THE DISCOURSES OF REGISTERED NURSES IN PRACTICE FIELDS:

NEGOTIATING PROFESSIONALISM AND THE DEMANDS OF WORK IN 21ST CENTURY AUSTRALIA

A thesis submitted by

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ABSTRACT

Through processes of Critical Discourse Analysis, this study examined the contemporary role of registered nurses in relation to their abilities to act as professionals. Data were elicited from 12 experienced registered nurses in Australia to reveal the discourses that they utilised to articulate and explain their practices, their role performance and their cultures of practice. The findings were examined against social theory and a theory of professionalism to conclude that professional nursing does exist in contemporary Australia, but it sits precariously between nursing's occupational expectations for professionalism and the realities of nurses' clinical practice.

Considering professionalism in a broad sense, the study was framed within Fairclough's (1992, 2001b, 2003) critical social theory and a theory of professionalism espoused by Stronach et al. (2002). Both theories offered valuable frames for this study, which examined whether practising registered nurses could exhibit behaviours of professionals as they negotiated the demands of their jobs. The nurses' narratives were elicited through interviews and analysed through methodological processes modelled from Fairclough's (1992, 2015) concepts of utilising three angles of analysis: at the levels of text, discursive practice and sociocultural practice. The findings were examined against discourses prevalent in contemporary nursing studies, thus using the research literature to explore the wider sociocultural context of nursing.

The discourses that were analysed from the nurses' discussions of their work revealed expectations for care-giving that competed with the necessities to complete that care. Work intensity, a litany of task-based patient care and pervasive audits, consumed much of the nurses' time and focus, leaving small margins for more comprehensive, holistic care. The nurses revealed emotions related to their nursing roles, ranging from pride in one's work to fear of failing the patient and causing harm. The discourses they utilised showed multiple tensions among institutional mandates, enculturated routines,

nursing ideals and variable perceptions of patients' healthcare needs. The nurses shared ways they dealt with the competing discourses they faced. These were most frequently mechanisms for re-storying themselves within the personal aspects of their jobs, such as professional development or employment conditions. They provided examples of challenges in relation to their ability to exert control over their daily work practices and they often expressed negative discourses, including a lack of hope for future improvements.

Amongst the agitation of daily work, the nurses showed professional behaviours in their practice. These often emerged when independent actions, emanating from their individual store of knowledgeable judgement and expertise, were needed in response to the demands at hand. At times, the nurses did show professional behaviours and could be called professionals in their work. The research showed they had the capabilities to act professionally, their ability to do so was hampered by the system constraints surrounding them. To continue as professionals, the nurses' contexts of labour must provide room and scope for them to act agentically. Improvements in system constraints are warranted in tandem with preserving and nurturing their capabilities.

CERTIFICATION OF THESIS

This thesis is entirely the work of Marie Frances Cleary except where otherwise acknowledged. The work is original and has not previously been submitted for any other award, except where acknowledged.

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Associate Supervisor: Professor Patrick Danaher

Student and supervisors' signatures of endorsement are held at the University

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LIST OF ABBREVIATIONS

ADDS	Adult Deterioration Detection System
AHPRA	Australian Health Practitioner Regulation Agency
AIN	Assistant in Nursing
ambs	ambulatory care
ambo	ambulance officer
APPT	activated partial thromboplastin time
CDA	critical discourse analysis
CN	clinical nurse
CPD	continuing professional development
CPR	cardiopulmonary Resuscitation
CVA	cerebrovascular accident
DON	Director of Nursing
EBP	evidence-based practice
ED	Emergency Department
EN	enrolled nurse
Gen Y	Generation Y
GFC	global financial crisis
govy	government
ICU	intensive care unit
ICC	intercostal catheter
KPI	key performance indicator
MET	Medical Emergency Team
MI	Myocardial Infarction
NDIS	National Disability Insurance Scheme
NEAT	National Emergency Access Target
NMBA	Nursing and Midwifery Board of Australia
NPM	New Public Management
NOF	neck of the femur
NUM	Nurse Unit Manager
O_2 Sats	oxygen saturation

