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What Is the Process of Relational Work of the Nurse?

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LOYOLA UNIVERSITY CHICAGO

WHAT IS THE PROCESS OF RELATIONAL WORK OF THE NURSE?

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

PROGRAM IN NURSING

BY

DANIELA TERRIZZI DEFRINO

CHICAGO, IL

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I would like to thank each of the nurses that I interviewed for this research. Their willingness to take time out of their busy days and nights was deeply appreciated. Not only did they show me the reality of nursing work, but dispelled incorrect assumptions on my part – leaving me with a clear, identifiable process. I can only hope in some way my work will bolster theirs in the future; marrying practice to theory.

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This work is dedicated to three women who have showed me creativity and resolve.
To my grandmothers, Albina and Agata, who lived at a time when they could not get the
formal educations they should have had.

To my mother, Judith, with most gratitude - a nurse and inspiration.

Thank you.

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ABSTRACT

The process of how nurses work together in relationships to accomplish their work, which in other disciplines is labeled relational work, is presented in this dissertation. This study has made the relational work process of staff nurses explicit and creates a foundation for further nursing research. Research demonstrates that increased nurse staffing is associated with better patient outcomes. In addition, nurses working in hospitals with increased nurse staffing are associated with nurses experiencing less burnout and job dissatisfaction. However, the process of nurses' work in creating better patient and professional outcomes is not explored in the empirical literature. While stating that more nurses on a shift is better for the patient and the nurse, the "how" of the work is not known. The science of outcomes needs to advance with new information on nursing work's process. The research of this dissertation explores the process of non-technical nursing work to discover currently non-quantified processes of nursing work. Knowledge generated from this research explicates the process of nursing work that is not readily identifiable, which other disciplines identify as relational work.

A naturalistic inquiry approach was used for this research. The research question was: "What is the process of relational work of the nurse?" Both data collection and data analysis conformed to the process of classical grounded theory. Interviews were face to face with 23 direct care registered nurses working as direct care staff nurses on inpatient units. Data analysis, known as constant comparison, occurred concurrently with data

collection to discover and conceptualize the process of relational work.

The core category, Coming Together to Get Through, emerged from the data as how the nurses worked with others to accomplish their work. Participants stated that they had to work together in order to complete their work on each shift. Without the help from their nursing colleagues, they could not finish each day's work efficiently and completely and do the best they could for their patients. Ten categories emerged from the data that represent the process of relational work of the nurse. These categories are: Spending Time, Knowing Other Nurses and Doctors, Asserting Authority, Trusting and Respecting, Being Approachable, Relying on One Another, Needing Each Other, Helping Each Other, Getting the Work Done, and Did the Best for Our Patients. This study is the first to empirically discover a basic social process that demonstrates how the nurse works in relationships. The importance of social and relational constructs and their creation in an organization posits relationships as work and the building blocks of work in organizations. Discovery of a substantive theory of relational work of nurses allowed for conceptualization of the process of work nurses engage in to accomplish their goals each day. This empirical knowledge fills a gap in the literature that may affect appropriate staffing levels which in turn impact both patient and professional outcomes. Future research will focus on creation of a scale of the relational work of nurses, the process of interprofessional relational work processes, and if high levels of relational work are a pathway to decreased levels of moral distress and burnout, as well as improved professional satisfaction, and better patient outcomes.

CHAPTER ONE

INTRODUCTION

Research demonstrates that increased nurse staffing is associated with better patient outcomes (Aiken, Clarke, Sloane, Sochalski & Silber, 2002; Aiken, Sloane, Cimiotti, Clarke, Flynn, Seago, Spetz & Smith, 2010; Dall, Chen, Seifert, Maddox & Hogan, 2009; Needleman, 2008; Needleman, Buerhaus, Stewart, Zelevinsky, & Mattke, 2006; Needleman, Buerhaus, Pankratz, Leibson, Stevens & Harris, 2011; Rothberg, Abraham, Lineauer & Rose, 2005); specifically, well-staffed shifts are associated with decreased patient mortality. In addition, hospitals with increased nurse staffing are associated with less burnout and job dissatisfaction in nurses (Aiken, Clarke, Sloane, Sochalski & Silber, 2002; Aiken, Sloane, Cimiotti, Clarke, Flynn, Seago, Spetz & Smith, 2010). However, the process of nurses' work in creating better patient and professional outcomes is not explored in the empirical literature. While stating that more nurses on a shift is better for the patient and the nurse, the "how" of the work is not known. This knowledge is vital to the profession. The science of outcomes needs to advance with new information on the process of nursing work. The research of this dissertation explores the process of non-technical nursing work to discover currently non-quantified processes of nursing work. The research question was: What is the process of relational work of the nurse?

An appropriately staffed hospital unit allows the nurse to deliver care effectively (Needleman, 2008). However, the challenge for nursing is to identify, separate, and name

the process of what nurses do and how nurses impact both patient care as well as professional outcomes. This paradox of the importance of nursing, and yet not fully recognizing the “how” of the work, is not new to nursing. Florence Nightingale (1860/1969) touched on this subject in her book *Notes on Nursing*, stating that what exactly constituted nursing was not known. For example, she noted that while delivering medicine to the patient is seen as doing something, the work of nursing is often considered not doing anything. She discussed this apparent discrepancy in the representation of nursing work. She stated: “...there is the universal experience as to the extreme importance of careful nursing...” (p. 9) while also stating that what created good nursing was poorly understood. The research to explore the process of nursing work, to a great extent has still not been done.

How the profession identifies its work creates a picture of what is understood as what is done as nurses. Much of nursing work is isolated into nursing tasks, assessments and interventions; these can be explained in a stepwise fashion. These parts of a nurse’s day allow for the number of nurses per patient to be decided upon for staffing numbers. The American Nurses Association (ANA) states that appropriate nurse staffing is a difficult and decades old dilemma, not amended with changes over time in determining a solution (Weston, Brewer, & Peterson, 2012). It currently describes adequate staffing as a situation when enough nurses can deliver care, while considering the type of staff, the organization and the consumer (Weston, Brewer, & Peterson). The ANA does not, however, consider the process of nursing work in outlining effective nurse staffing. Other recent nursing research takes easily measureable staffing variables such as education,

experience, skill mix, nurse to patient ratio and nurse hours per patient day as attributes of determining influence on patient outcomes (Manojlovich, Sidani, Covell, & Antonakos, 2011). But do these measurements effectively capture the entirety of nursing work? The ANA believes that a novel approach to understanding nurse staffing is needed; one that recognizes the value of nurse staffing in organizations at a time when payment is given in exchange for quality. Specifically, the ANA says that nurse staffing should be looked at as part of the process to achieving measurable outcomes in pursuit of the reward for the consumer (Weston, Brewer, & Peterson). Perhaps this can be seen as a call for a more comprehensive recognition of the totality of nursing work processes, both quantifiable (like number and intensity of nursing tasks and assessments) as well as non-technical work. A more thorough understanding of nursing work may illuminate the “how” nurses with better staffing achieve their work. Currently the “how,” or the process, is not, to a great extent, illuminated in empirical research.

The literature that represents the process of nursing’s work that is non-technical, is largely descriptive and non-empirical. Other disciplines, as will be discussed, recognize an effective, non-technical process of work as relational work; work that is necessary to reach effective outcomes. The process and definition of relational work exists as a concept within other disciplines, in organizational behavior especially, in psychology and non-clinical business literature to a certain extent, but within nursing not at all. Aside from a derived, non-empirical theory by the author of this dissertation (DeFrino, 2009), relational work in nursing is a concept that has not been explored with empirical methods. The research undertaken for this dissertation generates knowledge of nursing

work process through the qualitative methods of grounded theory. This allows for the generation of knowledge that aids in discovering the process of nursing work that is non-technical and not readily identifiable which other disciplines identify as relational work.

While much of nursing's work remains constant through time, healthcare has accelerated and pressures have shifted. These changes impact expectations on nurses to demonstrate quantifiable outcomes. Therefore, there is a gap in the current nursing literature that empirically examines the attributes of relational work on measurable outcomes for the patient, nurse, and healthcare team members. This gap needs to be empirically studied for the totality of nursing work and the space that relational work occupies in the day of a nurse, in order for that nurse to be effective for the patient and the nurse professionally. Relational work and its structure is conceptualized in this study. An empirically derived theory that explicates the unique nature of relational work to nursing work has been discovered. That was the work of this dissertation research; discovery has come from the perspective of those experiencing it, thereby informing this work from nursing's perspective. Consequently, the next stage will be relating that relational work to patient and professional nursing outcomes.

This introductory chapter addresses three primary issues related to the current conceptualization of relational work. Issues that pertain to the topic of relational work, such as a working definition synthesized from multiple disciplines' understanding of the concept in lieu of a perspective directly from nursing literature, the importance of recognizing relational work as work and not a happenstance personality characteristic, and overlapping characteristics between interprofessional collaboration (IPC) and

relational work are discussed in this chapter. These are topics that buttress the emerging understanding of relational work in nursing.

Working Definition

A single definition of relational work does not exist. Certainly in nursing its recognition as a concept is tenuous; it is an emerging concept. A working definition of relational work has been synthesized from the literature, taking into account shared understandings of many disciplines. The core of relational work is its recognition of the *interdependence* of workers in the definition of work (Couturier, Gagnon, Carrier, & Etheridge, 2008; DeFrino, 2009; Fletcher, 2001; Gittell, 2008). Relational work is deliberate action and facilitation that creates a net of connection that is both visible and invisible. Antecedents to relational work include shared knowledge and goals, proximity, time for engagement, resources and the element of uncertainty of the work (Foster & Hawkins, 2005; Gittell; Lambrechts, Grieten Bouwen, & Corthouts, 2009; Liaschenko & Fisher, 1999; McCabe, 2004; Miner-Williams, 2007; Norman, Rutledge, Keefer-Lynch, & Albeg, 2008). Consequences of relational work are better care and health outcomes, resiliency of the team, positive professional rewards, and high levels of task accomplishment (Benjamin, 2008; Butler & Waldroop, 2004; Cunliffe & Eriksen, 2011; Gittell; Havens, Vasey, Gittell, & Lin, 2010; Manning, 2010). The negative aspects of relational work are barriers to recognition of and sustaining high levels of relational work are: it is invisible, unrecognized, unending work and requires high levels of availability of the worker (Benjamin; Fletcher, 2001; Hartrick & Schreiber, 1998; Jacques, 1993; Vlasses, 1997).

Relational Work

Why examine non-technical processes of nursing? Without engagement in, and recognition of this type of work, it is theorized that nurses experience moral distress, resulting from powerlessness, are monetarily devalued, burn out, and work becomes a focus of the technical. This is represented in the theory of relational work (DeFrino, 2009; see Figure 1). DeFrino theorized that when this work is ignored as work, nurses experience negative professional outcomes such as moral distress and subsequent burn out. She theorized the necessity of recognizing relational work of nurses with time, money and resources.

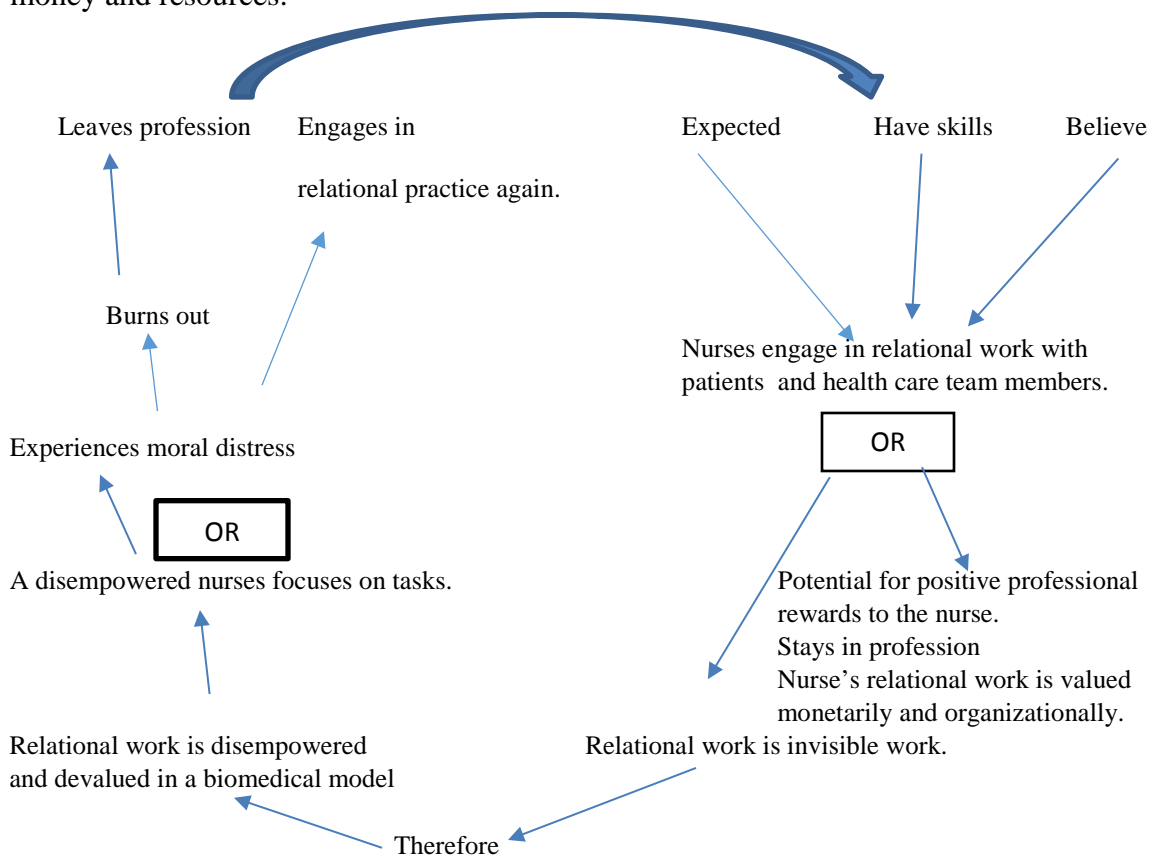


Figure 1. Disappearing dynamic of the relational work of nurses. From DeFrino (2009, p.301).

The understanding of the nurse as a worker that exists as an extension of the organization that he/she works within is vital to understanding how the organization and worker accomplish outcomes together (Liashcenko & Peter, 2004). The understanding of the health care environment's impact on the ability to engage in all aspects of work with the patient and with health care team members leads to the following question: If non-technical work is a valuable process for the patient's wellbeing, the organization meeting its goals, as well as for the nurse professionally, why is it left unprotected, in fact ignored, as nursing's major contribution to the care of the patient and sustenance of the working of the health care system?

It may be that the reason nursing's major contribution to the care of the patient is ignored in the health care system is because of the way in which nursing's work is viewed. Nursing work may be viewed as caring, social work and therefore not a part of what the health care system, as a business, pays for. When the splitting of professionalism is recognized (Hall & Schneider, 2008; Needleman, 2008), the relational becomes transactional. In a transactional model, care is constrained by the rules that govern a business. In a relational model, care is a part of relationships that the nurse enacts. The relational then becomes visible and subsequently transactional. To put it in different yet slightly similar terms, the social and business cases for quality related to nursing and the alignment of financial incentives that concurrently benefit the hospitals and payers with the interests of the patients would be recognized (Dall, Chen, Seifert, Maddox, & Hogan, 2009; Needleman). This moves the social case into the realm of

business and transaction. Workers with commodified knowledge are necessary to an organization (Liaschenko, 2002). When non-technical, relational work ceases to be invisible and unrecognized, organizations will be able to value and validate the entirety of nursing's work.

An etic view of the relational work of nurses and healthcare team members recognizes it as an intense, uncertain, time-constrained, high-stakes theater of group work. However, an emic view of relational work of nurses and others within the healthcare system does not recognize the centrality of relational work to accomplishing goals. Nursing in particular sees concepts related to relational work as invisible, individual work it alone shoulders and is expected to carry out, but is not given the time and resources to do it, nor the recognition of it as work (Fletcher, 2001; Hartrick & Schreiber, 1998; Jacques, 1993; Vlasses, 1997).

Organizational behavior and psychology have begun research on identifying and capturing relational work and examining its effect on outcomes. These disciplines have specifically turned to nursing and the broader health care environment as the penultimate pastiche of a workplace; where high stakes technical work is accomplished to save the patient.

Interprofessional Collaboration and Relational Work

The concept of relational work is recognized as the key component in today's latest view of teamwork in healthcare: interprofessional collaboration (IPC), also called interprofessional care and interprofessional work. IPC is strongly related to relational work. IPC, also called collaborative practice by the World Health Organization (Mickan,

Hoffman, & Nasmith, 2010) is the process where multiple professional groups work with one another to impact health care (Zwarentstein, Goldman, & Reeves, 2009). IPC occurs in the interest of caring for the patient, the relationships become work and relational work becomes the foundation for work's outcomes. The act of relational work is taken into the recognized and legitimizing realm of work.

IPC has the characteristics of the importance of the collective, the mutually dependent nature of work, shared responsibility, facilitation of connections with other members of the team, and breaking down barriers for the patient, and for one another. As the importance of IPC grows, nurses must make obvious their exceptional relational attributes and knowledge domains to the team so that they are recognized as integral contributors to the team and patient outcomes (Wright & Brajtman, 2011).

IPC is an evolutionary extension of teamwork and interdisciplinary work, and stresses the group over the individual as necessary to care (Couturier, Gagnon, Carrier & Etheridge, 2008; Reeves, 2011; Saba, Villela, Chen, Hammer, & Bodenheimer, 2012; Wright & Brajtman, 2011). IPC is a response to a complex system that addresses complex problems with patients' health at the center, and is based on the argument that the knowledge of one profession is not satisfactory in order to cure the patient (Couturier, Gagnon, Carrier, & Etheridge).

IPC takes the mythological model of the physician as the lone healer of the patient and exposes the fact that there must be a group in place to heal the patient (Emanuel & Fuchs, 2012). The relational approach to care coordination necessitates the use of relational work spaces that improve the quality of this care (Amundson, 2005; McEvoy,

Escott, & Bee, 2011) as well as “interdisciplinary discursive space[s] that allow for the collective formulation of a system of higher-level concepts...” that create the correct, prescriptive action necessary for this complex work (Couturier, Gagnon, Carrier & Etheridge, 2008, p. 347).

Some evidence demonstrates that nurses already view themselves, by nature, as a profession that works as a team (Baker, Egan-Lee, Martimiankis & Reeves, 2011; Wilhelmsson, et al., 2011), while physicians believe they will work as a team but continue as the necessary de facto leaders of that team (Saba, Villela, Chen, Hammer, & Bodenheimer, 2012). As a result of the crucial nature of IPC, the relational dimensions of interprofessionality become that much more imperative and increase the workload of those individuals involved (Couturier, Gagnon, Carrier & Ethridge, 2008). This is further indication that relational work is work.

Conclusion

The aim of this research was to conceptualize the process of non-technical work of nurses, which in other disciplines is labeled relational work; make it explicit and create a foundation for further nursing research. This dissertation answered the question: What is the process of relational work of the nurse? Other disciplines, specifically organizational behavior and psychology, have taken the lead in researching this type of work within nursing; yet in nursing the phenomenon has not been conceptualized empirically. Understanding the process of nursing work in order to achieve better patient and professional nurse outcomes will allow the science to move forward. Where has nursing been, one can ask, when nurses have been doing this relational work since

Nightingale's time? Why doesn't nursing get the credit, or step up and take the credit, for creating the blue print for effective relational work with interprofessional processes?

When the process is made explicit with discovery, the explication will allow for future research to demonstrate, within an overarching definition of nursing work, the space that this type of work occupies. Relational work will be taken from the realm of niceness and helpfulness of the nurse to specific professional activities that directly result in patient outcomes and professional achievement. Grounded theory inquiry (Glaser & Strauss, 1967) will be used because its structure allows for the theorization and conceptualization of the process of this work to occur and be understood based on interview data.

CHAPTER TWO

REVIEW OF LITERATURE

This chapter focuses on key theoretical and empirical literature related to relational work as it is represented in the disciplines of nursing, organizational behavior, psychology, and business, as well as review of current research articles that explicate measurement of nurse staffing and association with patient and nurse outcomes. Electronic databases, PubMed, CINAHL, and PsychInfo, were strategically searched for articles using the terms “relational work,” “relational practice,” “relational work and nursing,” “relational work and nurses,” “relational practice and nurses,” “relational practice and nursing,” “nurse staffing,” “nurse staffing and outcomes.” The dates used were from the present (2016) going back without a set date.

Relational work is a concept that exists largely outside of nursing. In nursing, portions of the term are understandings that have changed over time as concepts expand and reflect current trends; for example, from nurse caring behavior (Cossette, Pepin, Cote, & de Courval, 2007; Norman, Rutledge, Keefer-Lynch, & Albeg, 2008), to invisible work of nurses (Vlasses, 1997), to a theoretical conceptualization of relational work today (DeFrino, 2009). In the organizational behavior, psychology, and business literature, relational work is understood in a distinct manner within each discipline. In organizational behavior, relational work describes a type of high functioning collaboration within a group of workers (Havens, Vasey, Gittell, & Lin, 2010; Gittell,

2008; Lambrechts, Grieten, Bouwen & Corthouts, 2009). In psychology, relational practice and relational work stem from the work of Fletcher (2001) and her collaborators in which the relational practice of women is a manner of working that involves a number of relational skills such as empathy, mutuality, reciprocity, and sensitivity to emotional contexts. In the business literature, relational work is less uniformly defined but is largely how groups work together to accomplish goals (Benjamin, 2008; Cunliffe & Eriksen, 2011; Manning, 2010; Nye, 2008); whether these are businesses, departments in an engineering firm, sales managers, or a hospital unit.

Relational Work in Nursing

The Theory of the Relational Work of Nursing

There is one theory in the nursing literature that discusses the relational work of nurses (DeFrino, 2009). It is based on derivation from a theory (Walker & Avant, 2005) in psychology, the theory of the relational practice of women (Fletcher, 2001), as well as on conceptualization; it is not created from qualitative discovery. The theory describes a series of concepts that represent relational work, and the subsequent dismissal of these relational actions that are not seen as vital to successful nursing work. When this relational work is ignored by organizations and others who maintain powerful organizational positions, like administrators and physicians, nurses start to focus on tasks and cut relational work out of their work. They experience moral distress because they cannot enact their values in caring for patients, and subsequently often burn out. The burned out nurse then either leaves the profession and quits the job or, because he or she believes in the power of relational work practices, engages in relational work again, in a

repeating loop of behavior. It is theorized that when nurses enact relational work in order to help patients and nurses reach positive outcomes and professional goals, the organization has the opportunity to recognize relational work as work, not as an attribute of niceness, and value it with resources like appropriate staff numbers, recognition of the entirety of nursing work, as well as with money (see Figure 1, p. 6 in Chapter 1).

