nurse leaders working within that environment.

Stability of the healthcare structures

The restructuring of the West Australian health care system undertaken at the time of the study affected the stability of healthcare structures. The restructure resulted in the dissolution of established teams, the deployment of staff into acting up leadership roles with resultant questions on credible leadership and transparency in organisational processes. The commissioning of a large acute care hospital, upgrading and redeployment of healthcare services throughout the sector, resulted in instability for staff. The restructuring caused staff upheaval and subsequent stress and discontent throughout the sector. The Health Department's reorganisation of health structures left staff disrespected because their opinion or needs were not considered. In many cases, staff with high levels of expertise in a discipline

were moved to another area to fill a vacant position due to the shortage of senior staff. Feelings of uncertainty, reduced levels of confidence and increased stress owing to the movement of staff to new areas saw the dissolution of healthcare teams, which increased the potential for the demonstration of poor professional behaviours.

The lack of credible leadership by numerous staff "acting up" into nurse leadership roles, without appropriate experience or qualifications, was believed to have led to instances of poor practice or poor professional behaviours being left unchecked. The influence of credible leadership is important, especially within the context of an unstable work environment, to professionalism. A strong leadership team with experience and qualifications during the restructure would have provided stability in the clinical environment. Strong leaders, it was postulated, would have supported professional behaviours. The framework below outlines professionalism, its attributes and influence in an unstable work environment.

Attributes of professionalism

The four attributes identified in the framework consisted of respect, professional presence, accountability and collegiality. The first attribute of respect was interwoven through all attributes and consisted of two dimensions: appraisal and recognition respect. Appraisal respect refers to the character, values and merit of the registered nurse while recognition respect is an overarching principle which embodies the respect of others. Respect, in this framework, underpins how the registered nurse portrays themselves. That is their professional presence, which encompasses their appearance, their manner and how they demonstrate skills, knowledge and competence. Nurses demonstrate that patient care is provided respectfully and equally with dignity to each person irrespective of age, ethnicity, religion, sexual orientation or beliefs. The registered nurse achieves this through listening to the patient, allowing them time to voice their concerns and opinions, and involving the patient in any decision making, which affects their healthcare, where possible.

Respectful communication with others is demonstrated through the appropriate language, tone and syntax together with the place and timing of interactions. It may be as simple as responding to the patient's request for information, interacting with their family or answering their call bell in a timely way. In this framework, to be accountable means owning the problem and seeking solutions in the clinical environment. Respect becomes a quintessential aspect because to be accountable within the nurse's role means being respectful of their profession, maintaining personal competence and knowledge and being collegial in all interactions.

The following discussion elucidates the functional aspects of professional presence, accountability and collegiality. By looking at the "who, what and how" identified in the literature review, illuminated the gaps and provided new knowledge on professionalism conceived in the above framework. The "who" related to asking the nurse leaders working on the floor their views on professionalism. This was a novel and innovative method of finding the new knowledge of this study. The "what," referred to the identification of the essential attributes of professionalism as determined by nurse leaders. The "how," was the use of narrative inquiry which allowed for the telling of each nurse's story of professionalism. The "when," provided a new vision of professionalism as the study was conducted during the time of an unstable healthcare environment. The "when" also allowed the determination of the influences at play on the registered nurse in their demonstration of professionalism at such a time. The "where" related to the acute care clinical setting in a metropolitan area.

Professional presence in the framework captures observable elements of the registered nurse's appearance, their demeanour and their portrayal of confidence in undertaking clinical care. To visualise this as an attribute of professionalism, a well-presented, clean and neat nurse is evident. They are prepared for their role with knowledge and skills commensurate to their scope of practice. It is beyond the scope of this study to discuss the appropriate level of

skill and knowledge required to work within the scope of nursing practice. The nurse appears confident and kind in their demeanour, executes patient care proficiently and is viewed by others as seen to care.

Within the framework, accountability for care is divided into owning the problem and seeking solutions. This attribute appeared to be significantly impacted by the influences already discussed, that is an unstable work environment and credible leadership. Within the context of the unstable work environment, the unprofessional behaviours of registered nurses demonstrate their lack of professional accountability. These behaviours relate to poor performance, unreported errors and omissions and disrespectful behaviour. The professional behaviour of owning the problem was seen when a registered nurse held a perpetrator of poor behaviour, or disrespectful actions, accountable. Despite all nurses working within the NMBA codes and standards, it did not appear that all registered nurses adhered to these guidelines.

In a stable and supportive work environment when a behaviour or practice is not correct, and comment is made, it is seen as collegial. This may be because of a reflection on practice. Self-reflection on the way one communicates and conducts interpersonal interactions and provides nursing care becomes opportunities for self-improvement. This self-awareness through reflection provides registered nurses with a better understanding of how their behaviours impact on patient care, interpersonal relationships and the demonstration of professionalism.

The demonstration of collegiality by the registered nurse in the context of an unstable environment evidenced professional behaviour. Role modelling and the support of others as components of collegiality was evidenced in the study, as the work culture became professional. Here nurses were seen to have the ability to be able to voice their opinion and have discussions with co-workers regarding patient care outcomes and clinical practice

without fear of derision or the perception of being critical. The collegial environment was beneficial to less experienced nurses as partaking in open, non-critical discussions of patient care and clinical practice expands their knowledge and experience of these elements of patient care. Further demonstrations of collegiality were evidenced as working as a team when required to ensure that workload was equally divided; being inclusive when going for breaks to ensure everyone was able to go on time; responding to a call bell that was not their own; taking patient enquiries for another when needed, and being punctual for shifts so that the others can leave on time.

Figure 11

Framework of professionalism with attributes and influences

<table>
<tr><td rowspan="3">Respect</td><td>Professional presence</td><td>Appearance
A calm and confident demeanour
Skills, knowledge and competence
To care</td><td rowspan="3">Influence of a stable environment
Stability of the healthcare structures
▪ Instability of healthcare structure
▪ Dissolution of teams
▪ Non-transparent organisational processes

Credible leadership</td></tr>
<tr><td>Accountability</td><td>Owning the problem
Seeking solutions
Self-reflection</td></tr>
<tr><td>Collegiality</td><td>Working relationships
Work-home dynamics
Role modelling</td></tr>
</table>

In summary, the four attributes which inform this framework of professionalism are respect, professional presence, accountability and collegiality. These interlinking attributes determine the professional behaviours required of the registered nurse in their clinical role. Given that many healthcare environments are also in a state of instability due to workforce issues, budgetary restraints and other resource issues, understanding how the registered nurse

can demonstrate the attributes of professionalism in an unstable environment appears to be well suited to the current healthcare climate.

Strengths of the research

1. This is the first study to give voice to nurse leaders about their perceptions of professionalism in the clinical setting.
2. The attributes of professionalism identified as the functional component as these attributes consist of observable behaviours in the registered nurse.
3. This study has identified a new combination of attributes of professionalism from the nurse "at the coalface of nursing practice".
4. The nurse leaders also identified influences which impact on the registered nurse's ability to demonstrate professionalism in the workplace.
5. This study extends knowledge related to professionalism in nursing.

Limitations of the research points

1. The study was conducted in metropolitan Perth, Western Australia, so did not encompass the views of rural nursing nor alternate nursing settings.
2. The perceptions of professionalism did not give voice to registered nurses rather to those designated in nurse leadership roles (the leadership team).
3. The restructuring of the health department of Western Australia may have impacted the stories of participants.

Recommendations for management

1. Healthcare organisations, through human resource and fair work practices, need to ensure and maintain a safe work environment.
2. Management processes should support staff experiencing stressful home-work dynamics in the workplace.

3. Senior nursing executive and leadership teams need to acknowledge staff efforts and become more visible to the staff on the floor.
4. Consideration and implementation of fair process principles, with transparency of employment and promotional positions.
5. Position descriptions need to be reviewed in light of tertiary education qualifications and experience relevant to the position.

Recommendations for education

1. Academic institutions need to incorporate the tenets of the observable attributes of professionalism of respect, professional presence, accountability and collegiality in their educative processes.
2. Nursing education needs to teach and role model to students the importance of a collegial environment and how their professional presence and behaviours and those of their colleagues' impact on that environment.
3. Student assessment tools should be reviewed to provide the observable attributes identified.
4. Mentoring, formal and informal, should become an activity of nursing practice for students in their education program.
5. Hospital nurse educators have a role in the clinical setting to implement points one to four.

Recommendations for practice

1. Registered nurses need to be supported to work in a collegial and supportive manner with their colleagues, role modelling and mentoring new nurses and student nurses on the correct professional behaviours.

2. A culture of no blame should be encouraged to enhance the reporting of poor practice and behaviours to prevent fear of reprisal.
3. Establish processes whereby ward staff are cognizant of good nursing care and civil behaviour to acknowledge and reward.
4. Daily self-reflection should be encouraged, so nurses understand how their behaviours impact others, understanding that professionalism impacts the patient's view of the nurse and the organisation's professionalism and competence.
5. Registered nurses need to understand and be supported to undertake further education and attain further qualifications, as education has a direct link to increasing professionalism.

Recommendations for research

1. Follow up research should be conducted using the framework of professionalism identified in this study to develop a survey tool to measure the attributes of professionalism identified in this study.
2. Develop and test exemplars of the professional attributes identified in this study for incorporation into clinical assessment tools in the clinical setting.
3. Interview registered nurses in the clinical setting about their perception of professionalism.
4. Interview registered nurses in rural and remote clinical settings about their perception of professionalism.