OVP	Occupational Violence Prevention
PC	patient-care attendant
PD	professional development
PRIME	clinical incidents database
QAS	Queensland Ambulance Service
regi	registrar
Riskman	incident management system
RN	registered nurse
surg	surgical ward
TED	thromboembolic device
TL	team leader
trache	tracheostomy
TrendCare	staffing management system
Waterlow	Waterlow Pressure Area Risk Assessment Chart

CHAPTER 1:
BACKGROUND AND SCOPE

POINT OF ENTRY

A point of entry to this study came from the following words spoken by a colleague at a departmental meeting. They played a significant role in my decision regarding a topic for doctoral study:

> *We need to get them practice ready. Registered nurses "out there" want nurses who can function as nurses when they are registered. (Associate Professor in Nursing)*

Disheartened after hearing this perception, I questioned whether all my hopes and dreams for nursing as a profession were in vain. I had often explained to students that, although they would not be completely work-ready when they started in their positions, nursing was no different from other professions, and they were heading to be beginners in the field, not experts. An engineer does not sign off on a bridge during their first year of work; an accountant does not initially produce the year-end balance sheets and doctors receive mentoring as interns. I would add that I felt the nursing profession in Australia was having difficulty shedding the previous hospital-trained apprenticeship model and assistance was required in transitioning from student to practitioner including learning opportunities, supervision, mentorship and navigating the expectations of the more experienced staff members. I always assured students that they would get there. They would take the tools that they used at university and they would move beyond practising them to initiating sound decisions, learning what was best practice, and working to improve that practice for their patients/clients, for themselves and for the profession. They would be working and acting as professional nurses – not simply as technicians implementing skills.

I left this meeting wondering whether I was the one out of step. What did "get there" mean in current practice? I needed to find out where nursing as a profession sat in

contemporary Australian healthcare. In universities, were we appropriately educating nurses for something beyond their ticket to stepping into practice? Or should we be "producing" what industry asked for and "getting them" practice ready? Were we in fact setting up disappointment for them with ideals that could never be realised in face-to-face practice? Was the *reality shock* just as damaging as when it first appeared in the nursing literature in 1970? (Kramer, 1970).

I had wondered if my colleague had "gone to the dark side," but now I wondered if I was the dinosaur and creating an unnecessary "dark side" for undergraduates with an expectation for professionalism in their career.

NURSES AS PROFESSIONALS

Coupled with this anecdote and comparable prevalent negativity towards nurses in practice fields, my preliminary reading unearthed research that showed nurses undertaking many work activities that did not signify a professional scope of practice. Allen (2007) for example, closely analysed 58 publications that demonstrated what nurses "do." She established that within "bundles of activities" (p. 43) that occupy nurses in their work, a majority were not in line with traditional assumptions of what the profession of nursing espouses. Examples included "circulating patients" and "managing the work of others" (p. 43). She summarised a "mismatch between nursing's professional ideas and the workplace experiences of most practitioners" (p. 44). My observations and experience from clinical settings reinforced the idea that the present-day organisations, within which nurses work, could be difficult, if not oppressive, for their work practices. Much of the literature regarding nurses' work was written by thought-leaders and researchers; I wondered whether nurses engaged in patient care identified systemic influences on their everyday practices.

My research interests in the transition experiences of graduate nurses, and separately in the future of the profession, needed to wait until I had an understanding of the status of nurses as professionals in present-day Australia. Being educated in the United States, where professional nursing was a "given," I had to rethink whether this were

true in Australia. This left me with a passionate aim for my doctoral study: to investigate nurses' current fit within the work worlds in which they practise.