Relational work is defined with four attributes (DeFrino, 2009). These attributes are preserving work, mutual empowering, self-achievement, and creating team. These characteristics of relational work describe actions of the nurse that are necessary for the patient, the nurse, and the other healthcare team members to realize goals and outcomes. These definitions are analogous to Fletcher's (2001) parent theory. Fletcher is a psychologist. As in Fletcher's theory, these four components are the attributes of relational work of nurses, noted in Figure 1 in Chapter 1 on page six as "relational work."

Preserving work is the nurse taking responsibility for the whole. For example, the nurse organizes the hospital stay, is the patient's advocate, and bridge to other disciplines. This work preserves both the wellbeing of the patient and allows the institution to meet its desired outcomes. Details are very important and attending to details is a part of preserving work. The nurse anticipates and takes action to forgo problems, extending the job beyond boundaries to do what is necessary to get the job done. This extends beyond tasks and technical work (DeFrino, 2009).

Mutual empowering is when the nurse extends the meaning of outcomes to include outcomes rooted in the patient, such as increased knowledge or competence. This mutual empowering, or sharing of power attainment, translates to outcomes often

attributed to a physician but have occurred because of knowledge passed from nurse to doctor. For example, the nurse assesses that the patient has labored breathing and relays this to the doctor. The doctor orders an exam to discover a pulmonary embolism. The patient and family are grateful to the doctor for his expertise and knowledge in saving the patient. Further illustration of mutual empowering is when the nurse enables links between the patient and other health care team members. The nurse engages relational skills when working with the patients and healthcare team members. The nurse helps the patient without making them feel embarrassed or unknowledgeable. The nurse eliminates barriers to achieving goals for the patient and other healthcare team members (DeFrino, 2009).

Self-achieving is the when the nurse looks to self to modify and recognize the need for change in order for goals to be achieved. The nurse takes responsibility for breaks in relationships with both healthcare team members and patients after a misunderstanding and keeps working in spite of difficulty. Feelings are used as a source of data and understanding when deciding on reactions of others and consequences, and assists the patient and healthcare team members to chart an appropriate course of action (DeFrino, 2009).

Creating team is defined as the nurse preparing the environment and conditions that allow unit work and goals to flourish, and relational competence and teamwork to occur. The nurse pays attention to the individual by listening, respecting, and responding. Connections between others are facilitated by soaking up stress, decreasing conflict, and

creating patterns of practice that encourage *interdependence* among healthcare team and patients (DeFrino, 2009).

According to the theory of the relational work of nurses (DeFrino, 2009), the attributes of preserving work, mutual empowering, self-achieving, and creating team constitute relational work of the nurse. They are intentional actions that nurses enact to get their work completed, and for positive patient outcomes and other healthcare team members' goal accomplishment. The antecedents to relational work are having both the time to engage in relational work as well as acknowledgement of the effectiveness of relational work towards achieving goals – whether they are for the patients, the nurses, other healthcare team members or, as a result, the organizations.

Invisible Nursing Work

The conundrum of explicating all of nursing work was present in Nightingale's time and reflected in her book *Notes on Nursing: What it is and what it is not* (1860/1969). As she stated, nurses are vital to proper care of the patient and yet are perceived as doing nothing, and much of nursing's work is invisible. When nursing work is invisible, its value is decreased, which can play a role in feelings of powerlessness as a group (Bjorklund, 2004; Manojlovich, 2007). In addition, when the work of nurses is not visible, it is not recognized within the structure of healthcare and cannot be assigned economic value (Liaschenko, 2002).

Vlasses' (1997) dissertation research work uncovered the invisible work of nurses. Her dissertation, entitled "Too familiar for words: An analysis of 'invisible' nursing work," sought to conceptualize additional dimensions to nursing work within the

broad context of the patient's situation. She used ethnomethodology as her research approach, which allows the researcher to focus on the ordinary and routine. This research approach recognized the nurses at the heart of a complex dynamic between family, self, and organization.

Vlasses' (1997) research methods included non-participant observation, in-depth interviews (n=32), meetings, informal discussions and field journals. She used Leininger's ethnonursing data analysis which divides analysis into four phases; phase one is collecting, describing, and documenting raw data; phase two is identification and categorization of descriptions and concepts; phase three is pattern and contextual analysis; and phase four is identification of major themes, research findings, theoretical formulations, and recommendations. The themes that resulted from analysis of interviews were: creating presence, it depends on the patient, working the system; bridgework, the art of connecting, and flexibility, responsiveness, and mutualability: the mix. These dimensions of nursing work laid out the scope of 'invisible' nursing work. Her research demonstrated that the act of articulating work the nurses identify as vital but invisible, to themselves as nurses and from the perspective of others, is important to do. She stated that future work on the 'invisible' nature of nursing work should focus specifically on how nurses know what they know and how to validate the importance of nursing work.

Hartrick and Schreiber (1998) asked post-RN students (n=34) to write, in narrative form, about a metaphor that represented their experience of being a nurse. The thematic analysis of the nurses' writings led to clusters of concepts and then to central themes from the data.

The four attributes of nursing work that emerged from the data were: the character of nursing work, power and empowerment, nursing as a growth process, and the relational nature of nursing. More specifically, nurses found that through their work they were the link and responsible, yet viewed themselves as invisible to others. As a result of this invisibility they focused more on tasks, just getting the job done, unending work, and availability to patients. They stated that the result of their invisibility led to nursing's importance as diminished outside of nursing and even by nurses themselves.

Social Knowledge

Liaschenko and Fischer (1999) discovered and named nursing knowledge(s) extending past that of the nurse-patient relationship (NPR), but with relationship at the core, that produced effective outcomes. These researchers found that, during empirical studies they conducted about nursing practices, designations of knowledge arose. One study was an ethnographic study of psychiatric emergency room services and the aim of that study was clinical reasoning. The other study was a narrative study of psychiatric nurses using unstructured interviews and the aim was to examine moral dimensions of nursing. The concept of knowing the patient in different ways was evident in both studies. At the core, the understanding of this kind of work is that work is not an endpoint, but a process, and that their designations of work into different, yet connected, knowledges is an articulation of theorization between knowledge and nursing actions.

Liaschenko and Fischer (1999) identified four distinct types of knowledges that the nurse has in order to create effective patient outcomes. The first three knowledges are: case knowledge, patient knowledge, and person knowledge. Case knowledge is the task

and biomedical knowledge nurses have that allow them to do specific types of work. Work that the nurse does when he or she monitors disease processes or carries out therapeutic care is case knowledge. Patient knowledge is knowledge the nurse has about the patient's social and family background and situation; it is knowledge of the patient as a person within an institution and knowledge on how to monitor a patient's responses to care. This knowledge allows the nurse to guide a patient through the complex healthcare system. The nurse's knowledge guards against a fragmented system of the patient's benefit. Person knowledge is the nurse knowing the patient as a person over time, and reflection of this understanding gives the nurse perspective that aids in care of the patient.

The theorization by Liaschenko and Fischer (1999) continues to a fourth type of knowledge, which is social knowledge. This knowledge links the three types of knowledge - case, patient, person - with the in-between, filling-in knowledge. They call this relational practice and reference the work of psychologist Fletcher (1994). It is knowledge necessary to complete the job but is not acknowledged as work. Theorizing this kind of work is unique because a large part of nursing work is not task-oriented work. On the contrary, nursing is how work is achieved in extremely complex systems. Liaschenko and Fischer turn on its head the notion that the crucial work is scientific, and that everything else just happens – discrediting the argument that no knowledge is required to do this social work that connects the nurse, patient and healthcare providers.

Nurse Patient Relationship

One of the distinguishing features of nursing's work is the nurse's proximity and relationship with the patient. The nurse patient relationship (NPR) has been the focus of

theories and a distinguishing feature of the nursing discipline. The work of psychiatric nurse Hildegard Peplau (Peplau, 1997) and her interpersonal nursing theory is explanatory of the NPR. The focus of her theory is the interpersonal process and relationship between the nurse and the patient. Throughout each interaction with the patient there are three phases: orientation, working and resolution (Forchuk, 1995). These occur each time and throughout the process of interacting with the patient. The relationship that results with the patient is a major source of knowledge for the nurse about how to care for the patient. The centrality of relationships between people, including between the nurse and the patient, are vital for individuals to reaffirm their self-worth and connectedness (Peplau).

The majority of literature about the NPR is non-empirical literature and therefore will not be discussed at length in this dissertation. However, it is important to recognize the force of the NPR to the identity of nursing as a discipline (Fraser, Estabrooks, Allen & Strang, 2010; Jonsdottir, Litchfield, & Pharris, 2004; Stajduhar et al., 2011) and how this unique relationship can be viewed as a narrower or singular example of relational work. In order for nurses and patients to be able to enter into the NPR, the nurse must be proximate to the patient, reflect on feelings, have an awareness of the environment and be socially nice and open (Foster & Hawkins, 2005; McCabe, 2004; Miner-Williams, 2007; Norman, Rutledge, Keefer-Lynch, & Albeg, 2008). It is believed that as a result of the NPR, patients experience comfort, emotional support, better health outcomes, and the creation of a supportive relational space (Finch, 2005; Hartrick-Doane & Varcoe, 2007).

The nursing literature focuses intently on the dyad of the NPR as being crucial to defining nursing as a profession, not solely as a technical job. It is that understanding of beyond objective, medically directed work that the NPR exemplifies. Much of the same important characteristics of relational work can be found in those of the NPR; connectedness, mutual understanding, and knowledge gained through knowing the other person.

Summary of Relational Work and Related Concepts in Nursing

The attributes of concepts related to relational work are invisibility, bridging or filling in work, social knowledge, relationship work, and, in each case, necessary work of nurses as described in nursing literature (DeFrino, 2009; Hartrick & Schrieber, 1998; Liaschenko & Fischer, 1999; Peplau, 1997; Vlasses, 1997). Antecedents of relational work and related concepts are openness, proximity, availability (DeFrino, 2009; Hartrick & Schrieber, 1998; Liaschenko & Fischer, 1999; Peplau, 1997; Vlasses, 1997). Consequences are achieved outcomes for patients, nurses, other healthcare team members (DeFrino, 2009; Hartrick & Schrieber, 1998; Liaschenko & Fischer, 1999; Peplau, 1997; Vlasses, 1997).

Relational Work in Organizational Behavior

Relational work is a concept that is fairly well developed in organizational behavior. Relational work is employed to the sphere of collaboration of a team of workers. Organizational behaviorists are asked to evaluate the level of relational process of members of various kinds of organizations like airline companies, healthcare, and schools (Ghitulescu, 2013; Gittell, 2008; Gittell, Cameron, Lim, & Rivas, 2006; Gittell,

Godfrey, & Thistlethwaite, 2013; Lambrechts, Grieten, Bouwen, & Corthouts, 2009; Parker, 2002.) The essence of healthcare work emphasizes the group over the individual as essential to care for a person with manifold and layered problems; the knowledge of one discipline does not suffice.

Gittell (2008) sought to empirically explore a model of relational coordination as applied to the healthcare setting in a mixed methods study. In order to do so, one work process was chosen within healthcare for which outcomes can be easily measured: surgical care for joint replacement patients. Data were collected within nine hospital orthopaedic units, at nine different hospitals, for patients receiving joint replacements. Measurements included secondary data analysis for managed care penetration; administrator interviews to measure formal work practices; and interviews of administrators and direct care providers - one physician, one nurse, one physical therapist, one social worker, and one case manager from each of the nine hospitals. In addition, on each unit, unstructured interviews and observations were carried out, followed by more structured interviews where the researcher used survey measurements developed from initial interviews.

The measurements were the following: external pressure, captured as percentage of managed care penetration in each hospital's environment; perceived work stressor, one item, measured on a 3-point Likert-type scale; and collective coping response, reflected in seven dimensions of relational coordination: frequency, timeliness, accuracy, and problem-solving focus of communication among providers and how their relationships reflected shared goals, knowledge, and mutual respect. Each was measured on a 5-point

Likert-type scale (n=338); and relational work systems included items developed from initial provider interviews (n=27). Interestingly, nurses had the lowest response rate. Gittell (2008) speculated that this was because of a lower level of control over their day to day schedules (35% response rate of nurses as compared to 73-92% from all other providers).

Four regression equations were tested on a model of relationships that guided the study (Gittell, 2008). The findings demonstrated that relational coordination was powerful in supporting group coping responses. The relational coordination scale was noted to have a high level of internal validity with a Cronbach's alpha of 0.86. In addition, it was also found that external pressures, from amount of managed care patients and perceived work stress from managed care, did not affect formal work practices of a relational work system. The most prominent finding of the study was that relational coordination, which is communication and relating for the main purpose of integrating tasks, is a collective coping structure and resiliency against outside demands on internal workings of a group. In fact, external threats have an impact of magnifying the importance of shared goals, shared knowledge, and mutual respect among team members. These threats increase the number and quality of communications among the team members. Formal work practices support and strengthen group responses to an external threat. That means that work practices that had already been rooted in their hospital unit were highlighted – and were relied upon also for organizational support of the unit and its members. The stronger the team, the better able they are to deal with upheaval.

A second research article by organizational behaviorist Havens and colleagues (Havens, Vasey, Gittell, & Lin, 2010) underscores the impact of relational coordination among nurses (RNs) and other providers on the quality of patient care. This study was designed to measure nurse perceptions of relational coordination among nurses and other providers and the link between relational coordination and how nurses rated quality of care (n=747). The measurements were the Relational Coordination Survey of Patient Care (Cronbach's alpha was 0.93) (adapted from Gittell et al., 2000) as well as five measures to assess nurse perceptions of quality of care. Relational coordination was defined as shared goals, shared knowledge, mutual respect, frequent, timely, accurate and problem-solving communication. Four hypotheses were tested; two hypotheses were supported. The first supported hypothesis was that nurses reported higher relational coordination between nurses on their unit than between themselves and nurses on other units (no effect size reported). The second was that when nurses rated overall relational coordination among nurses and other providers as high, nurses rated quality of care to be higher ($r(746)=0.49, p<0.01$). In addition, as relational coordination among providers went up, adverse events declined, such as hospital-acquired infections and medication errors; the amount they declined was not noted, however (Havens, Vasey, Gittell, & Lin, 2010). One hypothesis was partially supported: relational coordination between nurses will be higher than relational coordination among nurses and their colleagues from other disciplines; it was highest between nurses practicing of the same unit, but not among nurses from other units. The other hypothesis not supported was that relational coordination between nurses and doctors will be the weakest form of relational

coordination. Relational coordination between nurses and doctors was, in fact, found to be the third highest type of observed relational coordination ($\bar{x} = 3.74$, $SD = 0.72$ on a five-point scale).

Parker (2002) studied relational work in a group context in care giving organizations; specifically identifying factors that influence relational work. The aims of her study were to identify specific behavior characteristics of relational work in the health care environment, as well as to identify workgroup-level influences that interrupt relational work behaviors. She used a qualitative case study design, conducting the research in two different women's primary health care groups in two different teaching hospitals. She observed work groups, read meeting minutes, and interviewed both providers and patients; data were analyzed using the constant comparative method of Glaser and Strauss (1967).

Parker's (2002) study was able to map out dimensions of relational work as well as the importance of relational work on multiple levels in the workplace, and its influence over work behaviors. The dimensions of relational work were: accessibility, boundary management, connection, collaboration, and continuity. Accessibility represented behaviors that members in a workgroup take to make themselves available to one other. Boundary management was behavior that allows them to be present, and with less distraction from outside sources, in order to effectively work with the party at hand so that they can connect. Connection was represented by engagement, empathy, and emotional authenticity. Collaboration entailed sharing information relevant to decision making in order to reach agreed upon decisions. Continuity involved staying in touch

and making sure each party was informed of other information necessary for the present discussion. The subsistence of workgroups where workers can create collective understandings of difficult work events was shown to be a forceful way to buffer against outside turmoil. The more relational work practices were engaged within the group, the better the group was to get through difficult work situations.

The importance of relational practice to work groups is the reason many organizational behaviorists are consulted to examine work processes, and how to change these to become more effective. In evaluating processes of work, the interactions within groups and within organizations are framed from the perspective of understanding what in the process works – and taking a relational practice perspective puts mutual relational work at the center of attention (Lambrechts, Grieten, Bouwen, & Corthouts, 2009). Relational work, from this perspective, recognizes that change occurs through relational work. When consulting, the organizational behaviorist frames observations from a relational practice perspective, and assesses if concrete and observable characteristics of interactions in work places are of high or low quality.

Low-quality relational practice is defined as one-sided relationships. Low-quality relational practice is defined as being distant, disengaged and uninvolved; statements are vague; no mutual questions; there is blaming and defending; no joint ownership of project; dominant voices control the interaction and others are silent (Lambrechts, Grieten, Bouwen, & Corthouts, 2009). High quality relational practice is defined as reciprocity between people. High quality relational practice is defined as talking with others; having sensitive and engaged interaction; engaging in mutually open and concrete

discussion; mutual questioning is encouraged for learning; having joint discussions and ownership for tasks; and many voices are heard. The importance of social and relational constructs in an organization posits relationships as the building blocks of all work in organizations.

Summary of Relational Work in Organizational Behavior

Gittell and colleagues (Gittell, 2008; Havens, Vasey, Gittell, & Lin, 2010) and other organizational behaviorists (Lambrechts, Grieten, Bouwen, & Corthouts, 2009) place interactions and relationships at the center when gauging if a work group will do well; that is, experience high quality outcomes, work resiliently as a team, or be able to make change processes occur. Interestingly, both Parker (2002) and Gittell (2008) found that the turmoil of healthcare necessitates group cohesion and relational work in order to care effectively for patients. In addition, relational work factors allow outside threats to be minimized and have less or no effect on the working and effectiveness of the group.

The work of nursing is to create change; it is the process of creating change in the patient's health status. While Gittell's (2008) and Havens' (Havens, Vasey, Gittell, & Lin, 2010) works examine the components of relational coordination and their influence on quality markers, these works do not examine the how of nursing's relational coordination or relational work. The explication of nursing work processes of non-technical relational work and how these processes both exist as change, as well as create change, are not captured by organizational behavior literature and research.

Relational Work in Psychology

Joyce Fletcher (2001) is a psychologist and scholar who developed a theory of the relational practice of women. The relational practice of women is a manner of working that involves a number of relational skills such as empathy, mutuality, reciprocity, and sensitivity to emotional contexts. These are concrete and intentional behaviors that are actual ways to accomplish goals and get work done; not simply natural, nice, feminine manners. Fletcher and colleagues (Fletcher, Jordan, & Miller, 2000) observed and interviewed women at work to see if there was proof of work practices that demonstrated a relational view of being effective and successful. Their sample was six female design engineers working in a high tech company that was predominantly male. The researchers observed the women for a full day and then interviewed the women for several hours. The day's events were reviewed and discussions grew from these observations. Then, other members of the work place were interviewed. Finally, a focus group of all participants was held. At the focus group, findings were discussed, input gathered, and reactions noted.

The multiple sources of qualitative data resulted in four categories that, put together, create the relational practice of women. These four categories are: preserving work (focus on task), mutual empowering (focus on other), self-achieving (focus on self), and creating team (focus on team). These definitions are analogous to DeFrino's (2009) definitions in her theory, the theory of the relational work of nurses, because this is the parent theory for her work's derivation. As in that theory, these four components are the attributes of the relational practice of women.

Preserving work (Fletcher, Jordan, & Miller, 2000) is shouldering responsibility for the entire group in order to save the life and structure of the project. The woman resolves conflict and keeps project connected to important resources. The woman takes actions to prevent disruption to the project. She places project necessities ahead of her own career needs.

Mutual empowering (Fletcher, Jordan, & Miller, 2000) is creating a larger definition of outcomes to include those rooted in others, like increased knowledge. The woman teaches with an eye towards the learner's gaps in knowledge, shares information, and makes connections occur. She protects others from the result of their relational limits. She gives help without making the other person feel guilty.

Self-achieving (Fletcher, Jordan, & Miller, 2000) is using relational skills to reach goals by noticing and accepting responsibility for lack of cohesion in relationships that could be a barrier to achievement. There is a reconnection after a breakdown in communication or working together. She uses feelings as a source of data and responds to emotional feelings and understanding situations. The woman uses reflection as a source of knowledge.

Creating team (Fletcher, Jordan, & Miller, 2000) is focusing on making sure everything is set so that the group can work well together. There is affirmation of the individual's contribution to the group by listening, responding, and talking to one another. She soaks up stress of those around her that she is working with, taking their feelings of stress upon herself, and, recognizing this, reduces conflict by encouraging *interdependence*.

The female worker often has these relational practices “disappeared” by what is viewed as important to getting work done in an organization. Often, the process of completing the work is thought of as unimportant in workplaces; it is only the outcome that matters. Fletcher and colleagues (Fletcher, Jordan, & Miller, 2000) state that in fact all of the growth through connections that women do is what allows outcomes to occur and a group or company to flourish. Often the work of women, and their engaging in relational practice, is seen as “natural and nice,” not effective attributes designed to get work accomplished. When this relational practice is ignored as work, women often try to disengage from this type of work and act more “masculine.” Then, as was found in this qualitative study, the women are looked at and punished as unfeminine.

Jacques (1993), a professor of psychology, published his work called: “Untheorized dimensions of caring work: Caring as a structural practice and caring as a way of seeing.” He spent a number of days on a medical unit of a hospital and asked the research question: What do nurses do? He used structured observation to subjectively categorize what he saw. The observations reflected research interests of the author and reflected his status as a non-nurse. He took his observations and examined the dimensions and boundaries of caring work within an organization. His observations reflect those of Fletcher’s (2001) who became his professional partner in relational practice writings.

Jacques’ (1993) noted that much of the work that the nurse does is not visible to others because it is trivialized; the nurse is seen as a happy helper in an organization where the real work is accomplished by a physician. His observations noted that if caring

work done by nurses is understood as a structural practice, it will be revealed that the connectivity work of nurses makes the entire organization's accomplishments possible.

Often, as Jacques (1993) noted, and as Vlasses (1997) cites Jacques as realizing, much of caring, while critical, is often invisible because it is interpreted through a positivist frame of reference where caring does not necessitate expertise or knowledge. Caring, in that frame of reference, has no real meaning to work outcomes. Further, Jacques notes, if nursing's knowledge is not articulated and is hidden, then its value is not demonstrable. If nurses' caring work is not understood as work, then it is seen as the antithesis of work – which is love; which, of course, is not professional, is not empirically definable, nor is it paid for with resources, money, or staff.

Summary of Relational Work in Psychology

Both Fletcher (2001) and Jacques (1993) believe much of the work of both women and nurses is hidden and not recognized as actions that define work. Without overt naming of the characteristics of relational and caring work as actual work, it continues to be ignored as activity that leads directly to goal attainment. There is limited work in psychology about relational work.