The researcher's final reflection on the research

Similar to most people, I enjoy listening to an interesting story. The use of narrative inquiry as the methodology and method provided me with the means to listen to the stories of nurse leaders and their views of professionalism within the clinical setting. The interviews

were undertaken at a place of their choice and generally ran for an hour to an hour and a half. Within these interviews, the nurse leaders provided wonderful rich descriptions of their experiences and those registered nurses with whom they had worked. Given that the average age of the nurse leaders was 50 years, they had much to say on both wonderful demonstrations of professionalism and accounts of registered nurse behaviour which they considered woeful.

Nurses are always good at "sharing a yarn"; however, this resulted in very long interview transcripts to be analysed. At first, the transcriptions were named as participant 1, participant 2, and so forth, however, I found it very difficult to differentiate between each one. So, I gave each participant a name of my family member or friend, and suddenly they each took on a persona and became alive.

Through the reading and re-reading of these narratives, it slowly became clear which items were common across participants. To assist me in the identification of commonalities, initially, I determined, as a new researcher, that the use of the software NVivo would be of enormous assistance in my quest to code. However, after some considerable time, it became clear that the software had resulted in my drilling down into the detail of the narrative rather than providing me with the bigger picture necessary to code. Luckily my supervisors realised my dilemma and set me to task on writing a different chapter to "get my head out of the data" and allow some clarity to return. With time away from the detail of the transcripts it was much easier to return and then, by using the traditional coding methods of butcher's paper and coloured marker pens, the overarching themes emerged from the data.

I now understand what is meant by the roller coaster of writing a PhD where one minute you are filled with the elation of having completed a chapter draft to the deflation of finding your "brilliant" work is far from brilliant and needs to be rewritten. However, this provided me with a fuller understanding of the subject through the process of writing,

supervisor's feedback and the rewriting of reams of work. It is through this process that those not blessed with the ability of a succinct, objective academic writing style develop some modicum of improvement in writing.

I am thankful that through the narratives of the nurse leaders with their years of experience, and willingness to share their stories, I was able to have a full, rich understanding of the professionalism of the registered nurse in the clinical setting through their eyes. Undertaking a PhD which examines an area close to one's heart is both uplifting and disheartening. I began this journey craving to understand what nurses believed constituted professionalism, as each person I spoke with had a different understanding, generally providing detail on unprofessionalism rather than what was professionalism. Teaching student nurses about the role of the registered nurse, the codes and standards of the profession and what it meant to be professional, demonstrated a lack of consensus of what constituted professional behaviour and the functional applicability of the concepts entailed in the codes and standards. It was difficult to explain these nebulous concepts to students so that they knew how to demonstrate professionalism. This framework will assist both students and those registered nurses working in the clinical setting to be able to easily understand and visualise what constitutes professional behaviour. It is the combination of these behaviours which constitute professionalism.

The timing of the study undertaken during the healthcare sector restructure has highlighted issues in practice which perhaps would have remained invisible and cloaked within the norm of a stable healthcare environment. The restructuring, however, brought issues of professionalism to the forefront. Nurse leaders believed many of the issues needed to be spoken about and examined and were delighted that their views would be given a voice through this study. Given that working in an unstable work environment is not unique to this time and place, I feel the framework of the attributes of professionalism as identified by the

nurse leaders stand in good stead for similar unstable workplaces. The framework will also provide a means for me to teach these new and enthusiastic nurses what it means to be professional and how best to demonstrate professionalism.

Conclusion of the study

Registered nurses are expected to demonstrate professional behaviours in their work life. This study has identified a framework which extends the current understanding of professionalism in the literature. This study also identified professional attributes in the clinical work setting and the influences that may impact how nurses behave professionally. These influences are significant to the current healthcare setting, which is often unstable and lacking credible leadership. Importantly, these were the influences identified in this study.

Previous studies have focused on the measurement of professionalism and the development of models of professionalism without giving voice to the members of the nursing profession. This study provides a unique perspective of nurse leaders and their perceptions of the behaviours associated with being professional. The combination of attributes identified in this study – respect, professional presence, accountability and collegiality – have not previously been identified in the literature. The interlinking of these attributes is significant because these attributes are observable and provide a clear and functional understanding of what it means to be a professional nurse.

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Appendices

Appendix A: Approval Letter

HUMAN RESEARCH ETHICS COMMITTEE
For all queries, please contact:
Research Ethics Officer
Edith Cowan University
270 Joondalup Drive
JOONDALUP WA 6027
Phone: 6304 2170
Fax: 6304 5044
E-mail: research.ethics@ecu.edu.au

AUSTRALIA ECU EDITH COWAN UNIVERSITY

OFFICE OF RESEARCH AND INNOVATION

270 Joondalup Drive,
Joondalup
Western Australia 6027
Telephone 134 328
Facsimile: (08) 9300 1257
CRICOS 00279B

ABN 54 361 485 361

10 January2014

Ms Gina Mata
Faculty of Computing, Health and Science
JOONDALUP CAMPUS

Dear Gina

ETHICS APPROVAL

Project Code:	**8553**	
Project Title:	**An examination of the registered nurses view of professionalism**	
Chief Investigator:	Ms Gina Mata	
Supervisor	Dr Joyce Hendricks	
Approval Dates:	From: 28 October 2013	To: 22 April 2014

Thank you for your recent application for ethics approval. This application has been reviewed by members of the Human Research Ethics Committee (HREC).

I am pleased to advise that the proposal complies with the provisions contained in the University's policy for the conduct of ethical human research and ethics approval has been granted. In granting approval, the HREChas determined that the research project meets the requirements of the National Statement on Ethical Conduct in Human Research.

All research projects are approved subject to general conditions of approval. Please see the attached document for details of these conditions, which include monitoring requirements, changes to the project and extension of ethics approval.

We wish you success with your research project.

Yours sincerely

Kim Gifkins
RESEARCH ETHICS OFFICER

Conditions of approval

1. Monitoring of Approved Research Projects

Monitoring is the process of verifying that the conduct of research conforms to the approved ethics application. Compliance with monitoring requirements is a condition of approval.

The *National Statement on Ethical Conduct in Human Research* indicates that institutions are responsible for ensuring that research is reliably monitored. Monitoring of approved projects is to establish that a research project is being, or has been, conducted in the manner approved by the Ethics Committee. Researchers also have a significant responsibility in monitoring, as they are in the best position to observe any adverse events or unexpected outcomes. They should report such events or outcomes promptly to the Ethics Committee and take prompt steps to deal with any unexpected risks.

All projects approved by an ECU Ethics Committee are approved subject to the following conditions of approval:

- If the research project is discontinued before the expected date of completion, researchers should inform the Ethics Committee as soon as possible, giving reasons.
- An annual report (for projects that are longer than one year) and a final report at the completion of the research will be provided to the Ethics Committee. You will also be notified when a report is due. The ethics report form can be found on the ethics website http://www.ecu.edu.au/GPPS/ethics/human_ethics_resources.html
- Researchers must also immediately report anything that might warrant review of the ethical approval of the protocol, including:
  - Any serious or unexpected adverse effects on participants
  - Any unforeseen events that might affect continued ethical acceptability of the project.

The Ethics Committee retains the right to require a more detailed and/ or more frequent report if the research is deemed to be of high risk, and to recommend and/ or adopt any additional appropriate mechanism for monitoring including random inspections of research sites, data and signed consent forms, and/ or interview, with their prior consent, of research participants.

2. Changes and amendments

Compliance with the approved research protocol is a condition of approval, and any changes to the research design must be reported to the Ethics Committee. Amendments to the research design that may affect participants and/ or that may have ethical implications must be reviewed and approved by the Ethics Committee before commencement.

Any changes to documents and other material used in recruiting potential research participants, including advertisements, letters of invitation, information sheets and consent forms, should be approved by the Ethics Committee.

In order to request approval for a change, please send an email to the Ethics Office outlining why the change is needed, describing the change (e.g. the new participants or new research procedures), and attach a copy of any amended documents.

3. Extension of ethics approval

All research projects are approved for a specified period of time – from the date of approval until the date of completion provided in the ethics application. If an extension of the approval period is required, a request must be submitted to the Ethics Committee. Please ensure that requests for extension of approval are submitted before the original approval expires.

In order to request an extension of ethics approval, please send an email to the Ethics Office providing a brief reason why the extension is needed and giving the new expected date of completion.

Appendix B: National Ethics Application Form

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Please note section 7 is not applicable to study.

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Appendix C: Authorisation Forms

Government of **Western Australia**
Department of **Health**
Our Ref: 2013-240 approval SCGG

Sir Charles
Gairdner Hospital

27 March 2014

Ms Gina Mata
School of Nursing and Midwifery
Edith Cowen University
270 Joondalup Drive
JOONDALUP WA 2067

Dear Ms Mata

HREC No: 2013-240
Project Title: An examination of the registered nurses view of professionalism in Western Australia.

On behalf of the Sir Charles Gairdner Osborne Park Health Care Group, I give authorisation for your research project to be conducted at the following site(s):

Sir Charles Gairdner Hospital

This authorisation is based on the approval from the Sir Charles Gairdner Group Human Research Ethics Committee and the review from the Research Governance Office. This authorisation is valid subject to the ongoing approval from the HREC, and on the basis of compliance with the 'Conditions of Site Authorisation to Conduct a Research Project' (attached) and with the compliance of all reports as required by the Research Governance Office and approving HREC. Noncompliance with these requirements could result in the authorisation be withdrawn.