THE STUDY UNFOLDS

To address this aim, I decided to examine the discourses that nurses utilise when discussing their work, to ascertain if those discourses demonstrate the ability to act as professionals in 21st century Australian registered nursing practice. After delineating this aim, and the research questions investigated, this chapter briefly examines academic literature to provide further background to the complexities of healthcare environments that nurses are experiencing. To establish the boundaries of my investigation, I explore *professional* and companion derivatives relating to the concept of *being a professional*. I also provide rationale for the theoretical framework, the research design of the study, and an outline of the chapters to follow.

Research aim

The research aim was to study data from a selection of experienced registered nurses in Australia to analyse the discourses that they utilised to articulate and explain their practices, their role performances, and their cultures of practice. This analysis involved examining the real versus the ideal for these nurses, in order to construct a picture of what nurses who worked directly with patients were negotiating both to fulfil the demands of the job and to attain a sense of satisfaction with their roles. The analysis considered the influences that impacted on these nurses' ability to perform as professionals and the determinants of success in that performance.

Research questions

The following research questions were utilised to examine the work world for the registered nurses participating in this study and their strategies for negotiating the multiple demands influencing their practices.

1. How do the discourses of registered nurses working in direct patient care reflect their ability to enact professional nursing practices in their day-to-day work?

2. How do nurses say that they (and other nurses) deal with competing discourses in their practice fields?

These work worlds are significantly influenced by the healthcare systems within which the registered nurses work. Complex influences of the Australian Healthcare system underpin the discourses that emerged from exploring these research questions. They are outlined below.

AUSTRALIAN HEALTHCARE CONTEXTS

Despite focusing on a variety of subject matter, considerable contemporary nursing literature (e.g., Baldwin et al., 2017; Garcia-Moyano et al., 2019; Sims et al., 2020) begins with declarations of the increasing complexity in healthcare organisations. Australian healthcare institutions, whether public or private, are working to incorporate and finance increased technology (J. Henderson et al., 2016; Twigg et al., 2013), increases in diagnostic procedures (Australian Government Department of Health, 2019), and multiple informatic and telehealth innovations, including electronic record-keeping (Brown, Crookes, & Iverson, 2015; Brunner et al., 2018; Walsh et al., 2018). Although demographic changes include that Australians are living longer (J. Henderson et al., 2016), the increased life expectancy is accompanied by chronic health conditions and comorbidities that escalate the demand for treatment services and home-life management, including financial support (Australian Institue of Health and Welfare [AIHW], 2020b; Calder et al., 2019). The need for bariatric equipment, including purpose-built beds, hoists and operating theatres, is just one example of

financial load arising from changes both in the demographics of 20th/21st century individuals and in the healthcare offered to them (Campbell et al., 2016). Inpatients' acuity levels have increased, with an accompanying escalation of care costs (Australian Institute of Health and Welfare [AIHW], 2020a; Hegney, Chamberlain et al., 2019), as well as the wait-times for outpatient clinics and the volume of throughput in most centres (Australian Health Ministers' Advisory Council, 2017; Calder et al., 2019).

The administration of healthcare has gradually changed in line with political will and economic forces impacting on most aspects of the 21st century economy. Several authors have attributed this to New Public Management (NPM), which is traced back to the economic practices of the 1980s, including those of Margaret Thatcher in Great Britain and Ronald Reagan in the United States (Duncan et al., 2015). The basic premises of these practices, which follow an ideology described as *neoliberalism* (Duncan et al., 2015), were to allow public entities with government oversight to embark on models of control and funding that aligned more with capitalist drives of markets than with government service. Within Australian public service organisations, healthcare was an early devotee (Germov, 2005), which edged forward until several decades later the landscape can now be described as transformational (E. Willis et al.,2017; E. Willis et al., 2020).