Relational Work in Business

In the business literature, there is a discussion of the centrality of relational work to being successful, specifically how relational behaviors impact different aspects of business success. Its importance to this dissertation is the recognition of the value of relational work to conceptual similarities – groups work together to accomplish goals; whether these are businesses, departments in an engineering firm, sales managers, or a

hospital unit. In addition, this literature demonstrates different dimensions of relational behaviors as independent variables and the impact on the dependent variables which are different aspects of a business's success.

Relational work in business is often viewed as the creation and use of relationships to achieve goals for the organization, the salesperson, or the business leader. In the business literature, it is often stated that the formation of relationships is necessary to create outcomes that are sustainable, beyond the accomplishment of technical tasks, such as winning a sales account, and vital to building positive mutual relationships with others in order to do work over time, not just in the short term (Benjamin, 2008). In addition, it is often stressed in the business literature that leaders must view their companies as a series of relationships, not a cluster of departments (Cunliffe & Eriksen, 2011; Manning, 2010). In fact, smart leaders recognize the use of soft power which recognizes the importance of collectivity, mutuality and networks, not hierarchies, in order for businesses to get ahead (Nye, 2008).

In analyzing psychological tests of more than 7,000 business professionals with the use of factor analysis, researchers found four specific dimensions of relational work. These factors were influence, interpersonal facilitation, relational creativity, and team leadership (Butler & Waldroop, 2004). The consequences of recognizing and rewarding these attributes in a management team, for example, is to help the organization keep on track, build connections within a group, and help to keep colleagues committed and engaged behind the scenes so that productivity reaches a higher level. However, the researchers cited Fletcher (2001), stating that while this relational work contributes to the

productivity of a team or company, it is often overlooked as real work. This is perilous for any business situation because employees do that for which they are rewarded.

Research examining relational behavior in the business literature includes a study on how relational governance improves coordination of business efforts and performance outcomes (Stephen & Coote, 2007). This study tested a model that was organized such that perceived relational behaviors were the mediators that impacted efforts to achieve goals. The data were collected on nine constructs that make up this conceptual framework. These nine constructs were leader support, leader feedback, flexibility, exchange of information, trustworthiness, goal alignment, financial performance, solidarity and behavior-based monitoring (Stephen & Coote). Relational behaviors were defined as actions that create the conditions needed to achieve goals. There are understandings, or norms, of mutuality of interest within the business relationship. These relational norms fill the spaces between explicit contracts and understandings.

Mail surveys were sent to construction contractors and sub-contractors for a total sample size of 76. The researchers found that relational behaviors mediated the relationship between relational governance and goal alignment. Practically speaking, this means that relational governance is a positive avenue to solving problems between management and workers. This research extends the business literature beyond formal management approaches and explicit communication lines.

Another recent research study by Hormiga, Batista-Canino, and Sanchez-Medina (2011) looked at the impact of non-tangible relational attributes on the success of new businesses. The authors defined relational capital with the following dimensions:

relationships with customers and suppliers, support from informal relations, reputation, external linkages, connectivity, location of the business, and physical image of the business. Relational capital was the idea that businesses cannot be thought of as independent systems, but instead depend largely on the relationships they create in their environment. They measured the impact of these assets of relational capital, or the independent variables, on the dependent variable, or the subjective understanding of success of the new business startups. A questionnaire was used to measure the participant's perception of each of these variables. The participants (n=130) were company owners. They found that the most important assets of relational capital on the success of a business were the informal support from family and friends ($r=.91$) as well as location of new businesses ($r=.53$). The findings did not support one of the hypotheses of the study which was that the amount of time dedicated to creating relationships with customers and suppliers would have an impact on success. Instead, personal ties with family and spouse, which give emotional support during business startup, were critical. Location of business was listed as a part of relational capital, which may reflect the number of times a business person has to interact with customers increases, but is not reflected in the measurement of time spent with customers.

Another study in the business literature, by Leuthesser and Kohli (1995), examined seven aspects of relational behavior on the influence of a buyer's satisfaction. A questionnaire was sent to business people, selected at random, from a central data base (n=454). The scales that measured the seven aspects of relational behavior were adapted from existing scales or developed by the researchers for their study. The seven aspects of

relational behavior, according to the model they present, were: initiating behavior, signaling behavior, disclosing behavior, interaction frequency, richness, lateral involvement, and vertical involvement (Leuthesser & Kohli). They found that initiating, signaling, and disclosing behaviors, as well as frequency of interactions, were strongly related to satisfaction of the buyer. Together, initiating, signaling, and disclosing behaviors were central to achieving mutual goals between the supplier and the buyer. Initiating behavior was when a supplier attempted to understand what a buyer needed and helped them attain it. Signaling was when a supplier gave information to buyers about changes to programs ahead of their occurrence. Disclosing was when a supplier gave honest and sometimes negative information about the company in order to demonstrate trust in a buyer.

Summary of Relational Work in Business

The literature surrounding relational work and relational behavior in the business discipline reveals attempts at quantifying what has historically been seen as an intangible and less important part of improving business outcomes. The literature identifies the understanding of mutual goals between one side of the business relationship and the other, filling spaces where traditional lines of communication fall short, and anticipating needs of the other half of the business relationship.

Nurse Staffing and Outcomes

As stated at the start of this dissertation, the focus of this work was to understand the how of non-technical nursing work. Part of understanding the depth of this topic was realizing the gap in how we as a profession organize ourselves, practically, each day on

each shift, to care for patients. Currently nurse staffing is based on, as research has shown, an uninformed and unaccountable system that holds the nurse responsible for outcomes but does not measure work in its entirety. Staffing continues to be a mysterious moving target, despite decades of examination. It may be that in fact the process of work, as some literature alludes to, is simply not explicated and understood (Needleman, 2008), thereby masking the totality of a day's nursing work. Therefore, the literature review of this dissertation is examining the literature of staffing and outcomes.

The American Nurses Association (ANA) maintains that a solution to appropriately staffing hospital units is as unclear and unscientific today as it was in the early 1980s (Weston, Brewer, & Peterson, 2012). Factors such as quick changes in census and increased patient acuity levels continue to hamper a concrete staffing solution. The ANA has continued to search for an adoptable plan for staffing that will result in patient safety, quality care, and, ultimately, better health for the nation. Their direction for staffing in today's healthcare environment include examination of selected core staffing components, principles related to the patient, principles related to registered nurses and other staff, principles related to the workplace, and the practice environment. Ultimately the organization must recognize the value of nurse staffing and the impact it has on the level of quality of care. These principles largely examine patient acuity, experience, autonomy and competency level of the nurse, adequate support services and time for documentation by the nurse, and nurse staffing to ensure safety of patient and nurse environment.

Harper (2012) used information technology to develop a pilot program that evaluated staffing needs based on observation of nursing work and data from patients' medical records. The research question was: "What are the factors that are significant to measuring nurse intensity?" (p. 263). Observation of nursing work, over a 72-hour period, was broken into three categories: direct patient care, indirect patient care such as preparing medication, and unit related care such as shift report. The data collected from the electronic health record included orders, documentation, clinical events and care plans. She attempted to identify activities that related to how nurses spend their time and impact on staffing numbers. The sample included ten patients observed, and six RNs who participated (three working days and three working nights, each doing 12 hour shifts). The results of the study were to be used to create a framework called the Clinical Demand Index that would calculate nurse intensity by looking at factors of how nurses use their time, use health informational technology data mining to understand data types, and identify factors that are closely related to nursing intensity. She stated that this pilot study work has contributed to the necessary knowledge because, "...knowledge driven health care processes must be created" (Harper, 2012, p. 267) in order to make staffing decisions based on evidence.

Canadian nurse researchers (Hall et al., 2006) conducted interviews (n=20) with different stakeholders in the nurse staffing decision making process, including nurse leaders, managers, direct care nurses, as well as union and nurse leaders in Canadian government. They were asked to discuss their perceptions of nurse staffing decision-making processes, supports for nurses, nursing workloads, and perception of nursing care

and outcomes. The data from the interviews were aggregated into themes. Overall, the findings were that nurses stressed that a lack of commonality in approach to staffing was a major problem to staffing appropriately. Participants discussed frameworks for staffing, nurse-to-patient ratios, as a solution, along with nursing workload measurements and use of intuition or gut understanding of staffing needs. The study underscores the need to work more succinctly with evidence and policy to create a more uniform understanding to nurse staffing.

Brooten and Youngblut (2006) described the concept of nurse dose as the essential component in the delivery of safe, high quality care. Their conceptualization was developed through a review of the literature from the disciplines of nursing, health services research, and medicine. The parts of nurse dose were identified as dose, nurse, host, and host response. A larger view of dose incorporates the number of nurses per patient available in a city or state. The more focused view incorporates nurse time and the number of contacts the nurse makes. The nurse part of nurse dose includes the nurse's experience, education and expertise. The host is the organization and the features of the organization; or, the host is the patient. The response of the host includes the response to the nurse's autonomy and how accepted he or she is. It was concluded that the greater the nurse dose is, the lower the level of patient mortality and morbidity. The authors argue that while more nurses per patient decrease negative outcomes, simply increasing the number of nurses is not adequate. Instead, through their review of literature, they demonstrate the importance of equal dosing of each component of nurse dose to make an effective impact on patient outcomes.

Manojlovich and Sidani (2008) continued the notion of nurse dose. They conducted concept derivation from dose and nurse dose. They also conducted a concept analysis to conceptualize the amount of nursing work necessary to effectively care for patients. Their resulting definition of nurse dose was "...the level of nursing reflected in the purity, amount, frequency, and duration of nursing care needed to produce favorable outcomes" (Manojlovich & Sidani, p. 310). The authors provided the four dimensions of nurse dose as representations of education, experience, total number of nurses per shift, and nurse to patient ratio. These elements together created a certain level or concentration of nursing care. However, with further analysis of the components of nurse dose (Manojlovich, Sidani, Covell, & Antonakos, 2011), they were unable to extract substantial data to support their initial concept of nurse dose beyond the importance of intensity. They measured active ingredient, reflected by measuring the level of the nurses' education, experience and skill mix. Intensity was reflected by quantifying the number of nurses per shift, with a low number of patients per nurse that impacted patient outcomes. Secondary data analysis was used for bivariate correlation and regression of nurse dose attributes on methicillin resistant staphylococcus aureus (MRSA) infections and patient falls. Active ingredient was significantly correlated with MRSA infections ($r = -.43, p = .03$) and patient falls ($r = -.44, p = .03$), as was intensity (MRSA, $r = -.70, p = .001$; reported falls, $r = -.44, p = .03$)" (Manojlovich et al., 2011). Ultimately the authors recommend that nurse staffing is not the only representation of good nursing care and that nurse staffing does not represent all of nursing's actions. Further research is necessary to understand the totality of nursing's impact on patient care outcomes.

In a retrospective observational study, Needleman and colleagues (Needleman, Buerhaus, Pankratz, Leibson, Stevens, & Harris, 2011) examined the association between mortality and exposure to nursing shifts that had nurse staffing below a targeted level, as well as the association between mortality and high patient turnover that resulted from admissions, discharges and transfers. Both of these associations were found to be significant and they recommended that nurse staffing be maintained at at least targeted levels in order to account for the turnover of patients on any given shift and the amount of turmoil these daily changes cause to nursing care. The data were from a large academic medical center for which the total number of admissions was 197,961 and 176,696 of eight hour nursing shifts in 43 hospital units.

Dr. Marcelline Harris (personal communication, email, March 20, 2011), one of the authors of this study, when asked by the writer of this dissertation, if nurse ratios, such as those that exist in California, would have mitigated the association between mortality and turnover, stated that ratios would not have produced adequate staffing levels because they do not reflect responsive staffing to needs of both nurse and patients. The authors further recommend that, based on their findings, the discussion about whether nurse staffing affects outcomes or not is no longer the correct question to ask. Instead, the discussion should focus on how providers can guarantee adequate and effective staffing. This was stated by Needleman (2008) who argued that private insurers have limited knowledge on quality and what impacts quality, such as nurse staffing, that reflects needs of both the patients and the nurses on any given shift. He insisted that pay

for performance systems do not pay enough attention on the processes of nursing care to be able to incentivize it.

Nurse scientist Linda Aiken and colleagues, through numerous qualitative and quantitative research studies have demonstrated the association, detailed below, of nurse staffing numbers on both patient outcomes and nurse satisfaction, turnover, and burnout. In one such study, Aiken and colleagues (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002) examined the association between the nurse-to-patient ratio on two outcomes, patient mortality and failure to rescue, as well as factors related to nurse retention. They used cross-sectional analysis of linked data between nurses and patient outcomes for over 10,000 nurses and over 230,000 orthopaedic and vascular surgery patients. They found that for each additional patient that the nurse cared for, the odds of that patient dying within 30 days of discharge increased by 7% as well as a 7% increase in failure to rescue and die from complications. Job satisfaction was measured with a question on a four-point scale and burnout which was measured with one portion of the Maslach's Burnout Inventory (Maslach, Schaufeli, & Leiter, 2001) for emotional exhaustion. In hospitals with high patient to nurse ratios, nurses were more likely to be dissatisfied with their job and suffer from emotional exhaustion.

In a second study, Aiken and colleagues (Aiken, Sloane, Cimiotti, Clarke, Flynn, Seago, Spetz, & Smith, 2010) used primary survey data from three states, California, New Jersey, and Pennsylvania, to examine workloads, staffing levels, and patient outcomes such as patient mortality and failure to rescue, as affected by these levels. Their interest was hospital staff nurses and they asked them to give their name of the hospital

they worked at, and information such as patient loads and numbers of nurses and patients on the last shift they worked. They took the responses and aggregated them, creating empirical data for each hospital. California has mandated minimum patient to nurse ratios since 2004, which was two years before the study took place. California nurses cared for, on average, one to two less patients per shift than the other two states and these lower patient ratios were associated with lower patient mortality than in the other two states. In addition, California nurses experienced lower burnout and turnover, which are outcomes predictive of better nurse retention.

A systematic review and meta-analysis of literature that looked at the association of registered nurse staffing levels and patient outcomes found that such an association did exist (Kane, Shamliyan, Mueller, Duval, & Wilt, 2007). The authors reviewed twenty-eight studies that reported adjusted odds ratios of patient outcomes in association with nurse to patient ratios. Increased nurse staffing was found to be associated with lower chances of hospital related death and adverse patient events, such as hospital acquired pneumonia, unplanned extubation, failure to rescue, and nosocomial bloodstream infections. Similar to what was found in the work of Needleman and colleagues (2011) and Needleman (2008), this systematic review demonstrated that even though acuity systems reflect changes in patient needs, the staffing level is not adjusted according to nursing needs that increase with the turmoil of discharges, transfers and admissions per shift, which significantly affect quality of nursing care. This review also stressed that the way to achieve good patient outcomes is through adequate nurse staffing as well as process factors of nursing work.

Summary of Nurse Staffing and Outcomes

These empirical studies demonstrate that nurse staffing and outcomes are linked. Better staffing is associated with better outcomes, for the patient and the nurse. However, what is not understood is how to create a nurse staffing blueprint that not only is cost effective for the payer and the hospital, but is representative of how the nurse works and how much the nurse works. In each of these articles, the question remains as to how to understand and therefore quantify the process of nursing work in order to be recognized as contributing value to outcomes. The literature has named the desired outcomes, but not how to capture and pay for the value of the nurse.

Interprofessional Collaboration and Nursing

Interprofessional collaboration (IPC) is the breaking down of silos of various professions and their distinct knowledges and work spaces in order to work together to meet the goals of not only the patients, but the health care team. IPC necessitates the collective, rather than the individual, when working to achieve goals. This section of the dissertation is a presentation of a selection of the research literature that examines IPC. As the importance of IPC in the work of healthcare teams grows, the concept of IPC has emerged as a complex process that is the umbrella term for many concepts such as cooperation, mutuality, communication processes, interdependence, blurring professional boundaries, and the culture of workplaces (Croker, Trede, & Higgs, 2012).

A phenomenological study aimed to highlight the experiences of collaborating on rehabilitation teams (Croker, Trede, & Higgs, 2012). Through the research they were able to identify the meanings of collaboration and the importance of seeing a professional on a

team, beyond the person's professional identity, and being cognizant of connected and interpersonal abilities. The method of research was hermeneutic phenomenology which interprets and makes visible lived experiences of the phenomenon under study. There were three research questions: "1) What is the nature of the lived experience of collaborating in rehabilitation teams? 2) How is collaborating experienced by team members? and 3) What dimensions of collaborating are evident in these experiences?" (Croker et al., 2012, p. 14). The sample consisted of 66 team members (medical, nursing, occupational therapy, speech therapy, and social workers) across nine teams in Australian hospitals. The researchers conducted observations of case conferences of rehabilitation teams. The team members were interviewed after the observation of the conference that was attended. Patients and caregivers (n=11) were also interviewed. Researchers' journals were analyzed with codes first, and then with descriptive codes, and finally with conceptual codes, to demonstrate the essence of the meanings. Interpretation of themes provided a meaning of higher abstraction of the data.

Their findings included dimensions of collaboration across teams and disciplines (Croker, Trede, & Higgs, 2012). The dimensions were engaging with other people's diversity, entering into the form and feel of the team, establishing ways of communication, envisioning together frameworks for patients, and effecting changes in people and teams. In addition, the dimensions of collaborating included reflexivity, or critical reflection of self in relation to others, reciprocity where mutuality of roles was enabled, and finally responsiveness, which is making and facilitating appropriate adjustments for goal attainment. From these dimensions, a list of reflective questions that

could be used to inform the creation of a collaborative practice were put together. The questions are a pragmatic use of research findings that could facilitate further research, such as an intervention.

A second research study (D'Amour, Ferrada-Videla, Rodriguez, & Beaulier, 2005) confronted the vital role of IPC and the limited knowledge of the complexity of interprofessional relationships within IPC. These authors conducted a literature review to recognize conceptual frameworks; specifically to look at definitions of collaboration in the literature and theoretical frameworks of collaboration. Databases, including Medline, CINAHL, PsycINFO, Sociological Abstracts, and ProQuest were searched during a 13 year period (1990-2003). Key words searched included interdisciplinary, multidisciplinary, interprofessional care, and team work. From 588 abstracts, 80 were retained. Two independent reviewers examined the 80 papers and searched for those in which collaborative care took place, noting the type of methodology, conceptual framework use, and its scientific strength. The reviewers found 17 papers discussed definitions associated with collaboration and 10 with collaborative care frameworks.

In the literature related to collaboration, the most mentioned common themes were sharing, partnership, interdependency, and power (D'Amour, Ferrada-Videla, Rodriguez, & Beaulieu, 2005). Teamwork concepts often used the terms interdisciplinary, multidisciplinary, and transdisciplinary interchangeably. The terms seemed to portray different amounts of collaboration on a team. On the one hand, collaboration on a team was a continuum of a professional's autonomy. On the other hand, the team as a group was autonomous, and its team members were well integrated,

but each professional on the team had less autonomy. Several frameworks on collaboration were found, but many of the frameworks looked at the issues related to the organization, composition, and settings of the collaborative activities, instead of addressing the collaborative processes of the teams. However, analysis of the models was able to indicate certain common points; many of the models took environmental, or space, factors into account. They also found that authors of the conceptual frameworks have imagined different outcomes of collaboration. However, most frequently it was found that outcomes were clinical outcomes, and defined in terms of the quality of care.

Another group of researchers reimagined the term “nurses’ station” to be “health team hub” (Gum, Prideaux, Sweet, & Greenhill, 2012). They conducted a collective case study of three hospitals to explore the collaborative work in the hospital. The physical environment was found to have a significant impact of collaborative practice. Ethnographic methods, such as observation and semi-structured interviews, were used. There were 33 interviews, one focus group, and 44 hours of observation. Observation excluded entering patient rooms when on hospital units. An observation tool was created by the researcher to provide a framework to organize the observations. The categories included setting, roles, activities and interactions, communication, collaboration and teamwork. Notes were descriptive. Observations occurred at the nurses’ station and in hallways. Interviews were conducted in the hospital. There were eight semi-structured questions to understand how the staff perceived their work environment and collaboration with other team members. The data were coded on multiple levels and the researchers made interpretations about the themes. Findings included understanding the nurses’

station as a symbolic space and a type of symbolic power. They described a power within the social space of the nurses' station, which they theorized as creating a social division and a separateness between the doctor and the nurse, increasing perceived discontent with one another's work.

Interprofessional collaborative educational competencies have been laid out in an interprofessional report of an expert panel (Interprofessional Education Collaborative Expert Panel, 2011). The vision of the group, comprised of experts from nursing, pharmacy, osteopathic medicine, public health, dentistry and medicine, was to create interprofessional competencies in an effort to achieve safe, high quality, patient-centered care. While teamwork amongst health professionals is a given, the goal of interprofessional learning is to prepare students of all health professions to work together in a deliberate fashion. The panel reiterated the work of the Institute of Medicine's (Institute of Medicine, 2004) report that looks towards decreasing preventable mortality and morbidity by decreasing errors in US hospitals. How care is delivered is as vital as what the care is that is delivered. The *how* is the prerogative of the report – effective teams and reimagined systems that break down the silos of professional activity and look at teaching practical means for achieving interprofessional collaborative practice.

Interprofessional education is seen as a means to improving patient and community care. To this end, the panel created four domains of core competencies for interprofessional collaborative practice: values/ethics for interprofessional practice, roles and responsibilities, interprofessional communication, and teams and teamwork. The

collaborative competencies represent those that each profession must work with others on in order to achieve goals.

The first competency domain is a description of values and ethics for interprofessional practice. These values and ethics are a new frontier in the creation of creating a professional identify; one that includes the interprofessional aspect of ethics. The focus of the expert panel was on values that should underpin the relationships as these exist and grow among the professions and in relationships with patients. The foundation of effective relationships is mutual respect and trust in order to collaborate across the professions. Organizational behaviorist Gitell (2008) is cited for her linkage of values and care coordination in health care, stating that if the recipient of accurate and timely information is not respected, the information will not be heard or acted upon.

The second competency domain is a description of roles and responsibilities and how these interface and complement one another. In order for interprofessional collaboration to be effective, each profession's roles must be able to be clearly identified in conjunction with the ability to identify the roles of collaborating professions. The diversity of expertise among the healthcare team is a hallmark that strengthens effective teams. However, stereotypes that are collectively held among one group about other groups on the healthcare team can undermine effective communication amongst the team, because these stereotypes erode mutual respect. These inaccurate perceptions prevent a full spectrum of work to be recognized and utilized. Thus, the interdependency of relationships with other professions is necessary to improve care and advance learning.

The third competency domain is a description of interprofessional communication. It is recognized that communication is a core aspect of collaborative practice. Nonetheless, health professionals have little training with effectively communicating, and little education to achieve this vital skill. Effective interprofessional communication occurs when members of the healthcare team are available in place, time and knowledge, as well as being able to receive information, and listen fully in order to be effective. Effective communication involves expressing opinions with confidence, clarity, and respect, as well as to actively listen and respect ideas and opinions of the other team members.