The responsibility for the conduct of this project remains with you as the Principal Investigator at the site.

Yours sincerely

Dr Robyn Lawrence
EXECUTIVE DIRECTOR
SIR CHARLES GAIRDNER AND
OSBORNE PARK HEALTH CARE GROUP

Sir Charles Gairdner Group Human Research Ethics Committee, Level 2 A Block, Hospital Ave, Nedlands, WA 6009
Telephone (08) 9346 2999 Fax (08) 9346 3307 ABN: 13 993 250 709
email HREC.SCGH@health.wa.gov.au Website www.scgh.health.wa.gov.au

Government of **Western Australia**
Department of **Health**
Our Ref: 2013-240 approval HREC

Sir Charles
Gairdner Hospital

26 March 2014

Ms Gina Mata
School of Nursing and Midwifery
Edith Cowen University
270 Joondalup Drive
JOONDALUP WA 2067

Dear Ms Mata

HREC No: 2013-240
Project Title: An examination of the registered nurses view of professionalism in Western Australia.

The ethics application for the project referenced above was reviewed by the Sir Charles Gairdner Group (SCGG) Human Research Ethics Committee (HREC) at its meeting on 20 February 2014. It has been approved and the following documents have been approved for use in this project.

Document
Research Proposal
Participant Flyer
Interview Guide
Focus Group Guide
Email template - registered nurses
Nursing Leader Introduction and Consent Form letter, version 10 dated 21 March 2014
Nursing Introduction Letter and Consent Form, version 10 dated 21 March 2014
Poster, version 5 dated 3 March 2014

Approval of this project from the Sir Charles Gairdner Group Human Research Ethics Committee EC00271 is valid to 26 March 2017 and on the basis of compliance with the 'Conditions of HREC Approval for a Research Project' (attached).

The nominated participating site/s in this project is/are:

Sir Charles Gairdner Hospital
Royal Perth Hospital

[Note: If additional sites are recruited prior to the commencement of, or during the research project, the Coordinating Principal Investigator is required to notify the HREC. Notification of withdrawn sites should also be provided to the HREC in a timely fashion.]

A copy of this ethical approval letter must be submitted by all site Principal Investigators to the Research Governance Office or equivalent body or individual at each participating institution in a timely manner to enable the institution to authorise the commencement of the project at its site/s.

This letter constitutes ethical approval only. This project cannot proceed at any site until separate site authorisation has been obtained from the CE, or delegate, of the site under whose auspices the research will be conducted at that site.

The SCGGHREC is registered with the Australian Health Ethics Committee and operates according to the NHMRC National Statement on Ethical Conduct in Human Research and International Conference on Harmonisation – Good Clinical Practice.

Should you have any queries about the HREC's consideration of your project, please contact Sean Howarth. The HREC's Terms of Reference, Standard Operating Procedures, membership and standard forms are available from http://www.scgh.health.wa.gov.au/Research/AboutUs.html or from the HREC Office.

Yours sincerely

Jenny Westgarth-Taylor
Delegate of the Chair
for
Hal Jackson
Chair
Sir Charles Gairdner Group
Human Research Ethics Committee

CONDITIONS OF HREC APPROVAL FOR A RESEARCH PROJECT

The following general conditions apply to the research project approved by the Human Research Ethics Committee (HREC) and acceptance of the approval will be deemed to be an acceptance of these conditions by all investigators involved in the research project:

1. The responsibility for the conduct of projects lies with the Coordinating Principal Investigator (CPI), all correspondence should be signed by CPI.

2. Projects that do not commence within 12 months of the approval date may have their approval withdrawn and the project closed. The CPI must outline why the project approval should stand.

3. The submission of an application for HREC approval will be deemed to indicate that the investigator/s and any sponsor recognises the approving HREC is registered with the National Health and Medical Research Council (NHMRC) and that it complies in all respects with the National Statement on Ethical Conduct in Human Research and all other national and international ethical requirements. **The HREC will not enter into further correspondence on this point.**

4. A list of attendance at a specific meeting is available on request, but no voting records will be provided.

5. The CPI will notify the HREC of his or her inability to continue as CPI and will provide the name and contact information of their replacement. Failure to notify the HREC can result in the project being suspended or approval withdrawn.

6. The CPI will notify the HREC of any departures of named investigators. The CPI will also notify the HREC if any new investigators and/or sites join the project that will utilise the HREC's approval.

7. The CPI will inform the HREC about any changes to the project. The CPI is responsible for submitting any amendments to the approved documents listed on the approval letter, or any new documentation to be used in the project. Any new or amended documentation should be submitted in a timely manner and cannot be implemented at any participating site until they have received HREC approval.

8. The CPI is responsible for reporting adverse events, indicating whether or not the project should continue. Reporting requirements are as per the WA Health Research Governance and Single Ethical Review Standard Operating Procedures. Additional reports other than those outlined that are submitted to the HREC will be returned without acknowledgement. The HREC can request additional reporting requirements as a special condition of a research project.

9. Where a project requires a Data Safety Monitoring Board (DSMB) it is the CPI's responsibility to ensure this is in place before the commencement of the project and the HREC notified of this. All relevant reports from the DSMB should be submitted to HREC.

10. For projects where the site is acting as the sponsor (ie. investigator initiated project) it is the responsibility of the CPI to report serious and unexpected drug/device reactions, as well as other reactions/events to the Therapeutic Goods Administration (TGA). Please refer to TGA website for further information and the relevant forms (see http://www.tga.gov.au/pdf/clinical-trials-guidelines.pdf p71 for medications or p77 for devices).

11. If this project involves the use of an implantable device a properly monitored and up to date system for tracking participants is to be maintained for the life of the device in accordance with the National Statement section 3.3.22 (g).

12. The investigator is responsible for notifying the Therapeutic Drugs Administration of a device incident in accordance with the National Statement section 3.3.22 (g).

13. An annual report on an approved research project will be required on the anniversary date of the project's approval. HREC approvals are subject to the submission of these reports and approval may be suspended if the report is not submitted.

14. The HREC has the authority to audit the conduct of any project without notice. Exercise of this authority will only be considered if there are grounds to believe that some irregularity has occurred, if a complaint is received from a third party or the HREC decides to undertake an audit for Quality Improvement purposes.

15. The HREC can conduct random monitoring of any project. The CPI will be notified if their project has been selected. The CPI will be given a copy of the monitor's report along with the HREC and Research Governance Office (RGO) at each site.

16. Complaints relating to the conduct of a project should be directed to the HREC Chair and will be promptly investigated according to the Committee's complaints procedures.

17. CPI are reminded that records of consent or authorisation for participation in a project form part of the Acute Hospital Patient Record and should be stored with that record in accordance with the WA *Health Patient Information Retention and Disposal Schedule (Version 2) 2000.* A copy of the 'Participant Information Sheet' should also be included in the medical records as part of informed consent documentation.

18. The duration of HREC approval for a project is 3 year (with the option of 5 years) from the date of approval. The date of approval expiry is stipulated in the HREC approval letter.

19. If the project is to continue beyond the stipulated approval expiry date a request for an extension should be submitted prior to that expiry date. One extension of 3 years can be granted but approval beyond this time period may necessitate further review by the HREC.

20. Once the approval period has expired, the CPI is required to submit a final report. If the report is not received within 30 days the project will be closed and archived. An outstanding final report could impact on the CPI's ability to apply for approval for future projects.

21. If a project is suspended or terminated by the CPI, or a project sponsor, the CPI must immediately inform the HREC and the RGO at each site of this and the circumstances necessitating the suspension or termination of the project. Such notification should include information as to what procedures are in place to safeguard participants.

22. If a project fails to meet these conditions the HREC will contact the investigator(s) to request they rectify the identified issues. If, after being contacted by the HREC, the issues are not addressed the HREC approval will be withdrawn. The HREC will notify the RGO at each site within WA Health that work may no longer be conducted in relation to the project other than that concerning the participants safety.

CONDITIONS OF SITE AUTHORISATION TO CONDUCT A RESEARCH PROJECT

The following general conditions apply to the research project authorised to be conducted at the site(s) nominated in the accompanying letter. The acceptance of the site authorisation will be deemed to be an acceptance of these conditions by all investigators involved in the research project at the nominated site(s).

1. The responsibility for the conduct of project at a site lies with the nominated Principal Investigator (PI) at that site, all correspondence should be signed by PI.

2. The PI will inform the Research Governance Office (RGO) about any changes to the project. The PI is responsible for submitting any amendments to the approved documents listed on the approval letter, or any new documentation to be used in the project. Any new or amended documentation should be submitted in a timely manner and cannot be implemented at this site until they have received HREC approval for use at site(s).

3. The PI will notify the RGO of their inability to continue as PI at the site(s) and will provide the name and contact information of their replacement.

4. The PI will notify the RGO of any departures of named site investigators. The PI will also notify the RGO if any new site investigators join the project.

5. The PI is responsible for reporting site adverse events, using the standard forms available from the website. Reporting requirements are as per the WA Health Research Governance and Single Ethical Review Standard Operating Procedures. Additional reports, other than those outlined, that are submitted will be returned without acknowledgement.