The tenets of financial pull-back were not limited to the public sector: private healthcare and other corporations entwined with healthcare, including insurance providers and pharmaceutical companies, worked within markets and contexts of globalisation and economic rationalism (Rudge & Toffoli, 2020). Several authors have credited the global financial crisis (GFC) with subsequent austerity moves in healthcare (Cope et al., 2016; Duncan et al., 2015), and a necessary concern for managing the workforce. Distinctively, E. Willis et al. (2017) noted that healthcare reform in Australia predated this crisis, and they emphasised that it was the markets themselves that caused collapse, not government public sector spending (p. 3103). In other words, those managing healthcare institutions in Australia were already reining in spending. Nevertheless, the links with economic forces, such as the GFC, did

legitimise a continued culture of austerity in the welfare state, including healthcare (E. Willis et al., 2017). Lipscomb (2020), in a provocative essay, cautioned nursing scholars against using the term *neoliberalism* loosely or without explanation.

Whether called *neoliberalism*, *NPM*, *new managerialism*, or *bureaucratic infiltration*, the prevailing administration of modern Australian healthcare institutions affects how healthcare is delivered, and consequently the environments/contexts within which nurses work. This includes austerity measures (Rudge & Toffoli, 2020), a flattened management structure that provides fewer nursing managers as direct line managers to their teams (J. Henderson et al., 2016), a propensity for outcomes and targets driven by standardisation or a desire for standardisation such as patient-care pathways (Rudge & Toffoli, 2020), and principles from organisational behaviour strategies such as lean procedures (Hegney, Rees, et al., 2019). In practice settings, lean strategies have surfaced, particularly in relation to throughput management such as targets for treatment times in emergency rooms (Crawford et al., 2014; Hegney, Rees, et al., 2019; Lowthian et al., 2015; Moffatt, 2014; E. Willis et al., 2017). Increasing bureaucratisation has also been influenced by increased legislation, procedures, and documentation related to safety and risk, which are not unique to healthcare, but which do occur in abundance within it (Brunetto, Xerri, et al., 2016; O'Keeffe et al., 2015; Ross et al., 2019).

With the underlying philosophy of consumers driving capitalism, the patient or client of the service is considered the consumer of their care (J. Henderson et al., 2016), and this has affected some policies. It has also attracted debate and cynicism about whether consumers really have a choice in Australian healthcare, given inpatient and outpatient hospital wait times (AIHW, 2020a; Harding et al., 2019), the marketisation of healthcare funding (K. Willis & Lewis, 2020) and the bureaucracy of systems such as the National Disability Insurance Scheme (NDIS) (Foster et al., 2016). Changes in economic forces have coincided with social awareness, pressing overt attention to people's rights, and compelling hospitals and other healthcare services to encourage and protect these rights (Dwyer et al., 2020; Grace et al., 2017). In addition to moves to increase patients', clients', and families' psychosocial empowerment, individuals

are also increasingly knowledge-empowered, with internet information readily available regarding symptoms, treatment and choices. This is a positive aspect of change, but it compels nurses and other practitioners to recognise citizens as the drivers of their care, and to accommodate this complexity in the care that they offer (Bergh et al., 2014; Delaney, 2018).

In addition to economic drivers, the management of healthcare organisations have added layers of documentation and record-keeping through mandated accountability procedures as an arsenal intended to mitigate risk and harm. Goodman (2014) stated that over the last couple of decades health services have "increasingly sought to eradicate uncertainties in care, and to control its costs, by the application of practices of regulation and surveillance – protocols, monitoring, targets, audits, evidence-based practice and performance measures" (p. 1266). Some authors have referred to this as an *audit culture* (Darbyshire, 2008; Rudge, 2011; Stronach et al., 2002). In his argument, Darbyshire afforded proper noun status to "Audit Culture," and he implied an established negative entity (p. 36). He supported this stance with the descriptor "metastatic lexicon" for the terminology used within the audit culture, such as "'quality,' 'excellence,' 'accountability,' 'best practice,' [and] 'transparency'" (p. 36). Rudge (2011) built a convincing argument that the audit culture in healthcare serves to keep the system running, and, by affording control to management structures, robs nursing and other professions of their own mandates.