The fourth competency domain is a description of teams and teamwork. Good teamwork behaviors are necessary to enact shared goals for patient care. Teamwork behaviors include collaborating in delivering care, and coordinating care with others on the team, so that there are decreased gaps in care, as well as reduced redundancies, and ultimately that errors are avoided. This teamwork involves shared problem solving and decision making. One must be competent in avoiding conflicts over leadership by staying focused on the ultimate goal of the team, which is the patient's health. One needs to be able to value all team members' contributions. Disagreements need to be managed constructively by engaging and committing to conflict resolution.

Summary of Interprofessional Collaboration and Nursing

IPC is a cohesion of professions aimed at effective and efficient patient and healthcare outcomes. IPC is evolving as professions work together to determine mutual goals and processes that engage in more than theory, but to create communication lines

and spaces as well as organizational expectations to effectively enact IPC. Education of multiple professions on enacting IPC practices is being taught to those entering healthcare so as to effect new generations of healthcare culture. One physician noted that (Interprofessional Education Collaborative Expert Panel, 2011) while he learned to identify microbes under a microscope in medical school, he did not learn how to work with the strengths of the other members of the healthcare team, a skill that he wishes he had learned because it is in fact what he needs it to be able to do his job well.

Chapter Summary

This chapter focused on the breadth and reach of relational work, from the private dyad of the nurse patient relationship to the multi-professions encompassing processes of IPC. The literature of nursing, psychology, organizational behavior, business, staffing and outcomes, and IPC literature have been presented. Common core elements are mutuality of goals on all sides, recognition of the value of relational work as active work, the difficulty of capturing and quantifying relational work as work, and its vital role in achieving outcomes. Non-nursing disciplines, such as organizational behavior, psychology and business have steadily built research knowledge about relational work, its existence, and value. Interestingly, IPC posits relational work as a new manner of team work. Much of nursing's work is still considered invisible (Jacques, 1993; Manojlovich, 2007; Vlasses, 1997).

CHAPTER THREE

METHODS

The focus of this study is the process of relational work of nurses. In this chapter, methods that were used to conduct the research are explicated. Specifically, the topics this chapter includes are research design; setting and sample; the recruitment of participants; data collection, management and analysis; methodological rigor; as well as ethical considerations of this study. The grounded theory method (Glaser & Strauss, 1967) was used to conceptualize the process of non-technical nursing work. The creation of a grounded theory aided in explaining relational work, and also in discovering how nurses engage in relational work; thereby moving beyond description to theorizing (Glaser, 1978).

In grounded theory, the researcher must be sensitive to how those experiencing the phenomenon interpret and give meaning to their experience (Glaser, 1978). Grounded theory allows for the discovery of substantive theory to explain social processes (Glaser & Strauss, 1967). Relational work of nurses is, to a great extent, work that is located in the social realm, thereby complying with the assumption of gleaning understanding of a social process through grounded theory.

Research Design

A naturalistic inquiry approach was used for this research. According to Lincoln and Guba (1985), there are five axioms that are characteristic of naturalistic inquiry that

need to be present when designing research. The first axiom reflects the assumption of the nature of reality, or ontology (Lincoln & Guba, 1985). Naturalist inquiry assumes that there is not one, single reality to discover, but that there are multiple, constructed realities. In this study, the researcher was not trying to validate a predetermined truth, but instead uncover the reality of the direct care nurses as they engage in relational work. The researcher used interview data and researcher memos as two types of data to assist in constructing this reality. The second axiom is that the “knower and the known are interactive and inseparable” (Lincoln & Guba, p. 37). In this study, the researcher interviewed the participants; looking to the participants for their unique knowledge about the social process under study. The researcher’s basic understanding of local concepts of relational work allowed for a foundational interview process to occur. The third axiom is that inquiry will conceptualize knowledge in the form of “working hypotheses” (Lincoln & Guba, p. 38). In this research, the researcher discovered hypotheses that explicate the process of relational work of nurses. The discovery of working hypotheses during the research process is a key element of grounded theory (Glaser & Strauss, 1967). The fourth axiom is that “entities are in a state of mutual simultaneous shaping” (Lincoln & Guba, p. 38), underscoring the inability of research to determine causality. Instead, there are effects of entities on one another. In this research, the researcher attempted to uncover the categories of the process of relational work of the nurse and how these categories shape one another. The fifth axiom is that “inquiry is value-bound” (Lincoln & Guba, p. 38). In this study, the subject of the inquiry was influenced by the researcher valuing the explication of the process of relational work.

Setting

The study was conducted in an urban teaching hospital in a major city in the Midwest. The hospital has 559 in-patient beds with over 25 in-patient units. The hospital has Magnet® designation for nursing care.

Sample and Sample Size

A purposeful sample of direct care registered nurses comprised the sample for the study. Purposive sampling was the selection of individuals for the study according to their particular knowledge of the process for the purpose of disseminating that knowledge (Speziale & Carpenter, 2007). The target sample size of nurses was 25, and the final number was 23. Twenty-five was an estimation based on a review of previous grounded theory dissertation research work over the past ten years. However, data were collected until the categories are saturated and no new data emerged. The researcher conducted theoretical sampling, the process of collecting data to generate theory; part of theoretical sampling involves deciding what data to collect and where to find these data to develop the emerging theory (Glaser & Strauss, 1967).

The inclusion criteria for the participants were registered nurses who provide direct patient care in a staff nurse role on any inpatient unit at the study site. Exclusion criteria were registered nurses who carry out direct patient care in a non-staff nurse role such as advanced practice nurses. Exclusion criteria were also registered nurses who were clinical nurse managers, in roles such as nurse navigator, or care coordinators, or other types of clinical nurse workers such as licensed practical nurses and nurse technicians. They were excluded from the sample because the focus of this research was

to identify the basic and universal process of relational work of registered nurses in the direct patient care staff nurse role and their work with others. When, during data collection and data analysis, the participants discussed relational work with these other nurses in particular, it emerged from the data. This type of finding pointed to further research.

Recruitment of Participants

In order to recruit the sample of registered nurses for the interviews, the researcher approached the head of nursing education at the hospital. The head of nursing education asked the nurse manager who leads weekly hospital-wide manager meetings if the researcher could present her study to the managers at their meeting. At the meeting, the researcher spent ten minutes presenting the study and answered questions. The researcher then followed up with an email to the inpatient nurse managers and attached the IRB approved study flyer, asking them if she could present the study to their staff nurses. When a manager agreed, the researcher went to the unit at the agreed upon time and spent 1-2 minutes presenting the study, handing out the IRB approved study flyer, and posting it in a common area on the nursing unit. When a nurse was interested in participating, the nurse and the researcher would establish a date, time, and place to meet for the interview. When a potential participant called the researcher, the researcher provided any further information requested, and answered any questions the potential participants may have had.

The researcher offered a token of appreciation to the participants, a \$10 gift card to a coffee shop; this was posted on the flyer. If a participant recommended other

participants, as is in line with the snowball, or networking, method of sampling, this was also acceptable to recruit the sample. The nurse that was recommended by the nurse who had already participated in the study had to have been an employee of the hospital where the research was occurring, as well as meet inclusion criteria for the study.

Data Collection

Data collection occurred through face to face interviews. The interview meetings took place either in a quiet, private area of the hospital if permission was given by the hospital, or a private meeting place outside of the hospital.

Before starting the interview, the researcher asked the participants if they had any questions. The interviews were conducted in a conversational manner so as to make the participant feel comfortable. The participants were reminded that the information that they shared was confidential so they felt able to express themselves. The interviews were recorded with a digital recorder. Once any questions were answered, the researcher gave the participant the informed consent to sign. When the participants said that they agreed to move ahead, the researcher read the informed consent, asked the participants if they had any questions, and then asked them to state that they understood the informed consent, and if they agree to the research. They signed the consent before starting the interviews.

The researcher then asked demographic questions of the participants. Specifically, the researcher asked them their age, amount of time in months or years working as a registered nurse (RN), amount of time in months or years working at the current hospital,

amount of time in months or years working on the unit on which they currently work (see Appendix A).

According to the grounded theory method, the interview process begins with basic questions for the participant that aim to uncover the reality of the phenomenon of interest as experienced by the research participant (Glaser & Strauss, 1967); in this research, the process of relational work that the nurse carries out. The researcher begins the study with a partial framework of what Glaser and Strauss call “local” concepts (1967, p. 45). These local concepts form the basic structure of the initial interviews (see Appendix A). The concepts give an initial understanding of research focus (Glaser & Strauss).

The goal of qualitative, in-depth interviewing is to have a deep understanding of the topic. This is achieved by confronting the complex nature of the topic when many, often overlapping themes occur that are sometimes in conflict with one another (Rubin & Rubin, 2005). The interviews were structured as a conversation (Rubin & Rubin). In order to dive below initial, often shallower, statements, the researcher had to probe for depth with additional questions; asking for details, examples or stories that represented what had been mentioned. The researcher created future questions based on what had been said. This approach required flexibility on the part of the researcher (Rubin & Rubin). The reality of the experience can emerge only from the data and cannot be predetermined, as theoretical sensitivity occurs during the simultaneous interviews and coding, more specific questions emerged to guide subsequent interviews. Subsequent interview questions changed based on the emerging concepts from the data. Data were systematically obtained from in depth interviews that included probes for depth, detail,

and examples. For instance, a probe was: “Can you say more about that?” or “Can you give me an example of when that occurred?” or “I’d like you to go back to when you said _____ and tell me more about that.” All interviews ended with the question: “Is there anything else you would like to tell me?” This gave the participant permission to divulge information that they may have not felt initially relevant, but decided they needed to share regarding the experience.

Data Management

The digital recordings were transferred to a drop box that was online and could be accessed by the transcription company. The transcriptionist was asked to sign a confidentiality agreement. The interviews were transcribed, word for word, by a transcriptionist. The researcher viewed the transcriptions on her home computer and printed the transcriptions. Verification of each transcript was conducted by the researcher. The researcher listened to each audiotape while reading the transcript and wrote in any corrections noted onto the transcript, as well as deleted and replaced any identifying information.

Each interview participant was given a study number. The master list of study numbers was maintained in a locked drawer at the researcher’s home office. The transcripts contained only this individual number to protect confidentiality. No names were attached to the transcribed interviews and there were no identifying markers. The transcripts were stored in a locked file cabinet at the researcher’s home.

Any potentially identifying information was changed to a pseudonym in the writing of the research findings. Any memos or notes that the researcher made while

conducting the interviews, or during the analysis process, were kept in a locked file cabinet at the researcher's home as well.

Data Analysis

The research question "What is the process of relational work of the nurse?" was best understood by asking the people experiencing it. In this research study, both data collection and data analysis conformed to the process of grounded theory method of Glaser and Strauss (1967).

The purpose of grounded theory is to generate theory from data. Qualitative data analysis involves the understanding of words, language, and their meaning (Walker & Myrick, 2006). Data are systematically obtained from participants who provide interview data. Findings from the analysis are used to generate a substantive theory (Glaser & Strauss, 1967). This process is called constant comparative analysis; it a strategic method used to discover empirically derived theory. The interviews were transcribed verbatim and analysis began after the first interview was conducted. The researcher conducted concurrent data collection and analysis in order to be sensitive to the emerging theory (Glaser, 1978). Constant comparison techniques permitted theoretical hypotheses to emerge during the data collection and analysis process. The researcher was open to learn the participant's reality about the phenomenon of interest.

Data analysis was conducted on three levels. Level one was the creation of substantive codes whereby the researcher codified the interview data and used the words of the participants to create the codes. As many codes as possible were created at this point (Speziale & Carpenter, 2007). The transcript was examined for words and phrases

that represented potential codes. Data from the second interview were compared to the data and codes from the initial interview. Data that fit initial codes were added to the coding sheet and new codes were added to account for the discovery of new codes. As new codes emerged, follow up questions were added to the interview guide to explore the new codes further. This was the start of an emerging understanding of the data from the interviews. All data that had the same properties were put into the same tentative category. If some data did not fit with other data initially, a miscellaneous category was created. As more coding occurred, the researcher returned to these data to see where they fit.

The first three interviews were coded by the researcher and her dissertation chair, an expert in grounded theory analysis, independently. The researcher and her dissertation chair met to reconcile the coding. Once there was agreement on coding, the researcher moved forward with independent coding.

Data analysis began with open coding whereby the researcher compared what she was finding with previous data (Glaser & Strauss, 1967). As data analysis proceeded, codes and properties of the codes were determined and categories were identified. Second level coding, called axial coding, occurred when the researcher looked for relationships among and between categories. Theoretical properties of each category were determined and dimensions of the categories became clearer (Glaser & Strauss, 1967). Identifying these dimensions also provided depth to the categories and facilitated the researcher in discovering how categories were conceptually related to one another in explicating the social process being studied. Negative cases, those cases with properties that were

counter to the stronger, or more explanatory, categories that were discovered emerged as well. The researcher continued coding for these categories to see if they saturated using theoretical sampling. The differences between these cases strengthened an understanding of the prominent categories by incorporating and demonstrating thickness of theoretical features (Glaser & Strauss, 1967).

The researcher was able to work out hypotheses that arose from the data analysis with the participants during the interviews. Selective coding allowed for the identification and description of the core category of the data (Glaser & Strauss, 1967). As the researcher continued to analyze data, a reduction in the original list of categories occurred that delimited the theory (Glaser & Strauss, 1967). A core category emerged from the data which had the most explanatory power of the theory (Glaser, 1978). The core category occurred frequently in the data and was related to all other categories in the data. It represented the majority of variation in the pattern of the behavior under study (Glaser, 1978). Level three coding occurred when conceptual definitions, directly derived from the data, were determined and the theoretical nature of the theory was mapped. The conceptual definitions can be operationalized for future survey measurement.

During the data analysis process, the researcher became theoretically sensitive to the conceptual nature of the data. Theoretical sensitivity is blocked when the researcher conducts research with a predetermined set of ideas that guide what he/she is looking for in the data. When preexisting categories were found in the data analysis, they were included in the theory, but only because they emerged from the study data also. To safeguard a priori categories from influencing the theory generation, the researcher

bracketed his/her pre-conceived ideas regarding the potential meaning of the phenomenon (Starks & Trinidad, 2007). The process of being sensitive to the conceptual meaning of the data from social situations required being open and creative as well as protecting against forcing the data into preconceived categories. The development of grounded theory was not a linear process (Glaser & Strauss, 1967; Glaser, 1978). Instead, the researcher returned, over and over, to the data and data analysis, to understand the reality of the participants as they experienced the phenomenon in real time and how their experience could explain a substantive process.

Theoretical saturation occurred when no new data were found from the interviews and the researcher could add no more information to the categories (Glaser & Strauss, 1967). The data collection and analysis occurred until each relevant category was saturated. If a new category emerged from the data half way through the research process, the subsequent participants were asked directly about that category to confirm, or disconfirm, that this category represented the participant's experience.

Part of constant comparison is memoing. Memoing is a way in which the researcher's thoughts are recorded while working closely with data (Glaser & Strauss, 1967). The writing of memos occurred during coding. Memoing thereby served as an illustration of ideas, highlighting the researcher's thought process during coding (Glaser & Strauss, 1967). Memoing served the additional function of serving as an audit trail in which the researcher kept track of the meaning of the emerging concepts and potential hypotheses (Starks & Trinidad, 2007). As Glaser (2002) pointed out, "all is data" [sic]. Theoretical conceptualization occurred between the categories as data analysis of codes

and categories were refined, links among categories were discovered, and the most conceptually parsimonious theory was determined. Once the researcher had completed this data analysis process, with the creation of categories, properties of categories, and hypotheses that linked the categories, an analytic framework emerged that formed a substantive theory (Glaser & Strauss, 1967). This substantive theory explicated the process under study and corresponded intimately with the data.

As Glaser (1978) stated, the goal of grounded theory is to create a theory that explains recurrent behavior that is significant. The organization of social behaviors that happen over time, and are elementary and recurrent processes, are termed basic social processes (BSPs) (Glaser, 1978). The discovery of a BSP happens around a core category, but not all grounded theories have a BSP (Glaser, 2002). While these patterns of a BSP are elementary, there are substantial variations within them, allowing them to remain durable to the fundamental process they conceptualize. BSPs are hallmarked by explicating a temporal process that has discrete stages of behavior.

Methodological Rigor

The goal of rigor in qualitative research is to truthfully demonstrate the experience of the participants (Speziale & Carpenter, 2007). Rigor is achieved by the researcher's attention to, and confirmation of, discovery of data's meaning/knowledge. The process by which understanding is achieved in a study must be transparent to those reading the study, in order for faith to be placed in the worthiness of the study. Rigor was ensured in four ways: transferability, dependability, confirmability, and credibility (Lincoln & Guba, 1985). Demonstration of rigor specifically for grounded theory is

discussed according to Glaser and Strauss (1967). The evidence for rigor is addressed in Chapter 4.

Ethical Considerations

The research proposal was submitted to the IRB of the institution, as well as the Loyola University Chicago for approval. Qualitative studies are dynamic processes involving human beings, emotions, and their experiences. These properties give qualitative research its richness, while simultaneously creating unanticipated situations. Therefore, the researcher was open to unforeseen ethical concerns (Speziale & Carpenter, 2007). The participants were involved in the process of informed consent. This process maintained the ethical principle of autonomy for the participant. The participant was given adequate information regarding the process of researcher and they had the power to decline further involvement (Speziale & Carpenter). The participant had the right to decline to answer any question as well as to stop the interview at any time. The participant was also told that they can request that the recording be stopped at any time. The nurses were asked to speak freely and the researcher would adjust or delete any identifying information from the transcript. The researcher stressed the fact she would not use this information in subsequent interviews so that the participant felt free to speak during the interview. This information was a part of the informed consent process.

The sensitive nature of qualitative research, which lends itself to the potential for embarrassment, misunderstanding, and conflicting values (Vivar, McQueen, Whyte, & Armayor, 2007), was in the forefront of the researcher's mind. The researcher gave reassurance to the participants that the information was confidential. Without

reassurance, the participant would not feel free to divulge information regarding the experience. During the interview, the researcher attempted to create a welcoming, non-threatening environment in which participants felt willing to share their experiences (Karnieli-Miller, Strier, & Pessach, 2009).

Chapter Summary

In this chapter, grounded theory has been discussed as a suitable method for answering the research question. This plan was carried out as a way to demonstrate that discovery of the dimensions of relational work was believed to be possible by approaching the research question from an emic position.

CHAPTER FOUR

RESULTS

The purpose of this chapter is to present the study findings that conceptualize the process of the relational work of hospital staff nurses. A discussion of the sample, recruitment, data collection, and analysis, conducted using the classical grounded theory method, are presented. A presentation of the findings follows and the chapter is concluded with a discussion of the components of methodological rigor.

Sample

Twenty-three direct care staff nurses who worked at one large Midwestern teaching hospital were interviewed face-to-face. The participants (22 females and 1 male) ranged in age from 24 – 62 years with an average age of 35.4 years. The nurses worked on their current unit an average of eight years, with a range of years worked on their current unit of six months to 35 years. The nurses had experience working as a staff nurses an average of 11.2 years, with a range of years of experience from 9 months to 40 years. Sixteen of the nurses worked in intensive care units and seven nurses worked on a floor.

Of the 25 nurses who emailed the researcher, 15 were interviewed. Five of the nurses were excluded because they were not currently employed as an inpatient staff nurse. Five of the nurses were not interviewed because they did not follow through with the further arranging of the interview. Eight additional nurses were recruited when the

researcher was on a unit and the nurse being interviewed asked other staff nurses working on that shift if they would also like to participate.

Data Collection

Data collection and data analysis occurred concurrently, in keeping with classical grounded theory methodology (Glaser & Strauss, 1967). However, in this chapter, data collection will be presented first, and then data analysis, for clarity of presentation.

The researcher conducted face-to-face interviews with the staff nurses. The study purpose was explained, informed consent was obtained, and the IRB approved consent document was signed by both the participant and the researcher. The interviews took place in the hospital in an empty manager's office, unit quiet room, call room, or staff room. The duration of the interviews ranged between 8 minutes to one hour and ten minutes with an average interview length of 27 minutes; the shortest interview (8 minutes) was the final interview and the longest was 25 minutes longer than the next longest (45 minutes). These two were outliers in that their lengths were much shorter or much longer than the others.

The interviews were audio recorded with a digital recorder. If another staff member entered the room, the interview was suspended, and the recorder turned off. The interview recommenced when the other staff member and the participant stopped speaking, and the participant wanted to resume the interview.

The interviews were conducted in a conversational manner, with a number of core questions, follow up questions for clarification, probes for increasing depth of understanding, and asking of examples to improve comprehension of the information.

Demographic questions were asked at the start of the interview. The researcher then used the interview guide to shape the interview (Appendix A). To start, the researcher asked the participant what they thought of when the researcher mentioned the words: relational work. This was in order to gather unstudied and unbiased ideas about the staff nurse's perception of the concept. In addition, this question allowed the nurse to understand that there was no right or wrong way to answer. Nurses were generally quite talkative and seemed eager to discuss the topics of the interview, both the good and bad aspects of relational work.

The researcher sometimes jotted down notes during the interview, and always after the interview. The notes during the interview helped her ask focused follow up questions. The notes after the interviews allowed the researcher to capture important points and insights. After the first five interviews, a pattern in what the nurses were saying emerged, and main categories came to the forefront. Also, it became clear that some initial ideas that the researcher explored initially were not as key to the participants. Therefore, in subsequent interviews, the questions became focused more on hypotheses that were emerging from the data analysis.

The first five of six interviews were conducted with intensive care nurses. Conducting concurrent data collection and analysis demonstrated the need to interview floor nurses as well, in order to expand the scope of the sample as well as examine the similarities and differences of staff nurses' discussion of relational work. This is called theoretical sensitivity (Glaser, 1978). Therefore, the researcher used theoretical sampling which necessitates exploration of these juxtapositions and concurrent understanding

(Glaser & Strauss, 1967). With theoretical sampling, the researcher concentrated on the recruitment of staff nurses who worked on the floor and not in the ICU. The inclusion of non-ICU nurses allowed for examination of emerging categories to see if they were relevant to non-ICU nurses as well, or if these existed only in an ICU environment.

For example, the ICU nurses discussed the importance of help of their fellow staff nurses to complete their work for each shift. The researcher wondered if this was also true for floor nurses or reflected work specific to ICU nurses and she posed this question to floor nurses as well. The researcher found it to be universal to both populations of nurses. ICU nurses used examples of needing to turn and bath their patients with the help of their coworkers, while the floor nurses used the examples of answering each other's call lights and hanging medications for each other. The same was true in the ICU nurses' statements about feeling comfortable going up the chain of command to reach a doctor that would respond to the needs of their patient. The researcher wondered if this ability held true for floor nurses as well in asserting their authority. The researcher found that this too was a similarity among the two types of nurses.