6. The annual report that is submitted to the HREC should also be submitted to the RGO. This should include the site specific information which should be completed by the site PI.

7. The site has the authority to audit the conduct of any project without notice. Exercise of this authority will only be considered if there are grounds to believe that some irregularity has occurred, if a complaint is received from a third party or the site decides to undertake an audit for Quality Improvement purposes.

8. The site can conduct random monitoring of any project. The PI will be notified if their project has been selected. The PI will be given a copy of the monitor's report along with the HREC and RGO.

9. Complaints relating to the conduct of a project should be directed to the RGO and will be promptly investigated according to the site Standard Operating Procedures.

10. The PI is reminded that records of consent or authorisation for participation in a project form part of the Acute Hospital Patient Record and should be stored with that record in accordance with the WA *Health Patient Information Retention and Disposal Schedule (Version 2) 2000.* A copy of the 'Participant Information Sheet' should also be included in the medical records as part of informed consent documentation.

11. Once the project has been closed at site, the PI is required to submit to the RGO a copy of the final report that is submitted to the HREC. This should include the site specific information which should be completed by the site PI. If the report is not received within 30 days the project will be closed and archived. An outstanding final report could impact on the PI's ability to apply for approval for future projects.

SIR CHARLES GAIRDNER GROUP
HUMAN RESEARCH ETHICS COMMITTEE

Effective Date: 14 February 2013

Adverse Event Reporting for Clinical Trials

Please be advised that, consistent with previous statements, the Sir Charles Gairdner Hospital Human Research Ethics Committee does not require sponsors or investigators to submit individual reports of Serious Adverse Events that occur outside of our institution for review. The HREC has adopted the reporting requirements outlined in the NHMRC AHEC Position Statement May 2009
http://www.nhmrc.gov.au/_files_nhmrc/file/health_ethics/hrecs/reference/090609_nhmrc_position_statement.pdf

Summary of Reporting Requirements

Type of Reporting	Event
24 (death) 72 hours (other)	SAEs occurring on site
In a prompt manner	Information which materially impacts the continued ethical acceptability of the trial or Information that requires, or indicated the need for a change to the trial protocol including changed safety monitoring in the view of the investigator or sponsor.
Six monthly	Listing of all SUSARS, Australian and international, occurring with a compound including Sponsor and investigator comments as to whether action is planned for the trial on the basis of the reports. (EU format is acceptable)
Annually	An updated Investigator brochure or An EU ASR (or similar format report) or Current, approved Product Information (PI), if appropriate (eg in a study for a product approved in Australia or where an Investigator Brochure is no longer maintained) Other reports consistent with section 5.5.5 of the National Statement and Good Clinical Practice (GCP) as adopted by the Therapeutic Goods Administration (TGA)

Investigator Initiated Trials
Please note that if you are the Principal Investigator of an Investigator Initiated Trial utilising a CTN for a medication or device where SCGOPHCG is the sponsor, it is a TGA requirement that you report adverse events that occur to the TGA, in addition to reporting to the HREC. Please refer to the TGA website for further information regarding definitions and reporting requirements available at http://www.tga.gov.au/pdf/clinical-trials-guidelines.pdf (See pages 70-75 regarding medications and pages 76-80 for devices).

Appendix D: Sir Charles Gairdner Ethics Application Letter

Government of **Western Australia**
Department of **Health**
Our Ref: 2013-240 approval HREC

Sir Charles
Gairdner Hospital

26 March 2014

Ms Gina Mata
School of Nursing and Midwifery
Edith Cowen University
270 Joondalup Drive
JOONDALUP WA 2067

Dear Ms Mata

HREC No: 2013-240
Project Title: An examination of the registered nurses view of professionalism in Western Australia.

The ethics application for the project referenced above was reviewed by the Sir Charles Gairdner Group (SCGG) Human Research Ethics Committee (HREC) at its meeting on 20 February 2014. It has been approved and the following documents have been approved for use in this project.

Document
Research Proposal
Participant Flyer
Interview Guide
Focus Group Guide
Email template - registered nurses
Nursing Leader Introduction and Consent Form letter, version 10 dated 21 March 2014
Nursing Introduction Letter and Consent Form, version 10 dated 21 March 2014
Poster, version 5 dated 3 March 2014

Approval of this project from the Sir Charles Gairdner Group Human Research Ethics Committee EC00271 is valid to 26 March 2017 and on the basis of compliance with the 'Conditions of HREC Approval for a Research Project' (attached).

The nominated participating site/s in this project is/are:

Sir Charles Gairdner Hospital
Royal Perth Hospital

[Note: If additional sites are recruited prior to the commencement of, or during the research project, the Coordinating Principal Investigator is required to notify the HREC. Notification of withdrawn sites should also be provided to the HREC in a timely fashion.]

A copy of this ethical approval letter must be submitted by all site Principal Investigators to the Research Governance Office or equivalent body or individual at each participating institution in a timely manner to enable the institution to authorise the commencement of the project at its site/s.

Sir Charles Gairdner Group Human Research Ethics Committee, Level 2 A Block, Hospital Ave, Nedlands, WA 6009
Telephone (08) 9346 2999 Fax (08) 9346 3307 ABN: 13 993 250 709
email HREC.SCGH@health.wa.gov.au Website www.scgh.health.wa.gov.au

This letter constitutes ethical approval only. This project cannot proceed at any site until separate site authorisation has been obtained from the CE, or delegate, of the site under whose auspices the research will be conducted at that site.

The SCGGHREC is registered with the Australian Health Ethics Committee and operates according to the NHMRC National Statement on Ethical Conduct in Human Research and International Conference on Harmonisation – Good Clinical Practice.

Should you have any queries about the HREC's consideration of your project, please contact Sean Howarth. The HREC's Terms of Reference, Standard Operating Procedures, membership and standard forms are available from http://www.scgh.health.wa.gov.au/Research/AboutUs.html or from the HREC Office.

Yours sincerely

Jenny Westgarth-Taylor
Delegate of the Chair
for
Hal Jackson
Chair
Sir Charles Gairdner Group
Human Research Ethics Committee

CONDITIONS OF SITE AUTHORISATION TO CONDUCT A RESEARCH PROJECT

The following general conditions apply to the research project authorised to be conducted at the site(s) nominated in the accompanying letter. The acceptance of the site authorisation will be deemed to be an acceptance of these conditions by all investigators involved in the research project at the nominated site(s).

1. The responsibility for the conduct of project at a site lies with the nominated Principal Investigator (PI) at that site, all correspondence should be signed by PI.

2. The PI will inform the Research Governance Office (RGO) about any changes to the project. The PI is responsible for submitting any amendments to the approved documents listed on the approval letter, or any new documentation to be used in the project. Any new or amended documentation should be submitted in a timely manner and cannot be implemented at this site until they have received HREC approval for use at site(s).

3. The PI will notify the RGO of their inability to continue as PI at the site(s) and will provide the name and contact information of their replacement.

4. The PI will notify the RGO of any departures of named site investigators. The PI will also notify the RGO if any new site investigators join the project.

5. The PI is responsible for reporting site adverse events, using the standard forms available from the website. Reporting requirements are as per the WA Health Research Governance and Single Ethical Review Standard Operating Procedures. Additional reports, other than those outlined, that are submitted will be returned without acknowledgement.

6. The annual report that is submitted to the HREC should also be submitted to the RGO. This should include the site specific information which should be completed by the site PI.

7. The site has the authority to audit the conduct of any project without notice. Exercise of this authority will only be considered if there are grounds to believe that some irregularity has occurred, if a complaint is received from a third party or the site decides to undertake an audit for Quality Improvement purposes.

8. The site can conduct random monitoring of any project. The PI will be notified if their project has been selected. The PI will be given a copy of the monitor's report along with the HREC and RGO.

9. Complaints relating to the conduct of a project should be directed to the RGO and will be promptly investigated according to the site Standard Operating Procedures.

10. The PI is reminded that records of consent or authorisation for participation in a project form part of the Acute Hospital Patient Record and should be stored with that record in accordance with the WA *Health Patient Information Retention and Disposal Schedule (Version 2) 2000.* A copy of the 'Participant Information Sheet' should also be included in the medical records as part of informed consent documentation.

11. Once the project has been closed at site, the PI is required to submit to the RGO a copy of the final report that is submitted to the HREC. This should include the site specific information which should be completed by the site PI. If the report is not received within 30 days the project will be closed and archived. An outstanding final report could impact on the PI's ability to apply for approval for future projects.

12. If a project is suspended or terminated the PI must ensure that the RGO at site is informed of this and the circumstances necessitating the suspension or termination of the project. Such notification should include information as to what procedures are in place to safeguard participants.

13. If a project fails to meet these conditions the RGO will contact the investigator(s) to request they rectify the identified issues. If, after being contacted by the RGO, the issues are not addressed the site authorisation will be withdrawn.

CONDITIONS OF HREC APPROVAL FOR A RESEARCH PROJECT

The following general conditions apply to the research project approved by the Human Research Ethics Committee (HREC) and acceptance of the approval will be deemed to be an acceptance of these conditions by all investigators involved in the research project:

1. The responsibility for the conduct of projects lies with the Coordinating Principal Investigator (CPI), all correspondence should be signed by CPI.

2. Projects that do not commence within 12 months of the approval date may have their approval withdrawn and the project closed. The CPI must outline why the project approval should stand.