As institutions seek efficiencies in a business sense, managerial rationalisation has resulted in subsequent changes to nursing work and workloads (Cope et al., 2016), including work intensification (Holland et al., 2019; Rudge & Toffoli, 2020; E. Willis, Toffoli, et al., 2015), and an inability to provide the care needed. A growing body of literature, with strong input from Australian authors, highlights missed care by registered nurses, and links these care practices with the settings within which they work (e.g. Albsoul et al., 2019; Harvey et al., 2017; A. Jones et al., 2016). Additionally, adjustments to nurse/patient ratios have not kept pace to counteract the demographics of illness, including the increasing acuity of patients yet shorter hospital stays (Scott

et al., 2019) that has left nurses expected to do more with less (Germov, 2005). Hospital management and nurses "working at the sharp end of care provision" (Scott et al., 2019, p. 1533) disagree in terms of adequate numbers of nurses needed to provide the care required.

This necessarily succinct overview has provided background to the complexities of the contexts described by the nurses whom I interviewed in this study. They spoke of their work and the contexts within which they worked, but they only indirectly referenced politics or business intentions behind management changes or edicts. Their highest concern was to discuss everyday work, and their abilities to enact ideal patient care. From this I had to glean the actions and thought processes that could be considered professional.

A CIRCULAR TERM: *PROFESSIONAL*

To examine the ability of nurses to act as professionals within the complexities of care outlined above, I need to articulate what I was researching in terms of *professional*. Defining a *profession* or *professional*, *professional identity*, *professionalisation* or *professionalism* is a "seemingly insoluble task" (Burns, 2019, p. 38), despite entire books and studies having been devoted to this enterprise (Burns, 2019; Garcia-Moyano et al., 2019; Gunn et al., 2019). The terms on offer remain problematic because authors attribute layers of language, perception and meaning in different contexts and with differing aims. Complicating this, writers frequently use the word *professional* when attempting to define the word itself or derivatives of professional, thus either working in a self-referencing, circular fashion or assuming a prior knowledge of its meaning.

Professional can be used as an adjective, such as a professional nurse or professional behaviour, or used as a noun when attempting to describe nurses in their occupation. Professional has also been studied in terms of its antonym: in Rees et al.'s (2015) study, students commented on *unprofessional* behaviours to delineate their views of professional practitioners. In nursing scholarship, authors have attached the adjective to other aspects of being a professional in attempts to narrow its meaning for clarity in

investigation. These have included: *professional dignity* (Sabatino et al., 2014); *professional self-concept* (Browne et al., 2018,); *professional capital* (Lasiter & McLennon, 2015); *professional dilemmas* (Rees et al., 2015); *professional commitment* (Garcia-Moyano et al., 2019) and *professional occupation* (Ayala, 2020). Moloney et al., (2018) looked at professional commitment with the related term *occupational commitment.*

While not unique to nursing, the claims and concerns about whether a discipline is a *profession* in the traditional sense of the word (Andrew, 2012; Faber, 2002) have occurred for well over a century (Goodrick & Reay, 2010). Nursing has not only joined the debate but can be accused of devoting "an extravagant amount of concentration to the subject of professionalism and professionalisation" (Rutty, 1997, p. 244). Regardless of whether it is called a *profession* or a *discipline* or an *occupation*, nursing has been "slow to move towards a referenced identity" (Andrew, 2012, p. 848), meaning a collective identity that is clear to both its members and onlookers. This could be attributed to a historical struggle for nursing to define its knowledge base and practice parameters (R. Springer & Clinton, 2015). Nevertheless, a professional standing is considered important, both individually and as a collective profession/discipline/occupation, because such an identity, and the practices behind it, move nursing beyond vocational work (Andrew, 2012, p. 846; Benner et al., 2010).

Interestingly, being preoccupied with whether nursing is a profession and whether nurses are considered as professionals seems to be more problematic for nurses and nurse scholars/researchers than for other experts observing nursing. Julia Evetts (2013), a well-published sociologist studying professionalism in a variety of occupations, included nursing seamlessly when making a point about professional work; she mentioned "doctors, nurses, teachers, social workers" in her examples of professionals (p. 778). Dart et al. (2019) unquestioningly used nursing as one of their research examples in a quest to define professionalism for the discipline of dietetics (p. 958).