Consideration of the similarities and differences between the relational work of nurses and their work environments allowed for growth of categories and properties (Glaser, 2002). The researcher conducted data collection until saturation was reached, which demonstrated that no additional categories or properties of categories emerged.

No difficulties emerged during the data collection process. Of note, however, was the occurrence of emotionality with which the nurses often spoke. Specifically, 9 of the 23 nurses teared up or cried during the interviews; during one interview the researcher

also cried. The topic discussed during this heightened emotionality was the difficulty the nurse had with a doctor or nurse co-worker that resulted in a poor outcome for the patient. In each instance, the nurse spoke about this conflict in relation to the sadness they felt about the resulting poor outcome of their patient. Heightened emotionality also surrounded distressing relationships involving nursing management.

Data Analysis

The goal of this study was to generate a theory from the data. The researcher conducted the data analysis using the constant comparative method of Glaser and Strauss (1967). The researcher began with the first level of coding, called open coding. The researcher went through the transcripts, line by line, circling key words and key phrases. The researcher approached the transcripts without a priori assumptions and read the data for what they would reveal. The key words and phrases were written on a separate piece of paper, using the original words of the participants to ensure original meaning of the codes. This list was the first level code list. The original list of first level codes had close to 250 codes. The codes demonstrated a positive to negative connotation. For example, one code was “being approachable” and another was “not being approachable.”

For each subsequent interview that was completed and the transcript coded, additional codes were revealed, compared to existing codes, and if new, were added to the list. There were also, for each transcript, data that did not generate a code and were put into a miscellaneous category. These data were reviewed at the end of all coding to see if any codes fit and were not relevant to the conceptualization of the derived categories.

Memos were written by the researcher during the coding process. Memos allow the researcher to record fresh ideas (Glaser & Strauss, 1967). Memos included questions that emerged about the possible relationships between the codes, and how codes might group together to form a category. Memos included notes taken just after interviews as well, noting for example, tearfulness during the interview by the nurse when describing a difficult relationship at work that impacted their patient's outcome. New questions that should be asked of subsequent participants, based on what previous participants stated, formed in the researcher's mind. These new questions were written down by the researcher and discussed with her advisor. During this process, as new questions arose and hypotheses formed, the researcher employed theoretical sampling with subsequent interviews to test the hypotheses with participants. The researcher also drew illustrations of connections between emerging categories. Theoretical sampling was conducted while coding and analyzing, and pointed the researcher towards what to collect next in order to develop the emerging theory (Glaser & Strauss, 1967).

The memos allowed the researcher to proceed to second level coding, called axial coding, where codes were put into categories; the codes became the properties of each category. Some properties had a range of positive and negative codes. For example, in the category *Relying on One Another*, the *having each other's back* property had the positive code "We were each other's help system" and the negative code of "It's like I'm abandoned out here."

At the end of coding all 23 interviews, the researcher had extracted 250 codes. The codes were collapsed into groups of like codes. With axial coding, a core category

emerged, along with ten categories with properties. The categories have explanatory power through the richness of their properties; these categories, linked together, explain the process of the relational work of nurses. The relationships between categories started to emerge during axial coding. A model of the process of relational work emerged from the relationships between the categories. The categories link together in a temporal fashion that represent a necessary beginning, middle, and completion to the process of relational work, with the outcomes being embedded in the completion of the nurse's work and having done the best for their patients. The researcher read through the transcripts to understand if the emerged model was derived from the data.

The next section will present the findings; the model, the core category, and categories that were constructed from the data that conceptualize the process of relational work of the nurse.

Findings

The findings presented here answer the research question “What is the process of relational work of the nurse?” and explain the basic social process of accomplishing work through relationships. First, the process and model are presented, followed by the core category and nine categories, defined by their properties. Quotes from the participants demonstrate the findings. The core category is *Coming Together to Get Through* and the ten categories of the model are *Spending Time*, *Knowing Other Nurses and Doctors*, *Asserting Authority*, *Trusting and Respecting*, *Being Approachable*, *Relying on One Another*, *Needing Each Other*, *Helping Each Other*, *Getting the Work Done*, and *Did the Best for Our Patients*. For this section of the findings the Core Category is capitalized,

the *Categories* are both italicized and capitalized, and the *properties* are in lower case and are italicized. Quotes of the participants are presented to demonstrate the properties of the categories. Each quotation will have the participant number and page number of the transcript in brackets following it. For example, [9.1] represents participant 9, transcript page number 1.

Process and Model

Based on the data, the process of relational work of the nurse depends on the nurse having spent time with nurses and doctors, which allows the nurse to know and trust them. This allows the nurses to move through the next phase of the process, which is to be approachable to nurses and doctors, understanding that they need and rely on one another to get their work done, which leads them to offer help to one another. It is through this network of relational bridges that nurses finish their work for the day and have done the best they can for their patients. The first section of the model through trusting and respecting, happen over time. A single shift, however, begins with the middle section of the model where nurses and nurses and doctors have established the start of the process already. However, if a nurse cannot trust or respect a doctor or nurse they are working with, but the process necessitates that they must, they break the process and assert their authority in order to go up the chain of command and replace that nurse or doctor with someone they can trust and respect and thereby move through the entire process to the end. Sometimes a nurse cannot find a replacement person and they must put more effort in completing their work in order to do the best for their patient.

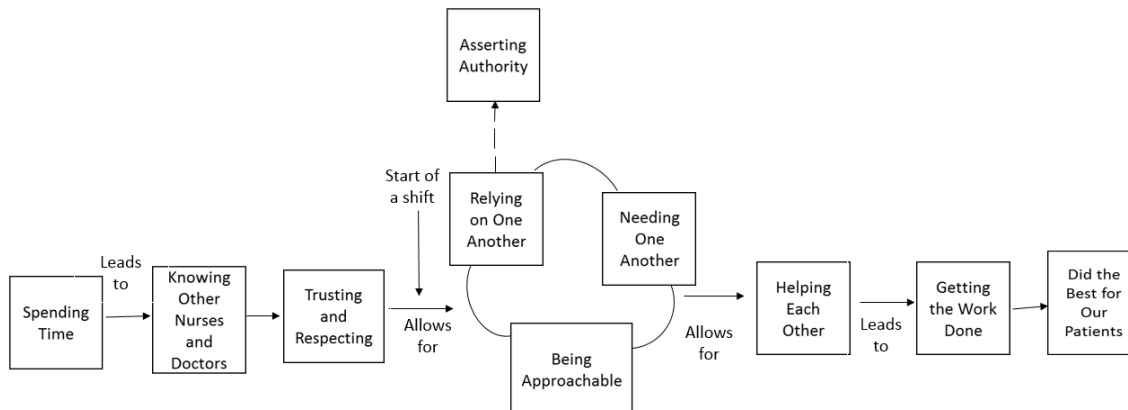


Figure 2. Model of the relational work of nurses.

The process is represented in the model (see Figure 2). The start of the process begins with nurses, and nurses and doctors, spending time together (*Spending Time*), and this leads to knowing others (*Knowing Other Nurses and Doctors*). Knowing others leads to trust and respect of others (*Trusting and Respecting*). This trust and respect allows for a co-existing grouping of categories that occur together, not one occurring before or after the other: *Being Approachable*, *Relying on One Another*, *Needing Each Other*. These allow for the nurses, and nurses and doctors, to help each other (*Helping Each Other*). It is by helping each other that nurses are able to complete their work and ultimately get to do the best for their patients (*Getting the Work Done* and *Did the Best for Our Patients*). However, sometimes there is a break in the process because of something that is said, done, or not done, and the nurse needs to assert their authority (*Asserting Authority*) by finding a replacement person, such as a different doctor, with whom the nurse can move through the relational work process in order to have a good outcome for their patient. When the nurse cannot find a replacement person, they are not able to engage the process and they must put more effort into completing their work.

The process of relational work of the nurse is temporal and dependent on the functioning of the group to go through each step of the process, starting with spending time, in order for patients to do well. Nurses have individual responsibilities, but identify the work they do and themselves as a collective.

Core Category: Coming Together to Get Through

The core category encapsulates the entirety of how nurses work together and to what end in order to get their work done. The core category has explanatory power of the entire process of relational work. This category emerged from the data as the core category in the process of how nurses engage in relationship building to accomplish their work. It is through being able to work together that they can get through their shift. One participant stated: “When everyone works together and helps each other and does things as a team, it just goes quicker” [6.3]. Nurses stated that without the help of fellow nurses, their shift would have to be twice as long to complete their work. Another participant stated: “I don’t think I’ve had a single shift where you can get through it without working with another person” [14.2]. Participants used the term “team” to refer to their nursing colleagues and coming together to figure out how to get tasks done, like turning patients in the ICU, or answering call lights on the floor. These were common examples that participants used to illustrate how the help of fellow nurses allowed them to collectively complete their work. The core category Coming Together to Get Through encompasses the ten categories in the model. The ten categories are *Spending Time, Knowing Other Nurses and Doctor, Asserting Authority, Trusting and Respecting, Being Approachable,*

Relying on One Another, Needing Each Other, Helping Each Other, Getting the Work Done and Did the Best for Our Patients.

Spending Time

The process of relational work begins with nurses *Spending Time* with nurses and doctors. The properties for this category are *spending time with other nurses* and *spending time with doctors*. *Spending Time* reflects a necessary step to begin the process, without which the process of relational work cannot occur. Nurses are together on the floor or unit. One participant stated: “I’m mostly talking about nurses, because they’re the ones that are always around us” [5.1]. One participant stated: “Things are more settled, and we’re [nurses] all charting and chatting” [14.5]. Another participant stated: “You work like 12 hour days together and you just spend a lot of time together” [6.8]. These properties are characterized by talking with one another, and being with one another in the same physical space. The participants, especially in the ICU said, the doctors are always around in a formal and informal way. One participant mentioned of spending time with residents: “You see them three days a week. They see all of us seven days a week” [12.5]. It is through *Spending Time* and talking that nurses get to know their fellow nurses and doctors.

Knowing Other Nurses and Doctors

In the *Knowing Other Nurses and Doctors* category, the nurse, because he or she has spent time with them, is able to develop a relationship with the others, incorporating knowledge of the others’ activities and abilities. It is a deep well of knowledge. The properties of this category are *knowing each other* (nurses knowing nurses and doctors

and nurses knowing each other), *developing a relationship with nurses and doctors*, *knowing what others are doing*, and *knowing others' expertise*. One participant gave the example of doctors knowing nurses: "So they (doctors) get used to your face like 'Oh, we know XX, she's been here a few years. We'll check with her'" [8.7]. Or another participant said: "I think it's just, once you get to know them (doctors), they get less intimidating...I think we still have a good working relationship, especially with the residents" [1.2].

Of knowing doctors, another participant said simply: "They know us and we know them and it works really good" [6.7]. Developing relationships through knowing one another was seen as the key to doing well for their patients. One participant stated of doctors: "so we need to be able to build relationships so that we can take care of patients" [4.3]. Developing relationships with nurses ranged from being neutral and friendly, but not good friends, to becoming friends with nurses. One participant stated: "You don't have to be best friends, but you do end up finding some friends from work" [14.6]. Getting to know other doctors and nurses allows the nurses to know the nurses' and doctors' work abilities.

Of knowing what doctors are doing, one participant stated: "We understand that they are sometimes in the trauma bay, or in the OR. We understand they are very busy and they have other patients" [20.6]. One participant stated of knowing what other nurses are good at was important for them to be able to call on that nurse: "I can rattle off three nurses that will get any IV or blood draw. I can realize that and go to them" [9.8]. Nurses with known expertise were often described as the "go-to" nurses. Nurses know that

doctors can count on their expertise. For example, one nurse stated: “They (doctors) know that we know the rules. That we won’t let them do things that don’t make sense” [3.8]. Nurses were aware of where doctors were during their shift and how much time they would have on their unit. One participant stated: “Trying to be respectful of the fact that they’ve (doctors) got 10 other things going on their plate” [12.5].

The nurses knew what others are doing, what they can and cannot do, and where their key colleagues are spending their time. This knowledge was critical in allowing them to understand who they can trust and respect at work. One participant stated: “You want to get to know them (doctors) because you want to know if they are good, or if you can trust them also” [19.4]. As the data show, the nurse required a surround-like knowledge of the people with whom they work.

Trusting and Respecting

In the *Trusting and Respecting* category, trust and respect exist with other nurses and doctors because of the time the nurse has spent with them and the knowledge the nurse has of them. This category has the properties of *trusting and respecting your co-workers* (nurses and doctors), *believing other nurses are knowledgeable*, and *nurses and doctors respecting each other’s knowledge*. Trusting and respecting your co-workers can only happen if the nurse knows their co-workers. One participant stated: “I am comfortable here. I know who I can trust, which I think is a big factor” [19.2]. Another participant said: “I know if I can trust them (doctor) because I’ve seen them do things before. I know I can trust them not to tramp all over my patient’s feelings, things like that” [16.7]. One nurse stated, speaking of another nurse: “I really try to nurture that

person and support that person, so that they know they can trust me” [15.9]. Or another participant stated:

Just knowing that the doctor’s going to be there. There’s equal respect because you’re at the bedside, and you respect them for what they can do, and their perspective and their intel. Then they respect yours because you’re there, you’ve been observing what’s going on, you’re at the bedside where they’re not always at the bedside. That respect is always important. [2.2]

The nurses spoke of respecting each other’s knowledge and abilities. One participant stated:

We have certain nurses who are really good with really sad situations, like our comfort care patients. That’s good to know that some people end up getting really upset, some people take death as a part of life. We have nurses that are really good with that. And everyone’s really good at something, so that’s really cool. [9.8]

However, the participants provided descriptions of situations when they did not feel respect of co-workers, both nurses and doctors. These comprised the negative codes of the property *nurses and doctors respecting each other’s knowledge* that reflected others making the nurse feel stupid. One participant stated: “You call them (doctors) and they make you feel stupid one day and, I don’t know, or seem like an idiot during rounds” [6.8]. Other characteristics of the negative codes were eye-rolling, examples of, as the nurses put it, “nurses eating their young,” and being yelled at by both doctors and nurses. One nurse stated:

If you had to ask a question, you would get rolling eyes. They would say it real slow: ‘Well, if the fever is over 38.5.’ That. Ugh. Aren’t we all grown-ups here? There was a lot of assignment dumping. It was just hard. It was very, very unpleasant. [11.6]

Trusting and Respecting their co-workers is a fundamental category in the process that bridges between knowing others and the middle grouping that leads to helping. Without

this bridge, the process ends with nurses having difficulty getting work done and it taking more effort to do their work, sometimes not being able to do the work as completely.

Being Approachable

A trio of categories that occur together, not one occurring before or after the other, are the middle of the process. These three categories are: *Being Approachable*, *Relying on One Another*, and *Needing Each Other*. *Being Approachable* refers to the nurse making themselves welcoming and consciously deciding to give the signal to others that they invite others to come up to them and ask questions and ask for help. This category includes the properties of *being welcoming* and *being open*. This category is marked by the characteristics of nurses being friendly, but not necessarily friends, while not being cliquey. The property *being welcoming* has a positive and negative range of codes. One participant said:

They (other nurses) have to be open to ask whatever is on their mind. I think that, and they have to be able to trust me or whoever their mentor is, that we're not going to ridicule or down whatever they are saying. [4.3]

Another participant stated:

I think friendly is being approachable, being kind. I might not like you or want to hang out with you outside of work, but friendly in saying 'Hey, we're working together today, do you mind if I help you?' or 'Can you help me?' [12.3]

Another nurse discussed the impact of being open and welcoming. She stated: "For them to be able to come up without hesitation, 'okay, I need you. The patient isn't doing well, can you come?'" [2.4]. The negative codes of the *being open* and *being welcoming* properties describe not seeming approachable. If a nurse is not approachable in manner, others will not feel able to ask him/her for help. One participant stated: "You feel bad

asking them or you feel like, awkward asking them for help or questions and because they're not very approachable" [6.6]. When a nurse floats to another unit, they do not know the other nurses. This was often recalled by the nurses as a difficult situation to be put in because, as one nurse stated: "You don't know who to approach or who is willing to help you" [23.3].

Relying on One Another

In the category *Relying on One Another*, the nurses discussed the fact that they rely on one another in order to get through each work day. The properties of *Relying on One Another* include *having each other's back*, *nurses being there with me*, and *being aware of each other's needs*. One nurse said of other nurses: "We were each other's help system" [8.4]. Another nurse said, in referring to other nurses: "I always feel people have my back. It'll always come down to people will always have my back" [5.4]. The nurses used the phrases: *rely on each other*, *lean on each other*, and *support each other*. A common comment was, just as this nurse said: "We're sharing the same space all day and we rely on each other" [11.2].

The nurses are covering each other's patients during an emergency, as well as nurses detecting tone of voice of fellow nurses demonstrating need for help, or simply giving each other "a look." One participant stated: "People can tell by the tone of my voice if I need help right away. So that is really important" [19.2]. Another participant stated: "I feel like when patients crash and pod mates, they all just come together and read each other's minds and we're one step ahead of each other and it just works out smoother" [5.4]. The nurses' interdependence comes through in common examples of

answering other nurses' call lights, drawing labs, helping with medications, and walking other nurses' patients in the hall. One participant discussed being "buried," or extremely busy, and stated:

That was the one reason why I gave XX the star, was because she really looked at my monitors herself and looked at the assignment to see who my other patients were, and then looked at their monitors. Then came to me and said, 'You've got this due, and this due. I am going to go hang them.' Really took it upon herself. Which I thought was super, super nice. [11.5]

The property *having each other's back* also included negative code of "It's like I'm abandoned out here" [16.8] that reflects having to work without being able to rely on anyone else and the difficulty that causes.

Asserting Authority

This category requires a certain knowledge unique to the nurse. It is knowing how and when to be *Asserting Authority* in order to get the best outcome for their patient. The nurses recounted that part of knowing doctors and nurses, and their roles as nurses, involved asserting their authority within the hierarchy of the hospital, often referred to by the nurses as the "chain of command," as well as setting expectations for other nurses. *Asserting Authority* gets the work done of keeping the patient well within the strength of a relational net of connection. If the nurse cannot move through the relational work process, and cannot rely on the nurse or doctor they are working with, because of something a doctor or nurse is doing or not doing, the nurse calls a superior, or a relied upon coworker, or a "replacement person," to ensure the process of relational work can continue throughout each necessary phase. They find another co-worker that they know they can rely on or end up relying on self to get as much of the work done as they can.

The *Asserting Authority* category has two properties. These properties are *going up chain of command* and *setting expectations*. The property *going up the chain of command* was a common example of asserting authority. One nurse recounted: “And I was like ‘Go get your attending and we’ll see if he wants another hemoglobin. Because this patient is not alive’ He’s like ‘Oh I’ve got to go to sign out.’ I was like ‘No. You stay here with your patient.’ “[12.6]. Another participant recounted:

I mean you have to tell them (doctors) what to do. If the patient starts to go south, and the resident is not managing it, you have to either... There’s two ways to do it. The first way, usually, I make them call their senior and have the senior come and see the patient. Usually the senior, at least, is someone that we know. [11.9]

One participant stated:

I had a patient that I was 90% sure was stroking. The neurologists were like, no, blah, blah, it’s fine. I went to a more senior nurse, and I was like, can you please come do an assessment because I’m really concerned. She came in and was like ‘Oh, no, we need to do something, you’re right.’ [8.7]

Setting expectations was a necessary part of asserting authority that has the effect of strengthening trust and respect between nurses. It occurs when the nurse speaks up about what is expected in a way that maintains the relationship, but delivers clarity. One participant stated: “I would try and say, ‘I think you’re a great nurse, but when you do this, make sure you do this and this and that.’ They don’t feel threatened and then go home and beat themselves up about it” [3.8]. This usually a more seasoned nurse who understands their role in the work group as one who has to be clear is what needs to be done.

Needing Each Other

In the category *Needing Each Other*, nurses said repeatedly that they could not do their work without the help of other nurses, and to some extent doctors, and that doctors need nurses. This need of each other is a condition of each day's work. The *Needing Each Other* category has the properties of *needing each other's help, having go-to people, doctors needing nurses*. This category is marked by an acknowledgment of this need, as a fact of work, and it is characteristic of the nature of the work and the work environment. The property *needing each other's help* is marked by codes recognizing this need. As one participant stated: "In this type of field, and what we do, we need each other" [4.1]. Another nurse said: "When we're in a dressing change, people, they all file into the room, they just look at the patient, they see what needs to be done. Everybody just divvies up" [17.2]. One nurse described recognizing need and offering help:

Sometimes you really have to tell people, because maybe they don't know what to do. They're feeling overwhelmed. Sometimes I walk into a nurse's room who is overwhelmed and I specifically ask 'Give me a job.' 'Do you need this?' 'Do you need that?' You know your colleagues and what to expect from them. [15.4]

Having go-to people was a recognition of this need for co-workers' help as well. For example, one participant gave the scenario: "So I do have people that I can go to when I'm like 'Hey, I need some back up. You need to do this otherwise I'm going to end up losing it.' So I have my people for that" [9.8]. *Doctors needing nurses* is a property that nurses on both the floor and intensive care unit described in example after example. One nurse said: "It was so simple, but he (doctor) was really grateful to have the help" [4.2]. Another nurse stated: "I definitely see residents come to other nurses and be like: 'What do you think we should do?'" [5.3].

Helping Each Other

The category *Helping Each Other* is the next category in the process that consists of the interdependent actions of relational work of coworkers helping coworkers. The properties are *you're helping each other* and *doing it for you*. The nurses consistently described how they worked with their co-workers in helping each other. They would say often: "I'll help you and you help me," with statements making note that without the help of fellow nurses, their 12-hour shift would last 24 hours. The statements were simple and abundant; generally, they were like this one, of working with other nurses: "You help each other out" [6.5]. One participant said:

An assignment becomes so heavy that if it wasn't for our co-workers, you couldn't get through that day. So always be cognizant of others and offer your help. That way when you're the one that has the heaviest assignments on the pod, people are saying 'Hey, how can I help you?' [20.6]

The property *doing it for you* was an aspect of *Helping Each Other* that occurs on a shift. One nurse stated: "There's no reason why I can't free up a few minutes and draw a lab for you" [1.5]. Another nurse said "And for the most part the coming-on shift will be like 'Oh that's fine, I'll take care of it'" [9.10]. One nurse said, representative of this *Helping Each Other*: "Because like I said before, you won't get through a shift on your own...It's not 'These are mine, those are yours.' It's "these are our patients"" [14.3].