3. The submission of an application for HREC approval will be deemed to indicate that the investigator/s and any sponsor recognises the approving HREC is registered with the National Health and Medical Research Council (NHMRC) and that it complies in all respects with the National Statement on Ethical Conduct in Human Research and all other national and international ethical requirements. **The HREC will not enter into further correspondence on this point.**

4. A list of attendance at a specific meeting is available on request, but no voting records will be provided.

5. The CPI will notify the HREC of his or her inability to continue as CPI and will provide the name and contact information of their replacement. Failure to notify the HREC can result in the project being suspended or approval withdrawn.

6. The CPI will notify the HREC of any departures of named investigators. The CPI will also notify the HREC if any new investigators and/or sites join the project that will utilise the HREC's approval.

7. The CPI will inform the HREC about any changes to the project. The CPI is responsible for submitting any amendments to the approved documents listed on the approval letter, or any new documentation to be used in the project. Any new or amended documentation should be submitted in a timely manner and cannot be implemented at any participating site until they have received HREC approval.

8. The CPI is responsible for reporting adverse events, indicating whether or not the project should continue. Reporting requirements are as per the WA Health Research Governance and Single Ethical Review Standard Operating Procedures. Additional reports other than those outlined that are submitted to the HREC will be returned without acknowledgement. The HREC can request additional reporting requirements as a special condition of a research project.

9. Where a project requires a Data Safety Monitoring Board (DSMB) it is the CPI's responsibility to ensure this is in place before the commencement of the project and the HREC notified of this. All relevant reports from the DSMB should be submitted to HREC.

10. For projects where the site is acting as the sponsor (ie. investigator initiated project) it is the responsibility of the CPI to report serious and unexpected drug/device reactions, as well as other reactions/events to the Therapeutic Goods Administration (TGA). Please refer to TGA website for further information and the relevant forms (see http://www.tga.gov.au/pdf/clinical-trials-guidelines.pdf p71 for medications or p77 for devices).

11. If this project involves the use of an implantable device a properly monitored and up to date system for tracking participants is to be maintained for the life of the device in accordance with the National Statement section 3.3.22 (g).

12. The investigator is responsible for notifying the Therapeutic Drugs Administration of a device incident in accordance with the National Statement section 3.3.22 (g).

13. An annual report on an approved research project will be required on the anniversary date of the project's approval. HREC approvals are subject to the submission of these reports and approval may be suspended if the report is not submitted.

14. The HREC has the authority to audit the conduct of any project without notice. Exercise of this authority will only be considered if there are grounds to believe that some irregularity has occurred, if a complaint is received from a third party or the HREC decides to undertake an audit for Quality Improvement purposes.

15. The HREC can conduct random monitoring of any project. The CPI will be notified if their project has been selected. The CPI will be given a copy of the monitor's report along with the HREC and Research Governance Office (RGO) at each site.

16. Complaints relating to the conduct of a project should be directed to the HREC Chair and will be promptly investigated according to the Committee's complaints procedures.

17. CPI are reminded that records of consent or authorisation for participation in a project form part of the Acute Hospital Patient Record and should be stored with that record in accordance with the WA *Health Patient Information Retention and Disposal Schedule (Version 2) 2000.* A copy of the 'Participant Information Sheet' should also be included in the medical records as part of informed consent documentation.

18. The duration of HREC approval for a project is 3 year (with the option of 5 years) from the date of approval. The date of approval expiry is stipulated in the HREC approval letter.

19. If the project is to continue beyond the stipulated approval expiry date a request for an extension should be submitted prior to that expiry date. One extension of 3 years can be granted but approval beyond this time period may necessitate further review by the HREC.

20. Once the approval period has expired, the CPI is required to submit a final report. If the report is not received within 30 days the project will be closed and archived. An outstanding final report could impact on the CPI's ability to apply for approval for future projects.

21. If a project is suspended or terminated by the CPI, or a project sponsor, the CPI must immediately inform the HREC and the RGO at each site of this and the circumstances necessitating the suspension or termination of the project. Such notification should include information as to what procedures are in place to safeguard participants.

22. If a project fails to meet these conditions the HREC will contact the investigator(s) to request they rectify the identified issues. If, after being contacted by the HREC, the issues are not addressed the HREC approval will be withdrawn. The HREC will notify the RGO at each site within WA Health that work may no longer be conducted in relation to the project other than that concerning the participants safety.

Government of **Western Australia**
Department of **Health**
Our Ref: 2013-240 approval SCGG

Sir Charles
Gairdner Hospital

27 March 2014

Ms Gina Mata
School of Nursing and Midwifery
Edith Cowen University
270 Joondalup Drive
JOONDALUP WA 2067

Dear Ms Mata

HREC No: 2013-240
Project Title: An examination of the registered nurses view of professionalism in Western Australia.

On behalf of the Sir Charles Gairdner Osborne Park Health Care Group, I give authorisation for your research project to be conducted at the following site(s):

Sir Charles Gairdner Hospital

This authorisation is based on the approval from the Sir Charles Gairdner Group Human Research Ethics Committee and the review from the Research Governance Office. This authorisation is valid subject to the ongoing approval from the HREC, and on the basis of compliance with the 'Conditions of Site Authorisation to Conduct a Research Project' (attached) and with the compliance of all reports as required by the Research Governance Office and approving HREC. Noncompliance with these requirements could result in the authorisation be withdrawn.

The responsibility for the conduct of this project remains with you as the Principal Investigator at the site.

Yours sincerely

Dr Robyn Lawrence
EXECUTIVE DIRECTOR
SIR CHARLES GAIRDNER AND
OSBORNE PARK HEALTH CARE GROUP

Appendix E: Royal Perth Hospital Approval Form

11.2 Declaration by Head(s) of Supporting Department(s)^ /Delegate at the Site(s)*.

^ This form is to be completed by the Head of any Department or delegate that is providing support or services to the research project; but which does not have any member(s) on the research team e.g. Pharmacy, Radiology, Pathology. In some Health Services the Head of Department may equate to a Divisional, Site or Regional Director e.g. WACHS.

* In the case of a low or negligible risk project involving multiple sites within a Health Service only one SSA Form is required for each Research Governance Office contained within a Health Service, but it must include a declaration of support on the SSA Form from all the Heads of Supporting Departments that are involved.

HREC Reference Number: 2013-240

Project Title (in full): An examination of the registered nurses view of professionalism in Western Australia.. *(NEAF 1.1; WAHEAF 1.1)*

Coordinating Principal Investigator: Gina Mata *(WAHEAF 1.1.5)*

11.2.1 Supporting Department 1:

11.2.1.1 I have discussed this project with the Principal Investigator and have read the research project. This Department is (*mark whichever applies*):

☑ able to perform the investigations/services indicated, within the present resources of the Department;

☐ able to perform the investigations/services indicated, if the following financial assistance is provided:

☐ unable to undertake the investigations/services indicated, on the following grounds:

Name: ROBIN KOMAC

Position: A/DON PSS

Department/Site: CORPORATE NURSING RPH

Signature ..... Date 11.06.2014

The CPI should ensure that this section is copied enough times to accommodate each department named in **9.3**.

Appendix F: Joondalup Health Campus Approval Letter

JOONDALUP
HEALTH CAMPUS

Joondalup Hospital Pty Ltd trading as
Joondalup Health Campus
ABN 61 106 723 193
Cnr Grand Blvd & Shenton Ave
Joondalup WA 6027
PO Box 242
Joondalup WA 6919
Telephone: 08 9400 9400
Facsimile: 08 9400 9054
Web: www.ramsayhealth.com.au

9 December 2014

Ms G Mata
School of Nursing and Midwifery
Edith Cowan University
270 Joondalup Drive
JOONDALUP WA 6027

Dear Ms Mata

RE: An examination of the registered nurses view of professionalism in Western Australia (ref 1450)

The Human Research Ethics Committee of Joondalup Health Campus (JHC) is pleased to notify you that your proposal to undertake research on this campus was approved at its meeting on Thursday 20 November 2014, conditional upon clarification of methodology, your obtaining formal approval for your study from the relevant JHC head/s of department/ manager and our receiving agreement from the JHC Executive.

We will be pursuing the organisational required response(s) as speedily as possible, and will notify you promptly when they have been obtained.

Please note that until you obtain departmental head/manager support and receive full written notification, you are not approved to proceed with your research.

Yours sincerely

Ann Y Hammer
Executive Officer, JHC HREC
hammera@ramsayhealth.com.au

ec J Hendricks, A Towell, C Churchouse,

Appendix G: Joondalup Health Campus Annual/Final Report

JOONDALUP
HEALTH CAMPUS

Joondalup Hospital Pty Ltd trading as
Joondalup Health Campus
ABN 61 106 723 193
Cnr Grand Blvd & Shenton Ave
Joondalup WA 6027
PO Box 242
Joondalup WA 6919
Telephone: 08 9400 9400
Facsimile: 08 9400 9054
Web: www.ramsayhealth.com.au

6th January 2017

Ms Gina Mata
School of Nursing and Midwifery
Edith Cowan University
270 Joondalup Drive
JOONDALUP WA 6027

g.mata@ecu.edu.au

Dear Ms Mata

RE: Annual report for
An examination of the registered nurses view of professionalism in Western Australia (1450)

I have attached an annual report form for the above study: you are required to provide this as one of the conditions of approval for your study. Regular monitoring of research projects is a requirement not only of the hospital, but for the hospital to maintain accreditation of its ethics committee with the Australian Health Ethics Committee.

Could you please complete the enclosed form and return it to us – along with your progress summary – by the deadline noted on the form.

Yours sincerely

Joanna Brisbane
Ethics Officer
JHC Human Research Ethics Committee
JHC-Ethics@ramsayhealth.com.au

enc Pro forma

JOONDALUP HEALTH CAMPUS - HUMAN RESEARCH ETHICS COMMITTEE

ANNUAL/FINAL REPORT – FOR PROJECTS INVOLVING PERSONAL CONTACT

REF NO.:	1450
PROJECT:	An examination of the registered nurses view of professionalism in Western Australia
INVESTIGATOR/S:	Ms G Mata

Please complete and return this form by 6th February 2017

When answering questions please circle the appropriate response.

1. Have all components of your research project been completed? **YES / NOx**

   If **YES**, please proceed to 2e.

   If **NO**, please continue at 2a.

		Past 12 months	Next 12 months
2.	**Please indicate the status of your study.**		
a	Project has commenced	**xYES / NO**	**xYES / NO**

If **NO**, please explain_____

If **YES**, please indicate how long you anticipate it will proceed another 12 months

b	Data collection/subject involvement completed	**YES / NOx**	**xYES / NO**
	If **NO**, will be continuing for 12 months_____		
c	Data analysis underway	**xYES / NO**	**xYES / NO**
d	Project has been terminated	**YES / NOx**	
e	Publications are anticipated	**xYES / NO**	**YES / NO**
f	Publications are being/have been published	**YES / NOx**	**YES / NO**

		JHC	Total
3.	How many participants have been recruited for this study so far?	2 leaders, 6 nurses	12 leaders 16 nurses
	How many do you plan to recruit in total?	completed recruiting	

If answering YES to any of the following questions, please provide details in your attached progress report

4. Have any subjects withdrawn or been asked to withdraw from this study? **YES / NOx**
5. Have there been any unfavourable comments from participants concerning the conduct of this study? **YES / NOx**

REF NO.:	1450
PROJECT:	An examination of the registered nurses view of professionalism in Western Australia
INVESTIGATOR/S:	Ms G Mata

6. Have there been any negative comments from participants about the consent form, or any claims that aspects of the study had not been explained in sufficient detail or with sufficient clarity? **YES / NOx**
7.. Have there been any serious or unexpected adverse events, in an emotional or medical sense, experienced by participants? **YES / NOx**
8.. Is there any information about the study which was not available to the JHC HREC Committee when the protocol was approved including changes to the Information Sheet or Consent form? **YES / NOx**

Please attach a brief report (no more than one page required) on the progress of your project during the past twelve months. Include details if there has been any departure from the approved requirements on maintenance and security of records or compliance with the consent procedures and documentation.

Any unforeseen events that have occurred or any proposed changes in the protocol that might affect continued ethical acceptability of the project must also be noted.

The summary for the final report is expected to include an indication of the study findings and reference to any publications

Please sign and date below and return to:

JHC Human Research Ethics Committee (HREC),
Joondalup Health Campus,
PO Box 242,
JOONDALUP WA 6919

or: JHC-Ethics@ramsayhealth.com.au

Signature Gina Mata Date 25/1/17

For office use:

Report 1. Satisfactory 2. Unsatisfactory

Signature of Executive Officer, JHC Ethics Committee

_____ Date_____

HREC Meeting (MMYY): _____

Progress report:

2 sections to the project- Nursing leaders and nurses.

- Data collection for the leaders is complete. The information from the leaders has been analysed with the focus interviews conducted. The nursing leaders' thematic analysis is complete.
- Data collection from the nurses still requires the focus groups at the completion of thematic analysis. The information from the nurses has been partially analysed, thematic analysis has not yet been completed. The focus group has not yet been undertaken.

It is anticipated that the nurses' analysis and focus groups will be undertaken by the end of 2017.

It would be appreciated if the ethic approval can be extended until the end of 2017.

Appendix H: Email from Sir Gairdner Hospital to participating Registered Nurses

Email to be sent by SCGH centre for nursing research

Dear Registered Nurse,

Attached is a letter of invitation for participation in a study which examines Western Australian nurses' views on professionalism.

The study is being conducted as part of a PHD project by Gina Mata. If you are interested please contact the SCGH contact given below.

You are being invited because of your experience and expertise as a nurse and as a key stakeholder for the profession. The overall aim of my research is to examine Western Australian nurses' views of professionalism. In workplaces where nurses demonstrate high levels of professionalism increased job satisfaction, better patient care and higher levels of staff retention have been found. All which foster a positive work environment. Given the predicted shortage of nurses, identifying factors that may improve and support staff in their workplace may assist in reducing attrition of nurses and in developing a positive work environment.

The study consists of audio taped interviews with the researcher, sharing stories on both positive and negative aspects of professionalism that you may have experienced or witnessed. You will also be invited to be part of a small focus group to discuss your experiences and views. The focus group will be conducted at Edith Cowan University in a meeting room at a time and place to be decided in consultation between the researcher and participants.

Participation is voluntary; if at any point you find you do not want to continue as a participant you are not compelled to do so. The interview should take approximately an hour to complete at a time and place of your choosing. It will be taped and transcribed. All details from the interviews will be de-identified and confidentiality of participants ensured.

Sir Charles Gairdner contact is

Sue Davis

Nurse Director Corporate Nursing Research & Education
Sir Charles Gairdner Hospital
Adjunct Associate Professor Edith Cowan University
9346 3538
0404891023

Regards Gina Mata
MTD, PGradDipNurs, BSc(HProm), DipNurs, RN
Lecturer
School of Nursing and Midwifery
Ph (618) 6304 3483 Fax (618) 6304 2323
g.mata@ecu.edu.au

Faculty of Health, Engineering and Science
Edith Cowan University
270 Joondalup Drive, Joondalup, 6027
Website: www.snmpm.ecu.edu.au
CRICOS IPC 00279B

Please note our Reception is staffed from 9am till 12pm and staff will be able to assist you with your inquiry during that time.
If you have an appointment with a staff member outside these hours please contact them directly using the Student phone located in the foyer next to the lift.

Appendix I: Participation Letter and consent form sent to Nurses Leaders

Gina Mata PHD candidate **Nursing leader Introduction letter & consent**

School of Nursing and Midwifery
Edith Cowan University
270 Joondalup Drive
JOONDALUP WA 6027

270 Joondalup Drive, Joondalup
Western Australia 6027
134 328
www.ecu.edu.au
ABN 54 361 485 361 CRICOS IPC 00279B

Dear Participant,

You are invited to participate in an ethics approved study (Edith Cowan University Human Research Ethics Committee, Perth, Western Australia), which is being conducted as a requirement toward the degree of Doctor of Philosophy.

You are being invited because of your experience and expertise as a nursing leader and as a key stakeholder for the profession. The overall aim of my research is to examine Western Australian nurses view on professionalism. In workplaces where nurses demonstrate high levels of professionalism there has been found to be increased job satisfaction for staff, better patient care and higher levels of staff retention. Given the predicted forthcoming shortage of nurses, identifying factors that may improve and support staff in their workplace may assist in reducing attrition of employees.

You are being invited to participate in stage one of the research study as a nursing leader working in a Western Australian public, private or magnet hospital. This first stage consists of an audio taped interview with the researcher, sharing stories on both positive and negative aspects of professionalism that you have experienced or witnessed.

Analysis of the shared stories of all nursing leaders will identify their view on key attributes of professionalism in nursing and workplace influences. You will also be invited to be part of a small focus group to discuss your experiences and views. The meeting will be conducted at Edith Cowan University in a meeting room at a time and place to be decided in consultation between the researcher and the participants.

The second stage of the research study consists of Australian nurses working in the ward areas at Western Australian public, private or magnet hospitals. They also will participate in audio taped interviews with the researcher, sharing stories on both positive and negative aspects of professionalism that they have experienced or witnessed.

Analysis of the shared stories of ward nurses will identify their view on key attributes of professionalism in nursing and workplace influences.

Participation is voluntary; if at any point you find you do not want to continue as a participant you are not compelled to do so. The interview should take approximately an hour to complete at a time and place of your choosing. It will be taped and transcribed. All details from the interviews will be de-identified and confidentiality of participants ensured. All research data will in a locked filing cabinet in a secure location.

There are no correct or incorrect responses, your involvement will help add to the current body of knowledge on the Western Australian view of professionalism. At interview you will be asked to sign a consent form, which allows the researcher to use your stories as part of the research. The information provided will be treated as confidential with access by myself and my research supervisors, Dr Joyce Hendricks, Dr Mandy Towell and Adjunct Professor Dr Christopher Churchouse.

Both the SCGH Human Research Ethics Committee and the ECU ethics committee have approved this study.

If you have any further questions or concerns regarding the study or if you wish to obtain a copy of the final results please contact me at g.mata@ecu.edu.au or (08) 6304 3483.

Alternatively you can contact my principal research supervisor Dr Joyce Hendricks via email at j.hendricks@ecu.edu.au.

If you have any concerns or complaints about the research project and wish to speak to an independent person, you may contact:

Human Research Ethics Committee Office
2nd Floor, A Block
Sir Charles Gairdner Hospital,
Hospital Avenue NEDLANDS WA 6009
P: (08) 9346 2999
E: SCGH.HREC@health.wa.gov.au

OR

Research Ethics Officer
Edith Cowan University
270 Joondalup Drive
JOONDALUP WA 6027
Phone: (08) 6304 2170
Email: research.ethics@ecu.edu.au

Thank you for your participation in this research.