The category of *Helping Each Other* was said to often be dependent on the condition of the shift having a leadership nurse (manager or charge nurse) who had balanced the shift with the right mix of new and experienced nurses, was able to step in and support the nurse with their clinical expertise in a difficult moment, or had staffed the shift fully. The nurses expressed gratitude for the manager's or charge nurse's leadership

in being there. One nurse stated: “Our manager will step in a lot, too. She’s really wonderful. I wouldn’t trade her for anything. ...She is great. XX is so great. She’s like ‘Oh yes, here, let’s work on this.’ That’s so helpful” [8.7]. One nurse stated:

She’ll (manager) see what we need and then she usually helps a lot with staffing especially on the weekends, enough staffing for the weekends. If we are busy, we at least have an appropriate number of nurses here so we can do our work and be able to help others. [23.3]

However, a negative condition of category *Helping Each Other* was a result of not having the manager’s support to be able to help others. If the nurse is not supported by management, the nurse has less ability to help others. Negative manager support affects nurses *Getting the Work Done* and *Did the Best for Our Patients* (the subsequent categories) in a negative way. One nurse described herself and fellow nurses as “drowning,” not being able to help other staff, and not providing safe care. The manager would not listen to their needs for staffing and they were short staffed. In order to get more staff, they turned to the doctors for help.

The resident that was on that night had to call her attending, her attending called the surgeon, and the surgeon called the manager. We paged our manager, we talked to the nursing supervisor. We have to deal with it. It wasn’t until the surgeon said something that we had registry nurses pre-assigned to our unit. [21.5]

Another nurse described the manager as ineffectively managing nurses who do not pull their weight and do not do their work. This leaves the nurse with extra work left over on their shift, for example, and then the nurse is less available to help others. The nurse stated: “From a managerial perspective she is a failure. That can at times throw the team into a tailspin. Stronger management always makes everything better” [17.9]. The nurses

help each other. When the environment is set for this to occur, the nurse can get their work done. Out of the complicated, reciprocal helping structure, work is accomplished.

Getting the Work Done

Getting the Work Done emerged as a goal of each shift. The category *Getting the Work Done* has the properties of *nurses going home* and *helping other nurses get their work done*. The characteristics of the *Getting the Work Done* category include a shift being smooth, a shift flowing, having a clear shift, and being organized. One participant stated: “The floor is working well and everything is going smoothly” [9.3]. The category is marked by finishing the work. One participant said: “The days that everybody gets to go home on time and you got everything done, and you helped other people the most you can, and vice versa, you’re able to think clearer” [3.5]. One nurse said in speaking of fellow nurses: “Everyone’s like ‘What can we do to get you out of here’” [1.6].

Organization and planning were key aspects to *Getting the Work Done* for the day. One nurse stated: “There’s those nurses on every unit and you’ll know them. If you have good organization skills, then you can prioritize things. It makes a world of difference in everyone’s day” [6.8]. Repeatedly, charting is last thing to get done for the day, or the nurse stays late to do it, because this is something no one can help the nurse do. Charting is not a group effort. One nurse said:

You are really busy and everyone is offering help, sometimes there isn’t anything they can do, because the things you are backed up on is charting. It’s like you get everything done, but you need to take a second. They can’t sit down and chart for you. [18.4]

When nurses had difficulty *Getting the Work Done* it was because they did not receive the help they needed. One participant stated: “Sometimes there are barriers to getting my job done because I feel like I’m working with three people who really could care less if I get my work done when I’m supposed to get my work done” [12.7].

Did the Best for Our Patients

Did the Best for Our Patients emerged as the end goal of not only the process of relational work, but also marks the definitive goal of nursing work that is embedded in the overall outcome of the patient. The properties of *not wanting the patient to suffer* and *getting the best outcomes for my patient* made up this category. The nurse is able to reach this outcome most effectively when they are able to get their work done during the shift.

For the property *getting the best outcomes for my patient*, one nurse said that the key to prioritization for the day revolved around a key outcome:” So you end up needing to do what’s best for the patient” [12.4]. Another nurse discussed the seriousness of nurses’ work to get the patient better in a clear, direct way: “By helping someone else out, I’m actually helping patients out...These are people with real lives. We need to do our best” [9.6]. *Not wanting the patient to suffer* was described as an important part of doing the best for their patients. Nurses said that even if other nurses had not helped them in the past, or they did not personally get along, they never want this to transfer to the patient. One participant stated: “Find out what’s in common, trying to help the people that help you, still trying to help the people, maybe, that don’t always find the time to help you. Because you don’t want the patient to suffer “[3.4].

Temporal Group, Goal Oriented Process

The process of relational work is one that exists largely between nurses, and also between nurses and doctors. Relational work takes *Spending Time*, knowledge, and trust, through to the end category, the goal of nursing *Did the Best for Our Patients*. The nurses said that the work of nursing cannot be done without the help of other nurses. The work of nursing necessitates the group. This group help happens with the creation of a bridging network of relational categories. Nursing, as the participants stated often, is a 24-hour job that is not accomplished in a strictly autonomous manner, but largely and most effectively in the collective. Turning patients and answering call lights and doing dressing changes and managing codes are work actions, but the knowing others, trusting others, being approachable, recognizing that they need one another, and relying on one another, and helping others to accomplish these work actions is relational work in action. As one participant stated when the researcher asked if there was anything else she would like to say, she stated:

Yes, I think our job is one of the really important ones that you need to rely on other people and have help from other staff. There might be other positions where you can do something by yourself and be completely fine with it, but nursing's definitely something that you need to rely on other people and have a lot of help in order to successfully do your job. It's really important that you build good relationships with other people. [23.4]

Assessing Trustworthiness of the Study

The goal of rigor in qualitative research is to truthfully demonstrate the experience of the participants (Speziale & Carpenter, 2007). Rigor is achieved by the researcher's attention to, and confirmation of, discovery of the meaning of the data. The process by which understanding is achieved in a study must be transparent to those

reading the study, in order for faith to be placed in the worthiness of the study. Rigor was ensured in four ways: transferability, dependability, confirmability, and credibility (Lincoln & Guba, 1985). These four criteria are addressed in this section as well as assessment of trustworthiness for grounded theory (Glaser & Strauss, 1967).

Transferability is the degree to which the findings of the study can be applied in other situations, and with other people in a similar situation. Transferability of the hypotheses of one study to a setting with similar participants will depend on the thickness and clarity of the study's findings such that a person outside the study could apply them (Lincoln & Guba, 1985). The findings of the relational work of nurses can be applicable to nurses working as staff nurses in hospitals. The findings are written such that the categories are conceptual and clear in representing the process of relational work. This theory has relevance to all inpatient direct care staff nurses, for working both on a floor or in an intensive care unit. In a setting where there are no house staff this process also has relevance because the conditions of nursing work are the same and there are attendings that go through this process with nurses as well, just as was demonstrated in this teaching hospital setting.

Dependability demonstrates that the study's findings can be replicated with a degree of consistency by another researcher. Dependability can be insured by an outsider, considered an "auditor" of the research process (Lincoln & Guba, 1985). The auditor could examine the process that the researcher undertook so that the same study can be conducted by another researcher. The researcher took notes that indicate the steps of the research, why certain steps were taken along the way in the process of research, and why

decisions were made. The steps that were taken, for example codes and categories that emerged from the data, were created with a faculty member who is an expert in grounded theory.

Confirmability demonstrates that the manner in which the researcher obtained the data is visible and evidentiary. There was an audit trail that the researcher maintained throughout the research process that includes transcripts, memos, coding sheets, and a final report (Lincoln & Guba, 1985). In addition, the researcher maintained theoretical memos that serve as demonstration of how data and categories are linked and categories to categories that comprise the theory.

In grounded theory, the theory fits the substantive area where it can be used (Glaser & Strauss, 1967). Another researcher should be able to undertake the same study, and the theory should be true to the daily realities of the relational work of nurses, because it has been induced from the data. The theory presented here fits, and can be used to predict what would happen in the daily realities in the relational work of nurses. It has been discovered inductively, from the data of the participants. For example, if a nurse has spent time getting to know other nurses, and knows what they are doing and can trust and respect them, those nurses are more likely to be approachable to one another, rely on one another and, as requisite of nursing work, need one another. They will offer help to one another and be able to get their work done in order to do the best they can for their patient. During the course of this research, the researcher discussed these findings with an expert in grounded theory and considered alternative explanations of the data such as the

importance of the type of unit the nurses worked on, or the importance of the years of experience the nurses had.

According to Glaser and Strauss (1967), a theory must demonstrate its usefulness in explaining the actions of those it represents. It must demonstrate that it fits, works, is logically consistent, has clarity, is parsimonious, dense, rich, has scope, is integrated and is modifiable. As Glaser and Strauss (1967) state, a theory must demonstrate that it fits. The current theory was inductively developed and works because it is meaningfully relevant to staff nurses and explains their behavior of working in relationships with others. The theory has logical consistency as it is a temporal group, goal-oriented process that has a beginning, middle, and end, making logical sense. It makes sense because it was systematically derived from the data. The theory has clarity as well because it has categories that intuitively lead from one category to the next demonstrating the process of how nurses engage in relationships with one another; using words of the participants, not pre-determined categories. The theory is parsimonious because it does not include added ideas or extraneous detail, but solely the rich, vivid data of the process that make up the properties and categories. The theory is dense, and the properties have range, such that positive and negative aspects to properties have been discovered. The theory is dense with the reality of the nurses as is the represented by the data. The theory has scope with many players; nurses from both the intensive care units (ICU) and the floor. These workers comprise the majority of the workforce in patient care in hospitals. The theory is integrated as it has parts that are related to other parts to represent a whole process. Finally, the theory is linked so closely to the data that it is not refutable. It is flexible

enough such that it can be modified to reflect the work process of an ICU or a general floor or a community hospital. This means it is "...destined to last" (Glaser & Strauss, 1967, p. 4).

Credibility is the authenticity of the data and that the data are a legitimate representation of the participant's experience, not a representation of the researcher's ideas. The conveyance of the credibility of a theory is presented by Glaser and Strauss (1967) as two simultaneous tasks. The first is for the researcher to create an understandable theoretical framework within which the theory exists. The second is to create a vivid representation of the world studied such that the reader feels he was present in the field. This has been accomplished with quotes, summaries of concepts and narratives. Credibility was demonstrated by saturating each category with data. Credibility is not presented as an illustration of proof, but through integration and relevance of the data (Glaser, 2002). Also of importance is the reader's understanding that the data were not simply a result of the researcher's impressions, but the result of using a systematic procedure for analyzing data.

Chapter Summary

In this chapter, the model of the relational work of nurses, the core category Coming Together to Get Through, and ten categories and their properties were presented. The data were presented in participants' quotes, and the descriptions explain the process of relational work. The chapter has ended with a discussion that establishes the trustworthiness and methodological rigor of the study. In the subsequent chapter, the findings are discussed in relation to both prior literature and new empirical literature. The

implications of this work on clinical and leadership practice, staffing and nursing education are discussed. Recommendation for future research are presented as well.

CHAPTER FIVE

DISCUSSION

The purpose of this chapter is to discuss main findings of the study of the process of relational work of the direct care registered staff nurse and how these relate to previous literature, both theoretical and empirical. First, the model and core category are discussed, then the ten categories are discussed with previous literature findings as well as unique findings from this research study. This chapter finishes with a discussion of limitations and strengths of the study along with implications for future research, nursing practice, and education.

Model

The process of relational work of the nurse begins with the nurses spending time with other nurses as well as with doctors (see Figure 2).

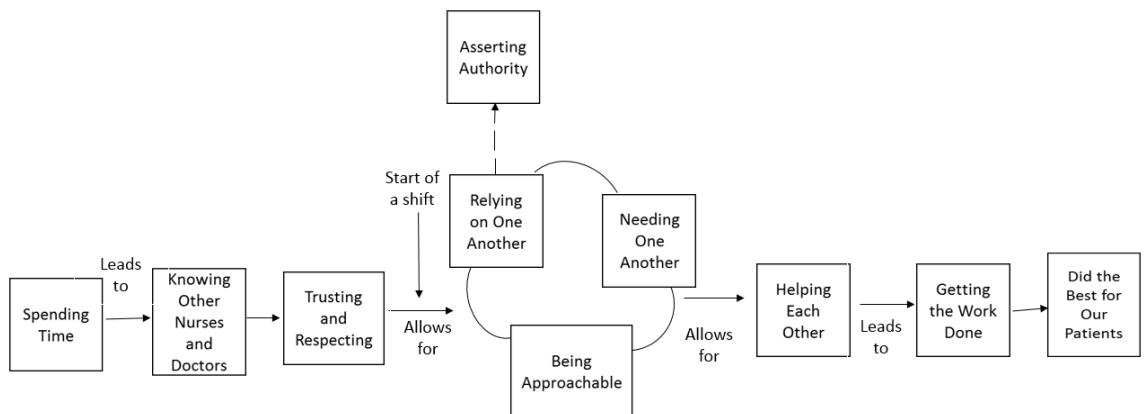


Figure 2. Model of the relational work of nurses.

The initial section of the process demonstrates that as a result of spending time together (*Spending Time*), nurses develop relationships with others, incorporating knowledge of the others' activities and abilities; it is a deep well of knowledge (*Knowing Nurses and Doctors*). Trust and respect (*Trusting and Respecting*) follow, because nurses and doctors have spent time with one another and understand who to trust as they care for patients and have developed respect for them as a result of the knowledge the nurse has of them.

At the middle section of the process, since there is a solid bed of trust and respect of the closest team members (i.e., nurses and doctors). Built through elements of time and knowledge, the nurses recognize and incorporate the interdependent attributes of nursing work life. Importantly, this part of the model represents the start of a shift. For example, if a nurse is a float nurse to the unit, they may not necessarily be known to the regular nurses and doctors of that unit, and therefore might not have the extended trust and respect. However, they would still have some trust and respect as a nurse asked to come to work on the unit for that shift. The benefits of relying, being approachable, and helping each other are not necessarily as prominent. The nurses in this study spoke of when they floated to other units. They did not know who to approach. They were not sure who they could rely on. They often felt isolated or abandoned. However, they still needed their co-workers; this did not change. The path to completing their work and their patients receiving the best care may in fact require more effort because they are not as known and trusted by others of the unit.

The characteristics of this middle process are a trio (*Being Approachable, Relying on One Another, Needing Each Other*) that occur together, not one occurring before or after the other. The nurses make themselves welcoming and consciously decide to signal to others that they are open to questions, inviting others to come up to them and ask for help. They rely on one another in order to get through each work day; this is an implicit trait of nursing work structure that these nurses explicitly recognized. They repeatedly stated that they could not do their work without the help of other nurses and doctors, and that they clearly identified that doctors need nurses, and that nurses need doctors. These are interdependent realities of each day's work which result in the visible mutually dependent actions of relational work of coworkers helping coworkers (*Helping Each Other*). These are the actions traditionally identified as work, and can be observed from an etic position.

However, the nurse cannot move through the relational work process because when a doctor or nurse is not doing what the nurse knows they should be doing for their patient, the nurse calls a more senior physician, or a relied upon coworker, a "replacement person," to ensure the process of relational work can continue throughout each necessary phase. The nurses recounted that part of knowing doctors and nurses, and their roles as nurses, involved asserting their authority within the hierarchy of the hospital when there was a break in the process because someone they were working with either said or did something that was not in the best interest of the patient. The nurses referred to going up the "chain of command," as well as setting expectations for other nurses (*Asserting Authority*) in order to re-engage the relational work process with a different

co-worker; one they could rely on. There are times when a replacement person is not available and the nurse must use more effort to complete his/her work.

The end of the process holds the goals for the nurse professionally, and for the patient clinically (*Getting the Work Done* and *Did the Best for Our Patients*). It is by helping each other that nurses are able to complete their work and ultimately get the best outcome for their patients. Getting the work done on each shift was a goal of nursing as a whole and for the nurse as an individual. Getting the work done meant the nurse was consciously pulling his/her weight for the collective because if he/she does not finish their work, someone else has to do it. It is by helping others that work is done for the group.

The process of relational work is one that exists largely between nurses, but also between nurses and doctors. Relational work progresses from *Spending Time*, knowledge, trust, helping, through to the end category, the goal of nursing, *Did the Best for Our Patients*. The work of nursing cannot be done without the help of other nurses. The work of nursing necessitates the group working together. This group help happens because of the creation of a bridging network of relational activities represented by the initial set of categories. Nursing, as the participants stated often, is a 24-hour job that is not accomplished in a strictly autonomous manner, but collectively. Turning patients, answering call lights, doing dressing changes, and managing codes are work actions, but the knowing others, trusting others, and helping others to accomplish these work actions is the relational work process in action.

This study empirically identifies the process of relational work. Relational work takes time (*Spending Time*) and knowledge (*Knowing Other Nurses and Doctors*) that lay the foundation for working within a hierarchy for the benefit of themselves as professionals, and the benefit of their patients (Peter & Liachenko, 2013). The work of nurses at this stage lays the necessary foundation of helping. Without the relational work foundation that results in trust and respect, the middle stage has no basis upon which to occur. It allows for the implementation and recognition of relational work as work (Liaschenko & Peter, 2004). The relational work activities that emerged are not tasks, and they are not documented as the day's accomplishments or handed off as part of shift report necessarily; however, they are important for tasks to get done, and for patients to do well. This theory shows what Liaschenko and Peter (2004) state: healthcare work is collaborative even if that collaboration is not recognized or acknowledged. This study shifts the "moral lens" (p. 494) to collective activities of work in health care, within an organization, on a nursing unit.

The model of the process of relational work of the staff nurse that emerged in this study shares similarities with, but is not the same as, two separate processes in the literature. But, as will be discussed, the two processes have not been shown from the nurse's perspective and, in fact, the entire relational work process has not been identified in the literature. The initial categories of the start of this process share similarities with some aspects of Relational Coordination (Gittell, Beswick, Goldmann, & Wallack, 2015). Relational coordination links relational dimensions – shared goals, shared knowledge, and mutual respect – and four communication dimensions – frequent, timely, accurate,

and problem solving amongst nurses and nurses and doctors, and among other healthcare workers. Relational coordination by Gittell posits all health care team members contribute equally with some type of knowledge. However, her theory does not take into consideration unique knowledge and perspective of the nurses. Relational coordination posits that it levels the playing field, and negates hierarchy in healthcare. In reality, however, her theory disappears knowledge that the nurse creates and the power the nurses generate from this knowledge to work. None of the relational work processes identified in the relational coordination theory are unique to the nurse, which this present study clearly shows as necessary for coordinated care to be carried out.

The nurses in the present study did not identify non-nurses and non-doctors as those with whom they work in relationship with in order to complete their work, despite repeated initial queries by the researcher. This is a unique finding of the study. In Gittell's (2008) work, mutual respect leads to increased receptivity of information. This finding is supported in the present study. The dimensions of interprofessional communication did not emerge in the present study as a process of relational work. However, data emerged on how communication occurs within the categories of *Spending Time*, *Knowing Other Nurses and Doctors*, *Asserting Authority*, *Trusting and Respecting* which are not solely dimensions of communication, but necessary steps in the process of the relational work of professionals' communication on an interprofessional team.

A group of nurses, and the dyad of nurse and doctor, emerged clearly in the current study, despite setting out to be a study of the relational work nurses. In other studies, relational coordination between nurses, and nurses and doctors, has been shown

to be higher than with other healthcare providers in hospitals (Hartgerink, Cramm, Bakker et al., 2014; Havens, Vasey, Gittell & Lin, 2010). These studies point to nurses, and nurses and doctors, creating a net of connection with relationships whose shared end goal is positive patient outcomes.

The middle section of the model includes a trio of co-occurring categories, *Relying on One Another, Needing Each Other, and Being Approachable*; the interdependent realities of nursing work that result in the actions of helping each other. *Helping Each Other* is the transactional core of the relational work process. These categories share similarities with themes of qualitative work by Kalisch, Weaver and Salas (2009) in conceptualizing teamwork. However, neither a theory of teamwork, nor a social process of teamwork, was found in the extant literature. Backup behavior and characteristics of closed-loop communication in Kalisch's work are similar to aspects of some categories in the middle section of the present study. However, unlike in Kalisch's work, the present study includes the nurses' perceptions of the importance of their relationships with doctors (doctors are called "visitors" to the unit in Kalisch's work). Kalisch did not include doctors in the study of teamwork of nurses because she focused solely on nurses, nursing assistants, licensed practical nurses, and unit secretaries. In the present study, when asked about how nurses work with others to get their work done, the nurses regularly spoke about working with other staff nurses, their manager, and with doctors; they viewed these roles as team members. They rarely discussed assistive personnel, even when queried specifically by the researcher.

Did the Best for Our Patients emerged as the end goal of not only the process of relational work, but of each shift. It marks the definitive goal of nursing work that is embedded in the overall outcome of the patient. This present study identified the categorical process of how nurses, specifically, with nurses and with doctors, enact the combination of both verbal and non-verbal practices in order to accomplish work defined as collective. These categories create the stage for a successful relational work environment that results in positive outcomes.

Core Category: Coming Together to Get Through

The core category emerged from the data in the process of working with others to accomplish their work. Participants stated that they had to work together in order to complete their work on each shift. Without the help from their nursing colleagues, they could not finish each day's work.

The core category Coming Together to Get Through is not found in the extant literature. However, the first part of the title, "Coming Together," is found as a category in a grounded theory study of the process of ethics consultation services in hospitals, involving doctors and nurses (Crigger, Fox, Rosell, & Rojjanasrirat, 2015). The healthcare professionals described working on the same page with others, as well as resolving and reflecting around end of life issues. Because they worked together, they felt a sense of unity, better communication, increased knowledge and best resolution in regards to the ethical dilemma at hand. They described a sense of respect as a result of coming together, having their questions heard and their perspective taken seriously. In the present study, nurses (and doctors) coming together was made possible because of

spending time, creation of types of knowledge, and trust and respect in order to resolve, in the case of the present study, the work at hand, both for the nurses' and for the patients' sakes.

The second part of the core category, "To Get Through," is found in a grounded theory study of nurses in understanding the process of nurses adapting to "real world" hospital nursing (Kelly, 1998). The category was named "Getting Through the Day" (p. 1139) and reflected the difficulty individual nurses reported at trying to finish work on time. The author identified the inability of completing work as wished as the cause of powerlessness and moral distress, both results of limited resources and time.

Coming Together to Get Through is alternate way of saying that nursing work is collective work. As Liaschenko and Peter (2004) state, healthcare workers operate with a collective ethical responsibility to work cooperatively and interdependently. Nursing work is relational work (Liaschenko & Peter); not only within the bounds of the nurse-patient relationship, but the work nurses do together to facilitate and organize care within "complex organizational networks" (p. 491), such as the hospital. There are few responsibilities in delivering care that are independently provided and these shared responsibilities have to continually negotiated (Peter & Liaschenko, 2013). This is what the nurses stated over and over again, and these data create the categories of this relational work process.