Gina Mata (PhD Candidate)
Principal Researcher
School of Nursing and Midwifery
Edith Cowan University
270 Joondalup Drive
JOONDALUP WA 6027
Phone: (08) 6304 3483
Email: g.mata@ecu.edu.au

270 Joondalup Drive, Joondalup
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ABN 54 361 485 361 CRICOS IPC 00279B

Consent Form

Australian Nursing professionalism: Chief Researcher: Gina Mata

Gina Mata is a PHD candidate studying at Edith Cowan University. Her study is listening to Registered nurses in Western Australia discuss what they perceive as the key attributes of professionalism. Her purpose is to provide information on the Registered nurses views on nursing professionalism. Through analysis the differences and similarities in factors influencing professionalism will be identified and compared against the current Australian codes of ethical and professional practice.

I understand that I will share stories on both positive and negative aspects of professionalism that I have experienced and be audio taped by the researcher.

I understand that participation is voluntary; if at any point I find I do not want to continue as a participant then I am not compelled to do so. I understand that the interview should take approximately an hour to complete and that it will be taped and transcribed. I also am aware that all details from the interviews will be de-identified and all research data will be kept in a locked filing cabinet in a secure location so ensuring confidentiality of all participants.

If I have any further questions or concerns regarding the study or if I wish to obtain a copy of the final results I can contact the researcher Gina Mata at g.mata@ecu.edu.au or on (08) 6304 3483. Alternatively I can contact the principal research supervisor Dr Joyce Hendricks via email at j.hendricks@ecu.edu.au.

If I have any concerns or complaints about the research project and wish to speak to an independent person, I may also contact the:
Research Ethics Officer, Edith Cowan University. Phone: (08) 6304 2170
Email: research.ethics@ecu.edu.au
OR Human Research Ethics Committee Office, Phone: (08) 9346 2999
Email: SCGH.HREC@health.wa.gov.au

I agree to participate in this research and as such have signed this consent form.

Participant's signature: _____ Date:_____

Researcher's signature:_____ Date:_____

Appendix J: Participant Flyer

WANT TO HAVE YOUR SAY?

This is an invitation to participate in a research study to examine Australian nurses' views of nursing professionalism.

Your comments and feedback will help to determine the key factors related to professionalism in the workplace.

This study by a PHD student enrolled in ECU's School of Nursing and Midwifery has been approved by Edith Cowan University's Ethics Committee, and the SCGH ethics committee.

Each interview is expected to take around an hour and will be conducted at a place and time that suits you.

Please reply to the SCGH email address if you would be interested in being interviewed. Sue will forward on your name to the researcher for further contact. Your details will be kept confidential and you will not be identifiable in the research.

Your Sir Charles Gairdner contact is Sue Davis

Phone: 9346 3538 Email: Sue.Davis@health.wa.gov.au

If you have any questions related to participation in this research please contact Gina Mata on 6304 3483 or email g.mata@ecu.edu.au

Thank you for your valuable participation this research and I look forward to hearing from you.

Yours sincerely,
Primary researcher: Gina Mata, Doctor of Philosophy student

Supervisors: Dr Joyce Hendricks; Dr Mandy Towell; Dr Christopher Churchouse

V5 3/3/14 ECU & SCGH HREC approved study

Appendix K: Interview Questions

Interview

Demographic questions

- What is your age?
- In which area of nursing do you work?
- Where do you work?
- How long have you been a nurse?
- How long have you been working in that area?
- Where did you go to school?
- Where did you do your RN training?
- Have you done any other training/ courses?

Central Questions

1. *What you believe demonstrates professionalism in nursing?*
2. *Do you think anything influences the ability of the registered nurse to demonstrate professionalism?*

Possible prompts where required

- Can you give me any examples, from your experience, where you have witnessed either good or poor professionalism in the workplace?
- Has professionalism changed in the time you have been a nurse?
- In relation to your workplace, on a scale of 1-5 where 5 is the highest level, where would you say professional behaviour rates on a daily basis?

Appendix L: Human Research Ethics Committee, Edith Cowan University, Monitoring approved Research Projects

HUMAN RESEARCH ETHICS COMMITTEE
For all queries, please contact:
Research Ethics Office
Edith Cowan University
270 Joondalup Drive
JOONDALUP WA 6027
Phone: 6304 2170
Fax: 6304 2661
Email: research.ethics@ecu.edu.au

MONITORING APPROVED RESEARCH PROJECTS

Monitoring is the process of verifying that the conduct of research conforms to the approved ethics application. The *National Statement on Ethical Conduct in Human Research* indicates that institutions are responsible for ensuring that research is reliably monitored. Monitoring of approved projects is to establish that a research project is being, or has been, conducted in the manner approved by the Ethics Committee.

Compliance with the following monitoring requirements is a condition of ethics approval:

1. The research project will be conducted according to the approved ethics application.
2. An annual report (for projects that are longer than one year) and a final report at the completion of the research will be provided. Failure to submit a satisfactory Ethics Report Form may result in withdrawal of approval. If ethics approval is withdrawn, a researcher must not continue the research.
3. Researchers must immediately report anything that might warrant review of the ethical approval of the protocol, including:
   - Any serious or unexpected adverse effects on participants
   - Any unforeseen events that might affect continued ethical acceptability of the project.
4. Amendments to the research design that may affect participants and/or that may have ethical implications must be reviewed and approved before commencement.
5. If an extension of the approval period is required, a request must be submitted. Please ensure that requests for extension of approval are submitted before the original ethics approval expires.
6. If the research project is discontinued before the expected date of completion, researchers should inform the ethics committee and, wherever possible, the participants, as soon as possible, giving reasons.

The ethics committee retains the right to require more monitoring if the research is deemed to be high risk. Other mechanisms for monitoring may include random inspections of research sites, data or consent documentation, and interviews with research participants or other forms of feedback from them.

PROCEDURES FOR COMPLETION OF THE ETHICS REPORT FORM

- Please complete the form clearly. Handwritten forms may be returned if illegible.
- Please answer all applicable sections and provide sufficient information. Further pages may be attached if necessary.
- Please submit the form as follows:
  Staff and higher degrees students — Research Ethics Office
  research.ethics@ecu.edu.au

The Ethics Report Form is available from the Ethics website
http://intranet.ecu.edu.au/research/research-ethics/human-ethics-applications/managing-your-ethics-approval

NOTE: THIS PAGE DOES NOT NEED TO BE PROVIDED WITH YOUR REPORT.

HUMAN RESEARCH ETHICS COMMITTEE
For all queries, please contact:
Research Ethics Office
Edith Cowan University
270 Joondalup Drive
JOONDALUP WA 6027
Phone: 6304 2170
Fax: 6304 2661
Email: research.ethics@ecu.edu.au

ETHICS REPORT FORM

PROJECT DETAILS	
Project code	**8553 MATA**
Project title	**An examination of the registered nurses view of professionalism**
Chief Investigator	**Gina Richards (MATA)**
Date of report	**18/12/2019**

Type of Project

Staff Research		Masters (Coursework)		Doctorate/PhD	x		
Honours		Masters (Research)		Other:			

STUDENT RESEARCH PROJECT				
This report form has been reviewed by my supervisor(s) and approved for submission.	**YES**	x	**NO**	

TYPE OF REPORT (MORE THAN ONE SECTION CAN BE COMPLETED)				
Request for extension of ethics approval • **please complete Section 1**	**YES**		**NO**	x
Annual Report • **please complete Section 2**	**YES**		**NO**	x
Final Report • **please complete Section 3**	**YES**	x	**NO**	
Request for approval for amendments • **please complete Section 4**	**YES**		**NO**	x

CONDITIONS OF APPROVAL				
Was the research project approved with any specific conditions of approval?	**YES**		**NO**	x

If YES, please provide a brief report on compliance with the conditions of approval

By submitting this report, you declare that:

- You understand the guidelines contained in the National Statement on Ethical Conduct in Human Research (2007) and the ECU Policy for the Conduct of Ethical Human Research and I accept the legal and ethical responsibilities associated with this research project.
- The research project has been/will be conducted in the manner approved by the Ethics Committee, which includes any approved amendments and/or any specific conditions of approval.
- Any further changes to the research project, timeline or investigators will be notified to the Ethics Office.

SECTION 1: EXTENSION OF ETHICS APPROVAL

Please ensure that enough time is requested. Ethics approval is required for both the collection and use (i.e. analysis) of data.

Dates of current ethics approval	
From: 31/12/2018	**To:** 31/12/2019

Will the project need an extension of ethics approval?	**YES**		**NO**	x
If YES, what is the new expected date of completion?				
What is the reason for the extension?				
NOTE: If ethics approval has expired, please provide details of what activities have taken place after the expiry of approval.				

By submitting this report, you declare that:

- You understand the guidelines contained in the National Statement on Ethical Conduct in Human Research (2007) and the ECU Policy for the Conduct of Ethical Human Research and I accept the legal and ethical responsibilities associated with this research project.
- The research project has been/will be conducted in the manner approved by the Ethics Committee, which includes any approved amendments and/or any specific conditions of approval.
- Any further changes to the research project, timeline or investigators will be notified to the Ethics Office.