The core category Coming Together to Get Through reveals the basic social process of the relational work of the direct care registered staff nurse and encompasses the ten categories: *Spending Time, Knowing Other Nurses and Doctors, Asserting*

Authority, Trusting and Respecting, Being Approachable, Relying on One Another, Needing Each Other, Helping Each Other, Getting the Work Done and Did the Best for Our Patients. These ten categories and their properties are discussed in the subsequent sections, in addition to how these categories relate to previous literature.

Categories

Spending Time

In the beginning stage of relational work, *Spending Time* emerged as the first step to the entire process. It sets up the knowing, trusting, helping and getting done. This means that if nurses, and nurses and doctors, do not spend time together, they have difficulty working in relationship with one another in an effective way that benefits themselves and their patients. There is nothing in the extant literature that specifically states that spending time is the necessary point of inception to a relational work process. This is a unique finding of this study.

Previous literature related to the category of *Spending Time* includes nurses spending time with patients, which leads to increased social/person knowledge. In the current study, spending time leads to knowing others. For example, a qualitative study of focus groups of nurses found that nurses had increased person knowledge because they had spent more time with their patients, as opposed to physicians (MacNeela, Scott, Treacy & Hyde, 2010). In a separate randomized control trial of a nurse-led behavior change in medication adherence, nurses were found to spend more time with patients as a specific action that was the successful mechanism of change (Hardeman et al., 2014). Most salient was a 1996 qualitative study (Milne & McWilliams) that framed nurses

spending time as a nursing resource that, while elusive for quantification, is essential for measurement of workload assignments and begs inclusion of spending time into the equation.

Part of what is happening when nurses spend time with nurses, and nurses spend time with doctors, is that they are talking. It is a characteristic of Spending Time and the precursor to *Knowing Other Nurses and Doctors* that follows. Talking was characterized as chatting, trouble shooting, or any type of talk that allows them to communicate with one another. The absence of talking has been characterized in other studies as isolating for the nurse (Duddle & Boughton, 2007; Lindwall & von Post, 2008). Healthcare organizations are sustained by conversations that constitute relationships (Jordan et al., 2009). Time and space need to be allocated for these exchanges and should not be seen as detracting from revenue. This was also concluded by Moore and Prentice (2015) who state that time is a requisite of building relationships and sustaining work that lead to mutual trust and respect among nurses. The combination of spending time and talking are the creation of sensemaking (Manojlovich, 2010). The talk between nurses and doctors, or between nurses, is an essential component of healthcare work that occurs, through often random conversations, that help accomplish work (Manojlovich, Squires, Davies & Graham, 2015). In a study of clinical staff in the emergency room, researchers found that face-to-face communication made up 82% of communication (Coiera, Jayasuriya, Hardy, Bannan, & Thorpe 2002). The precursor to knowing other nurses and doctors, is spending time together.

The initial stages of the process of the relational work of nurses include the formation of work relationships, with specific steps in the process (*Spending Time through Trusting and Respecting*). Manojlovich and colleagues (2015) have proposed a four-year multi-method (observation, interview, survey) study to investigate whether the introduction of health information technology (HIT) will decrease nurse and doctor collaborative relationships. They posit that collaborative interprofessional relationships are at risk of not fully forming and/or breaking with the advent of HIT. HIT is considered low in richness, as opposed to face-to-face and telephone discussions, which are considered high in richness. As demonstrated by the current study, relationships between nurses and doctors may be less likely to form if the temporal process of spending time, knowing one another, and trusting and respecting do not occur.

Knowing Other Nurses and Doctors

The second category in the initial process of relational work is *Knowing Other Nurses and Doctors*, which speaks to the development of a relationship between nurses and nurses, and between doctors and nurses. The properties of this category are *knowing each other* (nurses knowing nurses and doctors and nurses knowing each other) and *developing a relationship with nurses and doctors*. Developing relationships through knowing one another was seen as the key to doing well for their patients. Incorporating knowledge of the others' activities and abilities creates a deep well of knowledge.

The data from the present study show that out of relationships come the ability to care for patients in an interdependent fashion. This finding is reflected in the literature. Friese and Manojlovich (2012) found that good working relationships between nurses

and doctors are necessary for nurses having a favorable assessment of the workplace. Nurses' assessment of the workplace has been correlated with actual patient outcomes (Aiken et al, 2008). Increased levels of nurses and doctors collaborating in a medical intensive care unit setting has been shown to be associated positively with patient outcomes (Baggs et al., 1999). Nurse participants in a qualitative study on nurses' power found that nurses described having relationships with others (i.e., nurses and doctors) added to a sense of power (Fackler, Chambers, & Bourbonniere, 2015). That study acknowledged that time is necessary for doctors to develop trust in order for the relationship to exist and nurses' knowledge to be recognized and trusted.

In the present study, knowing other nurses and doctors allowed for a relationship and collaboration between nurses and doctors. Because nurses develop a relationship with doctors, the nurse can work within the relationship to share knowledge about patients with doctors. This is echoed by Manojlovich and colleagues (2015) who state that knowledge is derived from communication and that it is contingent on relationships to engender understanding. Hartgerink and colleagues (2014) found that the creation of effective relationships among nurses and doctors is of highest importance because it affects not only objective patient outcomes, but members' attitudes and sense of trust among their colleagues. Nurses believe that they influence decision making through collaboration because they can share their knowledge and influence outcomes through collaboration with doctors, who have the power to write orders (Baggs et al., 1999).

In the present study, nurses knowing other nurses, and having a range of feelings about the relationships, went from negative to neutral to good friends. These relationships

with other nurses allowed for a certain level of familiarity. One study points to the importance of friendships in clinical practice to deepen understanding of experiences in nursing students (Roberts, 2009). Friendships were found to engender an “ask anything” culture, which the current study reports here as well, as demonstrated in subsequent categories.

There is a paucity of empirical literature examining intraprofessional relations of nurses and limited research on nurse-nurse collaboration (Dougherty & Larson, 2010; Ma, Shang, & Bott, 2015). Most literature examines nurses’ work environment overall and the high stress, intraprofessional bullying and aggression, the effect on intention to leave nurse, and moral distress (Huffman & Rittenmoyer, 2012). Only some literature was found on nurse to nurse relationships, or nurse to nurse friendships in the empirical or theoretical literature. Moore and Prentice (2015) found that having a relationship with other nurses and knowing them was an antecedent to collaboration. No literature was found on “actual discursive practices in health care team interaction” (Apker, Propp, Zabava, & Hofmeister, 2006, p. 186) upon which to base collaboration. Most literature begins simply with the action of collaboration/teamwork, or lack thereof, among nurses.

One scale, called the nurse-nurse collaboration scale (Dougherty & Larson, 2010) was generated from published tools on collaboration. The authors’ stated assumption is that collaboration among nurses improves patient outcomes and decreases medical errors. The domains in the scale measure themes found in the literature. These themes are that nurses engage in: problem solving, communication, coordination, shared process, and

professionalism. No further work on this scale has been published since that article's publication.

A second group of researchers, Duddle and Boughton (2007), conducted interviews of hospital nurses (n=15) in exploring how nurses related to, and interacted with, one another. They recognized the lack of empirical understanding regarding effective, positive nurse-nurse knowing of one another. They found that nurses negotiate with each other and develop the ability to assess other nurses and the potential success or failure of an interaction before it occurs. Nurses in that study said they were aware, constantly, of each other's workload on the unit and knew exactly what was happening with co-workers throughout the unit. This knowledge of the other nurses allowed them to know how to interact and approach them; who they could ask for help and who they couldn't as easily. However, their thematic analysis found negative behaviors and coping with negativity; and no discussion of how nurses formed relationships. This is relevant to the current study as this study found that knowing other nurses and what they were doing during the shift was an important part of knowing other nurses and doctors.

Dahlke and Baumbusch (2015) conducted a thematic analysis of previously collected grounded theory work (n=24) interviews of nurses, licensed practical nurses and assistants caring for older adults, in order to explain how nurses worked in teams. They also collected 375 hours of observation. One of their findings included the importance of nurses creating relationships with other nurses in order to not only fit in, but as a way to get assistance at work. The findings in the current study include the creation of relationships in order to be able to move through the process of relational work to get

help from one another. However, the other categories of trust and respect, and relying on one another and needing one another, were not findings in the Dahlke and Baumbusch (2015) study.

Liaschenko and Fischer (1999) identified four distinct forms of knowledges that the nurse has in order to produce actual patient outcomes. Three of these knowledges are: case knowledge, patient knowledge, and person knowledge. The theorization by Liaschenko and Fischer includes a fourth type of knowledge, which is social knowledge and mirrors the properties of *knowing what others are doing*, and *knowing others' expertise* in the present study. This knowledge links the three types of knowledge - case, patient, person - with bridging knowledge. Liaschenko and Fischer call this relational practice and reference the work of psychologist Fletcher (1994). Social knowledge is necessary to complete the job but is not acknowledged as work. Theorizing this kind of work is unique because a large part of nursing work is not task-related work. On the contrary, nursing is how work is achieved in extremely complex systems. Liaschenko and Fischer turn on its head the notion that the crucial work is scientific, and that everything else just happens – bringing into question the argument that no knowledge is required to do this social work that connects the nurse, patient, and healthcare providers. This knowledge, as presented in the current study, represents connective power that nurses hold within the hospital, between nurses, and between doctors.

Trusting and Respecting

Nurses said that they trusted and respected, in the category of *Trusting and Respecting*, nurses and doctors, and believed their nurse and doctor colleagues were

knowledgeable, and that nurses and doctors respected and trusted one another. These properties are created by spending time together, getting to know one another through a relationship, and developing surround-like contextual knowledge. Trust and respect among nurses and doctors is evident in the empirical literature (Jordan et al., 2009). Fackler and colleagues (2015) found that nurses believed time was necessary for doctors to acknowledge and develop trust with nurses. They also found that relationships with doctors who acted in a collaborative fashion with them were characterized by trust and respect. The nurses did not feel less authoritative than doctors. Havens and colleagues (2010) found specifically that “respect for work that nurses do with patients” (p. 933) was the greatest predictor of care quality. Respect for each provider’s expertise is a key activity that they found.

In a mixed methods study of (N=42) doctors (n=16) and nurses (n=26) which involved observation, semi-structured interviews and questionnaires of two Israeli and one United States ICUs, researchers attempted to develop a model to describe ICU interprofessional shared clinical decision making (Ganz, Engelber, Torres, & Curtis, 2016). These researchers found that in the context of decision making, specifically within the dyad relationship between nurses and doctors, that “trust and respect can have a direct ramification” (p. 5) on decision-making, with nurses “going up the chain of command” (p. 5) to a doctor they trusted. Having a work relationship engenders collaboration and specifically in developing trust of nurse and doctor colleagues.

As Peter and Liaschenko (2013) theorize, and as was found in the present study, the relationships nurses and doctors form have histories and trust. Trust allows for future

work to occur within the relationship, or, as shown in this study as well, within a web or net of relationships. This shared understanding amongst nurses and doctors instruct what actions need to be taken in order to care for the patient (Peter & Liaschenko).

The *Trusting and Respecting* category demonstrated range in the present study. Nurses experienced lack of respect, from fellow nurses called “nurses eating their young,” as well as from physicians (Alspach, 2008; Johnson, 2015). Both groups, through verbal and expressive means, devalued the nurse. Research demonstrates that when this type of behavior is experienced, nurses experience moral distress (Huffman & Rittenmeyer, 2012) and burnout (Manojlovich & Laschinger, 2008). Lack of trust and respect represent a breakdown or failure to create the relationship. The knowledge and trust that is needed to experience value and expertise within the healthcare team is missing.

In a concept analysis of nurses’ workplace social capital, antecedents to social capital included building trust and relationships with other nurses and other colleagues (Read, 2013). Social capital increases the nurse’s likelihood of offering resources, information and support to colleagues (Read). The formation of trust and respect are necessary to move through the process of relational work to the middle section which shares elements of collaborative teamwork in the literature; this finding is supported in the empirical literature by Manojlovich and colleagues (2014). They hypothesize that “mutual respect may be a determinant of collaboration” (p. 582). The present study also demonstrates trust to be the antecedent linked to these types of behaviors.

Being Approachable, Relying on One Another, and Needing Each Other

Healthcare systems have been called complex adaptive systems (CAS) where individuals or different role groups have specific knowledge and “information asymmetry” between nurse and doctor (DeCiccio-Bloom et al., 2007). Each must share knowledge in order for there to be a successful outcome. These categories of being open (*Being Approachable*) to the interdependent reality of healthcare work (*Relying on One Another* and *Needing Each Other*) identify a breaking down of the process of how work in the healthcare system, between nurses and nurses, and nurses and doctors, occurs. Gittell (2008) posits that the quality of relationships determines the quality of communication in the actions related to task integration or coordination of care activities. Study after study begins with the assumption that the reason interprofessional coordination (IPC) is difficult for members of healthcare teams is because professions are not educated together (Baker, Day, & Salas, 2006). But is that the reason? There were no data in the present study that supported or upheld this finding. Instead, these categories at the middle of the process demonstrate that once a strong relational foundation is created that results in trust and respect among intra and interprofessional colleagues, IPC is able to flourish.

What these three categories represent is that work place interaction is relational and iterative; it goes beyond the scripted checklists or communication tools like SBAR (Situation, Background, Assessment, Recommendation) (Manojlovich et al., 2015). These categories demonstrate the nuance and complexity required for relational work, attesting to the skill and work that these behaviors and understandings require. There are

specific aspects of health care work, and more specifically, relational work of nurses, that characterize work in hospitals on nursing units. As Manojlovich states, healthcare team comparison to other types of groups may not be useable (2010). Characteristics of work on nursing units include, according to Manojlovich: "...team membership, fluidity, rotation, hierarchical relationships, and multiple forms of communication" (p. 941).

Being Approachable

Being Approachable is the nurse being open and welcoming to others. These behaviors are conscious ones that allow others, both nurses and doctors, to approach the nurse for help or with information. It is an explicit acknowledgment of the importance of the nurse's attitude towards co-workers to open communication pathways, towards accomplishment of work goals. Nurses made clear that being asked for help was an expectation of their role.

The literature was searched for studies of characteristics of nurse behaviors in working with doctors. There was a paucity of literature. In a quantitative study of ICU nurses (n=407), nurses stated that the nurse appreciated and felt satisfied with communication with doctors when doctors displayed openness (Manojlovich & Antonakos, 2008). However, no literature was found that specifically examined that nurses displayed the behaviors of openness and being welcoming in order to be helpful to doctors. This is despite the fact that in the present study, many nurses specifically identified this behavior as important in indicating to doctors that they were approachable, and expected to be asked for help from doctors. This is a unique finding of this study.

Nurses being welcoming and open with other nurses was only found in one study; a qualitative case study design of oncology nurses' experience of collaboration (Moore & Prentice, 2015). These researchers found two themes, one of which is relatable to the present study. The theme was that nurses practiced an "art of dancing together" (p. 512). Nurses in that study said that collaboration is facilitated by having a willingness to cooperate and collaborate. As one participant stated: "Having good communication skills is so important...they have to be open to suggestion, open to support and help..." (p. 512).

Specific behaviors that demonstrate an openness and being approachable were difficult to identify in the literature. Often the literature cited "collaboration and communication" (Apker et al., 2006; Dougherty & Larson, 2010; Fackler, Chambers & Bourbonniere, 2015; Kalisch, Weaver, & Salas, 2009) between nurses and doctors as the requisite to good care. Attributes of communication and collaboration were evident in the literature surrounding relational interactions in other disciplines. For example, Parker's (2002) organizational behavior study was able to map out dimensions of relational work as well as the importance of relational work on multiple levels in the workplace, and its influence over work behaviors. The dimensions of relational work were: accessibility, boundary management, connection, collaboration, and continuity. Accessibility represented behaviors that members in a workgroup take to make themselves available to one other. This was found in the current study. In the organizational behavior literature, high quality relational practice is defined as reciprocity between people; talking with: sensitive and engaged interaction; mutually open and concrete discussion; mutual

questioning is encouraged for learning; joint discussions and ownership for tasks; many voices heard (Lambrechts, Grieten, Bouwen, & Corthouts, 2009). These attributes of high quality relational practice share the properties of being approachable and open.

This category had range. Not being open or approachable led others to not ask them for help. Not being open or approachable was a specific finding of one qualitative study of 15 nurse interviews (Duddle & Boughton, 2007). They termed this negative theme: “Difficult Interactions.” This included recognizing that other nurses were not open to questions and to helping. One nurse stated: “You’re just struggling by yourself ...so uncomfortable that you don’t feel able to ask for help...” (p. 32). This is echoed in a separate study of peri-operative nurses, in which not acknowledging colleagues was found to hinder cooperation (Lindwall & von Post, 2008).

Relying on One Another

Relying on One Another includes the properties of having each other’s back, nurses being there with me, and being aware of each other’s needs. This is created by nurses looking out for one another and supporting one another. These behaviors allow for support without having to directly request it.

Kalisch, Weaver and Salas (2009) conducted a qualitative study of focus groups of nursing staff (registered nurses (n=116), licensed practical nurses (n=7), nursing assistants (n=28), and unit secretaries (n=19)). The focus groups were stratified by job role. Data analysis was conducted with software and data from the focus groups were placed into apriori themes from Salas’ earlier literature of five themes of teamwork, outside of nursing. This study is one of the few that examined nursing teamwork

specifically, and not nurse-healthcare team member work (Kalisch & Lee, 2010, 2013). These a priori themes used were team leadership, team or collective orientation, mutual performance-monitoring, back up behavior, and adaptability. The study did not identify a process of teamwork. Themes did not reflect the findings of the present study except for the theme of “back up behavior,” which is meant to be that in crisis, others help without having to ask for it. However, no antecedent behavior was identified, although in this present study, the process of relational work up to this point was found to be the necessary foundation. Baker, Day and Salas (2006) state that a critical component of teamwork includes each team member being able to anticipate the needs of others, which mirrors having each other’s back.

Collegiality may encompass actions taken by nurses to share heavy nursing workloads which are implied in the *Relying on One Another* category. In the category *Relying on One Another*, nurses stated that they were aware that other nurses were around them and that they could count on them for help. In a study by Miller and Kontos (2013), a heavy work load was managed through a strategy of collegiality. Just as a nurse stated in the present study: “We’re each other’s support system” [8, 4]; in the cited study, one participant stated: “...and it’s like you can count on your (co-workers) if you need something” (p. 1800). Siffleet, Williams, Rapley, and Slatyer (2015), in a grounded theory study (n=15) on how to maintain emotional well-being of critical care nurses, found that in achieving goals, nurses relied, broadly speaking, on teamwork. One of the participants stated “...I know there is always someone there, someone who can go further” (p. 308). Duddle and Boughton (2007), conducted interviews of hospital nurses

(n=15) in exploring how nurses related to, and interacted with, one another. These researchers found that often nurses communicated without words. One nurse said: ...you can communicate what you want without talking ... there is not language...” (p. 33). This is reflected in the current study through the property *being aware of each other’s needs*.

Asserting Authority

The present study demonstrates that nurses possess a knowledge of when and how to assert their authority within an established hierarchy, in order to get the best outcome for their patient. This is represented in the category *Asserting Authority*. While the literature recognizes a hierarchy in hospitals, it represents hierarchy with the following assumptions. First, that nurses feel they exist at the low strata of the hierarchy, below doctors (Manojlovich, 2010; Peter & Liashchenko, 2013). Second, that nurses perceive powerlessness because of this hierarchy and it causes self-silencing of nurses (Manojlovich et al., 2015; Morrison & Milliken, 2000). Third, nurses would do better professionally if there was no hierarchy (Weller, Boyd, & Cumin, 2014). Adoption of interprofessional collaborative (IPC) models of care is set forth as a pathway to abolition or flattening of hospital hierarchy (Gittel et al. 2015). The findings presented here demonstrate something different, however.

The nurse participants, time and time again, acknowledged the hierarchy within the hospital, and time and time again stated that they knew and had the power to work within this hierarchy without compunction. They stated, often through examples of recognizing poor physician patient management or poor nursing care, that for the good of the patient, they would effectively use their knowledge of patient, system, and expertise,

to remind others of expectations, and call on their colleagues to remediate care of the situation. When they found that the course of action with their colleague was not appropriate and there was a break in the process, because of something said or done, they would find a “replacement person” to move the relational work process forward, someone they could rely on. This authority is possible because of the contextual situation the work of nursing creates. It necessitates the nurse work, relationally, within it; this structure is of the collective work place and collective goals. Because of the relational abilities described in the relational work process thus far, the nurse has authoritative power.

These results show, from the present study, when there is the time spent and knowledge of others, the nurse is in fact able to assert authority within the hospital hierarchy. This social relationship is powerful for the nurse, not silencing (Edmondson, 2003; Morrison & Milliken, 2000) and it thus empowers the nurse, and ultimately aids the patient by improving outcomes. This is in direct opposition to Manojlovich and colleagues (2015) who posit that the hospital hierarchy is a barrier to collaboration. This present study demonstrates that the creation of social relationships generates knowledge, and the relational work, that situate the nurse in a position of power for him/herself professionally and for the patient.

Fackler, Chambers and Bourbonniere (2015) found that power, or authority, resulted from nurses “knowing their patients and speaking up for them...and using their power to improve patient care” (p. 271). The present study found that it was the knowing

of nurses and doctors and how to assert authority within the system that was a path to power or authority.

This category, *Asserting Authority*, may be a pathway to decreased moral distress. Moral distress is conceptualized as an antecedent to burnout (DeFrino, 2009). Moral distress is a result of intrapersonal role conflict when workers must do something that forces them to act in ways that are in conflict with their values (Varcoe, Pauly, Webster, & Storch, 2012). In a study of understanding variables that influence moral distress of nurses, researchers found that when nurses, even in the face of poor organizational support for voice, had voice were able to reduce their experience of moral distress (Rathert, May, & Chung, 2016). Voice was measured with two questions: “Have you ever felt uncomfortable speaking up about ethics issues when caring for patients?” and “Have you ever felt uncomfortable speaking up about ethics issues at staff meetings?”

The present study did not find that nurses “speaking up” about their patient’s care was noted to be an internal, personal characteristic, nor tied to manager’s role specifically. What was found was that nurses were able to “speak up” and work for their value of caring for their patients in the way they asserted their authority, because of the initial relational work process identified by this study. For example, when the nurse turns to a doctor or a nurse they know and have a relationship with, the nurse can authoritatively advocate for the patient, changing the situation for the patient, and enacting their values. As a result, the nurse engenders the trust and respect of these colleagues. Currently, the empirical literature demonstrates that better collegial nurse-doctor relationships promote decrease burnout of nurses (Manojlovich, 2010), but does

not identify how this happens. The present study may demonstrate that the process of relational work of the nurse, from *Spending Time, Knowing Other Nurses and Doctors, Asserting Authority, Trusting and Respecting* is how moral distress, the antecedent to burnout, is circumvented.

Needing Each Other

The category *Needing Each Other* encompasses the work assumption that in order to accomplish work, co-workers are necessary. Nurses often said that they would have to work twice as long to accomplish the amount of work of each shift (24 hours of work instead of 12) without the help of their staff nurse co-workers. The properties of this category included nurses *having go-to people* who, because of their knowledge of others and their expertise, they could count on; *needing each other's help* as a condition of their work, and *doctors needing nurses*.

Manojlovich (2013) stated that “physicians and nurses need the knowledge of each other’s unique contributions” (p. 298). The participants in the present study said the same things. Experienced nurses specifically discussed the close work of nurses and attendings with whom there was a long work history, knowledge, trust, respect and interdependence. Clearly patients need good nursing and are dependent on nurses. But doctors need them as well. This has not been studied specifically in research.

Doctors needing nurses is a different concept from doctors and nurses equally collaborating. In the present study, nurses often stated that doctors, from interns to attendings, would ask them: what should we do? In the empirical literature, evidence of shared decision making exists (Fackler et al., 2015; Ganz, Engelberg, Torres & Curtis,

2016). The job of nursing and medicine necessitates the work of the other. The study presented here clearly and explicitly identified nurses identifying their role as the needed profession for doctors; the teacher, the helper, and the collaborator. Their work is interdependent in a more expansive way that is not explicitly recognized. It may be that, according to the findings of this study, professions and organizations must explicitly recognize this need in order to make changes to improve coordination between nurses and doctors, and ultimately improve the quality of patient care and patient outcomes.

Helping Each Other

Helping Each Other is the next category in the process that consists of the visible interdependent actions of relational work of coworkers helping coworkers. These are the properties of *you're helping each other* and *doing it for you*. It is not that nurses help and others receive. It is that nurses help nurses, nurses receive help from doctors, and nurses help doctors. Nurses help doctors through teaching and giving them access to their specific knowledge. Nurses help other nurses by teaching other nurses; again, transmitting knowledge. And if the nurse has the relational environment to enter this cyclical and reciprocal swirl of giving and receiving help, he/she can help their patients better.

These properties lead to nurses offering help to each other to accomplish their collective work. In the empirical literature, nurses stated in examples exactly what the participants in this study stated (Kelly, 1998; Moore & Prentice, 2015; Siffleet et al., 2015). In these studies, nurses stated that they would go in and offer help to others they

saw struggling. Siffleet and colleagues found that nurses believed that they always had nurses around them to help.

Havens and colleagues (2010) believe that improved coordination between nurses and nurses, and doctors, is fundamental to patient care quality. They identified the nurse's role in helping doctors, stating that the doctors looked to them for help, knowledge, and expertise. This is often unstated in the literature and perhaps overlooked because of the taken for granted role of 24 hours of eyes and ears that nurses are; but also that they are teachers of doctors, especially junior physicians. The theoretical and empirical literature does not necessarily use the word "helping," as this present study does; the literature uses terms like collaboration and coordination of care. This may be related to nursing's interest in getting away from being identified as helpmates or the "helping" profession. However, it is used in the present study because these are the words the participants used to describe how they work, and what they do, with others in relationships, to complete their work. Is the weight of this reliance and co-working recognized in the power nurses bring to a healthcare organization, in the valuation of nurses? Is it a factor in staffing, retention, outcomes?

In order to be able to help others in order to move to the next two categories, *Getting the Work Done* and *Did the Best for Our Patients*, nurses often said that they needed help in the form of support from their managers and charge nurses to staff appropriately on each shift. When these leaders staffed appropriately, helped with interdisciplinary conflicts, or gave clinical expertise, nurses had time to help their coworkers, which is a pathway to getting done and doing the best for the patients. The

participants stated that they listened to the staff nurses and were accessible. In a synthesis of research studies on how staff nurses view manager support, Schmalenberg and Kramer (2009) identified eight themes of manager support, four of which nurses in the present study identified, that allowed them to engage in relational work with their colleagues in order to get done. These themes are that the manager: resolves conflicts, staffs appropriately, watches our back, and is accessible.

The Nursing Worklife Model (Manojlovich & Laschinger, 2008) presents major elements representing practice environment factors that nursing has control over and demonstrates two interesting points. In the Nursing Worklife Model, they state that leadership is positioned as driving staffing adequacy. In the current study, nurses stated they are able to complete their work and do the best for their patients when their managers staffed their shifts well. Second, that nursing leadership also drives another factor, nurse-doctor collaboration. However, in an important divergence, the pathway to helping one another (in the current study) is demonstrated to be able to occur when nurse managers staff well, not two separate paths. When nurse managers staff well, helping one another can occur.

A recent secondary analysis of cross sectional data from the National Database of Nursing Quality Indicators was studied for effects of unit collaboration and leadership on nurse outcomes (intent to leave, job satisfaction) and quality of care (Ma, Shang, & Bott, 2015). They found nurses on units that had higher levels of nurse to nurse and nurse to doctor collaboration were associated with lower intent to leave and higher job satisfaction. However, a weakness of that study is that it utilized different parts of

established measures. For example, the measurement for nurse-nurse collaboration was adapted from a scale called the Index of Work Satisfaction, created in 1978 with seemingly dated questions (Stamps). The same situation is noted for the nurse-doctor scale. Further, they operationalized collaboration with questions that do not have literature to support their creation. It can be assumed that the authors generated them. They found that nursing leadership led to better nurse-reported quality of care (outcomes). This is echoed by Kramer and colleagues (2007) who found that leadership behaviors and practices directly impacted the working relationships of nurses. The reason for this finding in Ma and colleagues is not discussed, and perhaps was not understood by that study. It states, however, that nurse to nurse collaboration has not been studied empirically as it related to patient outcomes. Nurses helping other nurses was also not found in the empirical literature. However, while the nurses in the current study did not use the term collaboration, they did use the term helping. The current study empirically demonstrates how nurses helping nurses is a part of the process to reach better patient outcomes.

In a study by Havens and colleagues (2010), relational coordination as measured by Gittell's Relational Coordination Survey of nurses (n=747) found that "respect for the work that nurses do" (p. 933) on the Relational Coordination Survey was most predictive of quality of care. Havens and colleagues stated that this dimension of relational coordination can be mediated by managers through organizational support. The present study found this to be the case as well. Nurses in the present study are able to help others,

and engage in the relational work process through to the end, doing the best for their patients, when they are supported by leadership with staffing.

Getting the Work Done

Getting the Work Done emerged as the result of the relational work process up to this point for nurses on each shift. The properties of this category are *nurses going home* and *helping other nurses get their work done*. Nurses repeatedly stated that when they were able to get help, and give help to their co-workers, they could get work done, go home and ensure, through helping others, that other nurses could go home too. The shifts when this occurred were repeatedly said to be smooth, clear, organized. The properties *nurses going home* and *helping other nurses get their work done* may be seen as a structure of accomplishment and solidifying nurse's unique contribution and identity; being seen as a work action leading to positive identity that the nurse creates for his/herself (Manojlovich, 2013). Nurses in the current study repeatedly stated that they recognize when everything is going well and everyone is getting done. This is an accomplishment of nursing – a collective view of the interconnected workings of a unit, a shift. This sense of accomplishment at getting done and going home emerged as an important goal of the day for nurses in the current study.

This same finding was described in the study by Siffleet and colleagues (2015), a grounded theory study (n=15) of staff nurses in an ICU. These researchers found that “achieving goals” (p. 308) was an important component to facilitating nurse's happiness and satisfaction at work. In the Siffleet study one participant stated: “...when I go home after most days when I know that I have been thorough and my work has been achieved

and my goals have been achieved. I can go home and be completely relaxed” (p. 308).

Another participant in that study stated: “I can always go home and not feel any guilt...I know everything has been done from my patient” (p. 308).

Did the Best for Our Patients

Did the Best for Our Patients emerged as the definitive goal of nursing work that is embedded in the overall outcome of the patient. The properties of this category are *not wanting the patient to suffer* and *getting the best outcomes for my patient* and are the ultimate aim and intention of the nurses’ relational work process. The outcome is embedded in the patient. The entire process to this point has proceeded, as a complicated system of interrelated, collective workings, to make sure patients did well. Nurses did not discuss nursing specific outcomes explicitly. The data were related to patients doing well generally. The literature identifies specific nursing sensitive outcomes that can be measured such as decreasing sepsis, central line infections, pressure ulcers, ventilator-acquired pneumonia, and falls (Sharpe, 2015). However, nurses in the current study spoke to making sure their patients did not feel pain, were bathed and turned, had questions answered, and did not decompensate.

The process of how staffing, and more specifically what nurses are able to do on a well-staffed shift, impacts outcomes has not yet been described in the empirical literature (Needleman, 2008; Needleman, Buerhaus, Pankratz, Leibson, Stevens & Harris, 2011). Kalisch and Lee (2011) used the Nursing Teamwork Survey and staffing data, but not patient outcomes, to collect data on how staffing affects perceived nursing teamwork. These researchers conclude that providing quality patient care (similar to the current

study's properties of *not wanting the patient to suffer* and *getting the best outcomes for my patient*) is associated with teamwork. Surprisingly, the study did not include measures of patient outcomes. In their study, teamwork requires nursing units to be well-staffed with higher levels of registered nurses. Specifically, the subscales of better back up and higher amounts of shared mental models were associated with increased staffing of registered nurses per shift.

Unique Findings

The present study of the relational work of nurses is the only study to empirically discover a basic social process that demonstrates how the nurse works in relationships, with whom, and for what goal. In their words, the nurse participants describe a process of how they learn about one another, identify and gain trust and respect, and work together with specific behaviors and attitudes that allow nursing work to be accomplished. The importance of social and relational constructs and their creation in an organization posits relationships as work and the building blocks of all work in organizations. This process is unique because it was not found in an extensive literature search.

The collectivity of nursing work has emerged as the key finding of this study. This study explicates the shared ownership of everyday work processes. The core category, *Coming Together to Get Through*, encompasses, in simple and direct terms, the gestalt of the relational work of nurses. The process shown in the model of relational work (Figure 2) is linear. However, it can be imagined in a dimensional fashion as well, which demonstrates the collectivity of relational work of the nurse (Figure 3); with many nurses, and doctors, working on a shift together.

This collective relational work model (Figure 3) represents multiple coworkers on a nursing unit during one shift and how the process occurs during one day. In looking at the model, there are three people (but it could be number of coworkers on a shift above two) who are able to go through the relational work process in its entirety, by working together, in order to do the best for their patients.

In some cases, an individual nurse will assert their authority to move to a coworker with whom they can replace the coworker they are not able to work with or make clear the expectations, because of something that is said, or done, that is not in the best interest of the patient, and try to re-engage the process, resuming it with a co-worker they can rely on. When the nurse is able to do this, the process can be re-engaged and occur, in order to get their work done and do the best for their patients. There are times when they cannot find a replacement person and cannot rely on their coworker(s), but still must care for the patient. In this case, the effort to complete the work is greater, sometimes with poor outcomes, as was demonstrated by the emotionality of many of the nurses interviewed. Additionally, when a nurse is a float nurse, as some nurses said they were at times, they arrive at the start of a shift not knowing who to approach, not being able to necessarily rely on others, but still needing the help of the others. In these cases, they received less help, and completing their work required greater effort because they did not have the benefit of spending time, knowing others and having trust and respect of the coworkers on that new unit.

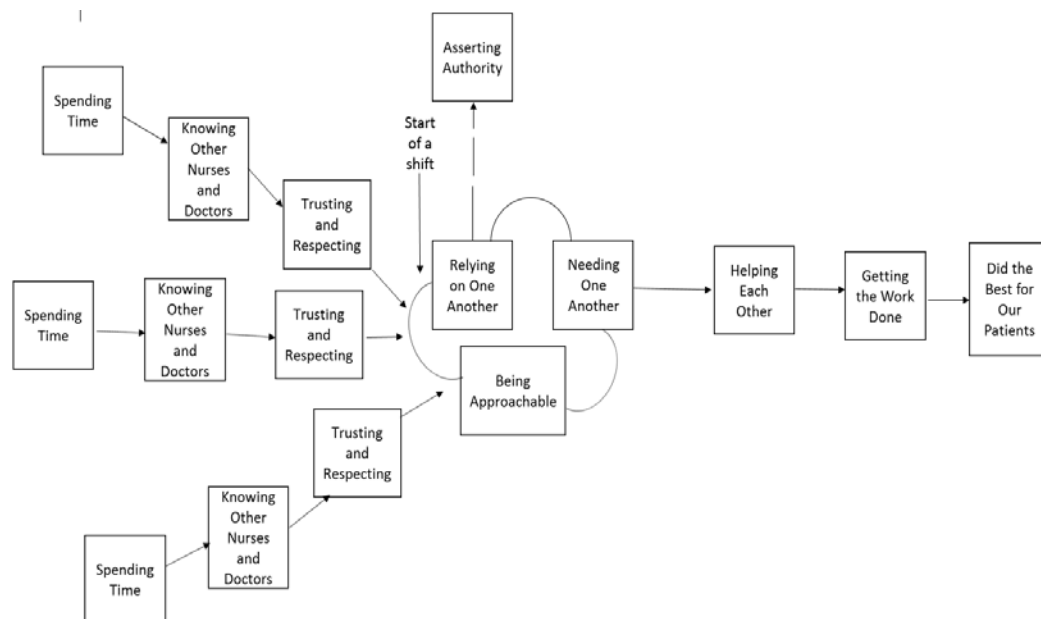


Figure 3. Dimensional model of the collective relational work of nurses.

Limitations

A potential limitation of the study was the higher number of ICU (n=16) nurses to floor (n=7) nurses in the study. ICU nurses volunteered more for the study. This ratio is more than two to one. It may be that additional properties would have emerged had there been more representation of floor nurses. However, the categories were saturated by data from both ICU and floor nurses alike. In most studies of nurse-doctor collaboration, ICU environments are studied. In addition, while the novice researcher believed initially that the hospital setting for interviews may have inhibited negative comments that did not come to pass. Nurses felt free to honestly discuss their experiences with co-workers. The researcher was certain to always meet in a location that was private and free from co-worker observation or listening range during the interview.

Further limitations included that this was a single site, and may represent a relational process only of this institution. For example, this was a Magnet® institution with a high number of registered nurses, and not many ancillary nursing staff, such as licensed practical nurses, certified nursing assistants, or patient care technicians. The perspectives, therefore, of the registered nurses interviewed for this study may not have identified ancillary nursing staff as those with whom they form relationships in order to complete their work because they do not work with them in substantial numbers. House staff were readily available at this institution, which may be reflected in the nurses identifying doctors as those with whom they form relationships in order to complete their work. In addition, this may have only represented the relational process of nurses on nursing inpatient units, and not in ambulatory care settings, where there may be more diversity in nursing roles.

Implications for Nursing Practice

Through the grounded theory method, a theory has emerged which has explanatory power to contribute to nursing knowledge about how nurses work together, and with doctors, to develop a high functioning relational work process which could benefit their goals of finishing work, and doing the best they can for their patients. The relational work of nurses is exposed as work, not socializing. It is a powerful work process, not subservience and niceties. It is a process with clear attitudes and behaviors of give and take in helping one another, not just “teamwork” domains. This is a collective, social process of work.

Nurses should be encouraged to get to know their co-workers, spending time with them, chatting on the unit. They can be encouraged to form relationships as an important work process and not something that is looked upon as socializing and time-wasting. They should engage in a culture that promotes acknowledgment of the strengths of others, and the promotion of their own as a part of collective resources for their work unit, their shift, all of the patients. This can be a new nurse feeling comfortable asking a more senior nurse to help with a blood draw in exchange for computer help. They have to have the time to be aware of and make it their business to know what others are doing, as this shapes the overall outcome of the work shift. Nurses should then be encouraged to recognize these types of knowledge as part of their work day, their skills and, as a result, a powerful part of being a nursing professional. Nursing is situated, literally, in the heart of each unit, all day long, all night long. It is a continuum of care that does not end. As such, nurses should then be encouraged to recognize their knowledge of not just the patient's status, but also of their colleagues' status, so-to-speak. Once the relational foundation is formed, there is a trust and respect between them and their colleagues. If there is a break in the process, the nurse should be encouraged to assert his/her authority within the hierarchy, up the chain of command, and be confident to bring up whatever is needed in order to enact their values in conducting good patient care. This can be in asking the chief resident to come to see a patient that is decompensating because the resident will not act on the nurse's knowledge. This can be the nurse speaking with the manager about helping him/her make clear expectations of treatment by an attending.

Implications for Nursing Leadership

Subsequently, because nurses have the respect and trust of their colleagues, nurses can shift their focus toward the collective completion of nursing work. By being open and welcoming to other nurses and doctors, the nurse will be asked for help. By understanding that nurses rely on one another to do their work, nurses will help one another without even having to ask for it. By recognizing that the work on any nursing unit necessitates interdependency of nurses, and nurses and doctors, nurses will offer help to one another and to doctors. By recognizing that leadership is vital to offering to help one another, managers should be able to staff appropriately to allow the relational work process to occur and become the culture of the unit. Staffing appropriately is a supportive action by the manager. These actions will allow for the completion goals of each shift: getting done on a more smooth-running and relaxed unit, and doing the best for their patients. It is a basic social process.

Implications for Nursing Education

Educators can foster this relational work process to their students. One avenue is to explicitly encourage the actions of the process among nursing students during clinical rotations. Teaching the students to explicate each of these behaviors of spending time, knowing, building relationships, trusting, and respecting as key attributes to getting work done and caring for patients is important. Educators can be sure that during preparation and debriefing sessions the students are asked if they acted in relational ways with their fellow students. They should focus not only on their individual patient, but being sure that they helped their fellow students and other staff during their time on the unit. They

should be recognized by the instructor during debriefing for behaviors such as being reliable and making themselves approachable to others. The key is that this process does not just occur for a certain group, or a certain culture, and those who work on those units are lucky. It is that this is a learned behavioral process that can be fostered.

This type of learning could occur with nursing and medical students together. IPC education could incorporate the theory into developing these relational abilities in nursing and medical students from early in their career, so that their collective understanding of how work gets done in a relational fashion is germane to their everyday work.

Implications for Future Research

Nursing is the largest healthcare profession (Sharpe, 2015) and the basic social process of relational work is not fully understood. Being the largest group of healthcare professionals, the most numerous and present 24 hours per day, the discipline of nursing needs its own theory of relational work; one from the first person perspective of nurses who have experienced the phenomenon.

Manojlovich and colleagues (2011) approach nurse-doctor communication and relationships by observing them during rounds. However, they did not see significant interaction. As corroborated by the current study, nurses did not, even when asked directly by the researcher, say that rounds were a significant place for nurse-doctor communication. These empirical findings will direct future research to observe where and when they interact, with whom and how, on nursing units. The categories of the process described here will serve as guidelines for observation. This second qualitative method would strengthen the understanding of the process. Observation of relational work of

nurses and doctors would allow for a fuller explication of relational work, with triangulation (observation of relational work of nurses and doctors). This would be an important pivot in the literature because most literature state with assumption to its correctness, despite lack of evidence, the way to increase IPC or nurse-doctor collaboration is through nurses participating during rounds (Casanova et al., 2007; McComb, Lemaster Henneman, Hinchey, 2015). Rounding is, however, a doctor-centric communication space. While nurses may find it to be one place to communicate, it is not the main place for communication, as this study demonstrates.

Further research would be to develop an instrument from the processes identified here, to measure relational work of nurses. This would allow nurse managers to identify areas for improvement in the relational work processes of their staff. Another study would be to interview doctors, asking them the same questions to uncover the relational work process of doctors. This may create a complementary understanding to the process of relational work. The process of relational work of nurses may be a pathway to better Interprofessional Collaboration (IPC) that does not just call for abolition of hierarchy, which seems undoable, and nurses being invited to speak during rounds, which are not necessarily the answer to increased IPC. Instead, research could be conducted looking at whether the promotion of a current pathway that was found in this theory, the process leading to nursing trust and respect, to the central interdependency and behaviors thereof, lead to better patient outcomes, and better IPC. Another study is to understand, once the relational work process of nurses is quantified in a measure, if increased relational work of nurses is related to both better patient and professional nurse outcomes. These studies

are areas to pursue because they would allow for measurement of relational work such that weak relational work behavior on a unit could be targeted for change. Quantification of relational work of nurses and doctors warrants research to identify its impact on professional and patient outcomes.

In conceptualizing future studies, the model of relational work of nurses of the current study could be fit into the figure of the disappearing dynamic of the relational work of nurses (DeFrino, 2009) where relational work behaviors are currently (Chapter 1, p. 6) located. Based on the conceptualization of the disappearing dynamic of relational work of nurses, being able to quantify and measure the amount of relational work of nurses on a unit and also measure moral distress, burnout and intention to leave would be a research avenue to pursue for future studies. A study of this nature would be interesting to shift the discussion away from the relentless talk of high levels of moral distress to potentially an intervention, hiding in plain sight, to mitigate moral distress.

Conclusion

The path to explore the relational work of nurses stemmed from a long-time interest to understand where hospital nurses hold power. The route was circuitous, fascinating, and rich. Concepts of power, gender, invisible work, relationships, voice, burn out, moral distress, economic value, ethics and staffing have all floated around in trying to understand power. Ultimately, the puzzle pieces of discovering this emerging process of the relational work of nurses bore themselves out, straight from those who enact this process each day on nursing units. The results make the most sense and create an almost complete picture of the social process.

In this grounded theory study, the model emerged from the data and identifies the process of relational work of nurses. As the findings show, the nurse requires not solely patient and clinical knowledge, but a surround-like knowledge of the people with whom they work. The model is useful for nurses, educators, doctors, hospital management, and researchers interested in getting closer to quantifying the entirety of what nurses *do* on a shift. It is time to move into a new era when all work is recognized as work and if this is done, it can be not only identified, but then valued; valued with time, resources, money and the power that flows from this increased understanding of nursing's work.

APPENDIX A
INITIAL INTERVIEW GUIDE

- 1) What is your age?
- 2) How long have you worked as an RN? (in months or years)
- 3) How long have you worked at this hospital? (in months or years)
- 4) How long have you worked on the unit you currently work? (in months or years)
- 5) In thinking back on when you starting working at the hospital, can you tell me about working with others?

Can you give me examples of that?

- 6) Tell me about some of the things you noticed that helped you develop relationships with people you worked with.
- 7) Tell me about how you accomplish work, working with others.
- 8) Think back and try to describe a shift when you were able to accomplish all of your work.
- 9) Tell me about some of the things you notice that hinder or cause barriers to you developing and maintaining relationships with people you worked with.
- 10) Are there any things you would like to tell me about your relationship to others you work with that I haven't asked you?
- 11) Is there anything else you would like to tell me?

APPENDIX B

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VITA

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