SECTION 2: ANNUAL REPORT (LAST 12 MONTHS OR SINCE THE LAST REPORT)

PROGRESS

Please provide a brief outline of the progress to date including:

- **Number of participants**
- **Data collected to date**
- **Any preliminary results and/or conclusions**
- **Mechanisms in place to monitor the conduct and progress of the research**

If the project has not commenced, please provide reasons why.

This project was part of a PhD study. The project was split into two sections, 12 Nurse Leaders and 18 registered nurses. The participants came from any acute care hospital in the metro area of Perth.
Data collection and analysis completed on both sections. Focus group interviews were undertaken with the nurse leaders, but there will be no focus groups with the nurses.

At present the thesis is in its final stages of writing up with completion expected late in 2019/ early 2020. The findings of the study are still being determined and written up in the findings and discussion chapter and conclusion.

CONDUCT OF RESEARCH

Has participation in the research project resulted in any adverse events, e.g. distress, harm, side-effects, Serious Adverse Events or Suspected Unexpected Serious Adverse Reactions?	**YES**		**NO**	x
Was it necessary to refer participants for counselling or any other form of support?	**YES**		**NO**	x
Were there any complaints from participants in the study or from others affected by the study?	**YES**		**NO**	x

If YES, please provide an explanation of the events, including the following information:

- **Number of participants affected**
- **Whether the adverse events were expected and identified in the ethics application.**
- **Any action taken in response to the adverse events/complaints.**

SECURITY AND MAINTENANCE OF CONFIDENTIALITY

ANNUAL REPORT

Please indicate:

- the form in which information, data and/or samples collected from participants will be stored during the research project (individually identifiable, potentially identifiable, or non-identifiable)
- location of storage
- precautions that are being undertaken to ensure the security of information, data and/or samples collected from participants containing names and/or other identifying information

By submitting this report, you declare that:

- You understand the guidelines contained in the National Statement on Ethical Conduct in Human Research (2007) and the ECU Policy for the Conduct of Ethical Human Research and I accept the legal and ethical responsibilities associated with this research project.
- The research project has been/will be conducted in the manner approved by the Ethics Committee, which includes any approved amendments and/or any specific conditions of approval.
- Any further changes to the research project, timeline or investigators will be notified to the Ethics Office.

Please provide an outline of the measures taken to ensure security and maintenance of confidentiality, including the points noted above

- All data deidentified at commencement of study; identifying information of no relevance to the study in any way, all information only available with the applied pseudonyms.
- All software deidentified data is accessed through an ECU password locked computer to One-Drive, no data held on the computer.
- Any de-identified hard copy documents stored in the researchers locked filing cabinet in a locked office on a locked floor with staff only access.

By submitting this report, you declare that:

- You understand the guidelines contained in the National Statement on Ethical Conduct in Human Research (2007) and the ECU Policy for the Conduct of Ethical Human Research and I accept the legal and ethical responsibilities associated with this research project.
- The research project has been/will be conducted in the manner approved by the Ethics Committee, which includes any approved amendments and/or any specific conditions of approval.
- Any further changes to the research project, timeline or investigators will be notified to the Ethics Office.

SECTION 3: FINAL REPORT

NOTE: Ethics approval is required for both the collection and use (analysis) of identifiable data. If no further contact with participants is required and all data have been made non-identifiable, a Final Report can be submitted. Non-identifiable data may be used for write-up and/or publication without requiring further ethics approval.

PROGRESS/OUTCOME

Please provide the following:

- **a brief outline of the outcome of the research project.**
- **a list of any reports or publications.**
- **details about how the results of the research project have been (or will be) provided to the participants.**

If the project has been discontinued, please provide reasons why.

At present the thesis is in its final stages of writing up with completion expected in 2019. The findings of the study are still being determined and written up in the findings and discussion chapter and conclusion.

There have been two poster presentations derived from the findings of the study so far.

1. Poster presented at Sigma Research congress Melbourne, 2018 on the Importance of mentoring to the professionalism of registered nurses.
2. Poster accepted for the Nursing and Midwifery leadership conference 2019 on the Professionalism of the bedside nurse.

Upon completion it is expected there will be a number of publications and further conference presentations.

CONDUCT OF RESEARCH

Did participation in the research project resulted in any adverse events e.g. distress, harm, side-effects, Serious Adverse Events or Suspected Unexpected Serious Adverse Reactions?	**YES**		**NO**	x
Was it necessary to refer participants for counselling or any other form of support?	**YES**		**NO**	x
Were there any complaints from participants in the study or from others affected by the study?	**YES**		**NO**	x

If YES, please provide an explanation of the events, including the following information:

- **Number of participants affected**
- **Whether the adverse events were expected and identified in the ethics application.**
- **Any action taken in response to the adverse events/complaints.**

By submitting this report, you declare that:

- You understand the guidelines contained in the National Statement on Ethical Conduct in Human Research (2007) and the ECU Policy for the Conduct of Ethical Human Research and I accept the legal and ethical responsibilities associated with this research project.
- The research project has been/will be conducted in the manner approved by the Ethics Committee, which includes any approved amendments and/or any specific conditions of approval.
- Any further changes to the research project, timeline or investigators will be notified to the Ethics Office.

SECURITY AND MAINTENANCE OF CONFIDENTIALITY
Please indicate • the form in which information, data and/or samples collected from participants will be stored after the completion of the research project (individually identifiable, potentially identifiable, or non-identifiable) • location of storage • the length of time for storage • how information, data and/or samples will be disposed of when no longer required

Please provide an outline of the measures taken to ensure security and maintenance of confidentiality, including the points noted above

SECTION 4: APPROVAL FOR AMENDMENTS

NOTE: Ethics approval is granted for a research project on the condition that it will be conducted according to the approved ethics application.

PREVIOUS AMENDMENTS				
Have any previous amendments (either minor or major) been approved?	**YES**		**NO**	x
Have any amendments to the project (either minor or major) occurred that have NOT been approved by the ethics committee? This includes amendments to research team, project timeline, research participants, recruitment methods, research procedures, information letters and consent forms, risk to participants and data storage and retention?	**YES**	x	**NO**	

If YES, please briefly explain each amendment. If approval was not obtained, please provide an explanation.
Research team of supervisors changed and changes advised and approved by ethics committee.

REQUEST FOR APPROVAL FOR NEW AMENDMENTS				
Please indicate the proposed changes and provide a brief explanation below				
Research personnel				
Change of Chief Investigator (and/or contact details)	**YES**		**NO**	x
Changes to the members of the research team	**YES**	x	**NO**	
Change of supervisor	**YES**	x	**NO**	
Participants				
Number of participants	**YES**		**NO**	x
Type of participants	**YES**		**NO**	x
Changes to inclusion/exclusion criteria				x
Addition or withdrawal of participants	**YES**		**NO**	x
Recruitment and informed consent				
Changes to the recruitment methods used	**YES**		**NO**	x
Recruitment at new sites	**YES**		**NO**	x
Changes to the information letter/consent form	**YES**		**NO**	x

By submitting this report, you declare that:

- You understand the guidelines contained in the National Statement on Ethical Conduct in Human Research (2007) and the ECU Policy for the Conduct of Ethical Human Research and I accept the legal and ethical responsibilities associated with this research project.
- The research project has been/will be conducted in the manner approved by the Ethics Committee, which includes any approved amendments and/or any specific conditions of approval.
- Any further changes to the research project, timeline or investigators will be notified to the Ethics Office.

Data collection				
Changes to approved data collection procedures e.g. method of interviewing	**YES**		**NO**	x
Changes to approved data collection instruments e.g. change of questions	**YES**		**NO**	x
New data collection procedures	**YES**		**NO**	x
New data collection instruments	**YES**		**NO**	x
Risk				
Changes to the potential risk to participants	**YES**		**NO**	x
Changes to the number of participants	**YES**		**NO**	x
Participants have withdrawn from the research project	**YES**		**NO**	x
Other changes not noted above	**YES**		**NO**	x

If YES, please briefly explain each new amendment.

By submitting this report, you declare that:

- You understand the guidelines contained in the National Statement on Ethical Conduct in Human Research (2007) and the ECU Policy for the Conduct of Ethical Human Research and I accept the legal and ethical responsibilities associated with this research project.
- The research project has been/will be conducted in the manner approved by the Ethics Committee, which includes any approved amendments and/or any specific conditions of approval.
- Any further changes to the research project, timeline or investigators will be notified to the Ethics Office.

Appendix M

WA HEALTH SYSTEM -AUSTRALIAN NURSING FEDERATION - REGISTERED NURSES, MIDWIVES, ENROLLED (MENTAL HEALTH) AND ENROLLED (MOTHERCRAFT) NURSES - INDUSTRIAL AGREEMENT 2018

WESTERN AUSTRALIAN INDUSTRIAL RELATIONS

COMMISSION

PARTIES CHILD AND ADOLESCENT HEALTH SERVICE, EAST METROPOLITAN HEALTH SERVICE, HEALTH SUPPORT SERVICES

Please refer to full report on link below:

https://ww2.health.wa.gov.au/-/media/Files/Corporate/general-documents/Awards-and-agreements/Nurses-Registered-and-Enrolled-Mental-Health/Australian-Nursing-Federation-Registered-Nurses-Midwives-Enrolled-and-Enrolled-Nurses-Industrial-Agreement-2018.pdf