Nursing holds status as a profession, not in the archaic, historical sense of clergy, medicine and law, where the ability to control one's own practice and to reign with autonomy were the high ideals of claiming prestige as a profession (Atkins & Tummons, 2017; Ayala, 2020; Degeling et al., 2000), but in the sense of holding a place as an occupation with a distinct body of knowledge. Some authors have accepted uncritically that the move to university education was what sealed nursing as a profession (Keogh, 1997; Sabatino et al., 2014; ten Hoeve et al., 2014; Willetts & Clarke, 2014), with more than one suggesting that prior to this transition nursing was considered a semi-profession (Garcia-Moyano et al., 2019; O'Connor et al., 2020). Other characteristics commonly defined include: a mandate for practice from the government that is also sanctioned by the community (Stievano et al., 2019; Willetts & Clarke, 2014) and robust educational requirements, standards for practice and a code of conduct (Cowin et al., 2019; Willetts & Clarke, 2014), which are self-governed by the profession to achieve and maintain that standing (O'Connor et al., 2020). In Australia, registered nurses are regulated by the Nursing and Midwifery Board of Australia (NMBA), which works in partnership with the Australian Health Practitioner Regulation Agency to accredit bachelor degree programs and to maintain current codes, standards and practice guidelines (Cusack et al., 2019; Nursing and Midwifery Board of Australia [NMBA], 2020).

Some frameworks for professional practice include additional descriptors of practices for nurses, including: promoting professional autonomy, involvement in healthcare decisions, and strengthening professional associations. Interestingly, and possibly indicative of the landscape of professional nurses in Australia, these expectations were confined to the North American literature either overtly (Slatyer et al., 2016) or else referenced in Australian-generated investigations (Gunn et al., 2019; Slatyer et al., 2016). Kramer et al. (2017) in their study of United States (US) and Canadian nurses' professional actions, referred to nursing behaviours as *capabilities*, and included items such as "making autonomous decisions" and "engaging in practice based on evidence (EBP)" (p. 278).

When endeavouring to delineate nursing, some authors have added attributes as descriptors of a profession in line with society's recognition of other professions (Monrouxe et al., 2011; Rees et al., 2015), or they have emphasised the care aspects of nursing, including moral values, compassion, honesty, and upholding the dignity of patients and the public (O'Connor et al., 2020). In the Australian context, many of these added descriptors are incorporated into the standards of practice mentioned previously (Cusack et al., 2019; Grace et al., 2017) – for example: being "respectful of a person's dignity, culture, values, beliefs and rights," and recognising "that people are the experts in the experience of their life" (Nursing and Midwifery Board of Australia, 2016).

Beyond authentication of nursing as an occupational entity branded as a profession, the concept of professionalism further impedes "definitional resolution" (Burns, 2019, p. 49). Atkins and Tummons (2017) wrote that "professionalism can be understood as a fluid concept with a range of different meanings and interpretations, changing over time and according to context" (p. 355). They referenced different orientations to professionalism, including ideology such as "knowledge, autonomy and service" (Eraut, 1994, as cited in Atkins & Tummons, 2017, p. 355), or the capacity for agency (Winch, 2014, as cited in Atkins & Tummons, p. 355). Bliss et al. (2017) argued for the opposite emphasis, claiming that an overemphasis on intellectual knowledge consigned the profession to being simply an occupation if it is devoid of moral aspects. For Monrouxe et al. (2011), professionalism is an internalised self. The behaviours that operate from this internalised self encompass a wide scope, ranging from development in attitudes, skills, knowledge and competence, to capturing attributes of presentation, communication and workplace etiquette (Cowin et al., 2013; Wilkes et al., 2014). Benner (2015) referred to the latter with a parochial US expression "comportment" (p. 1). Cowin et al. (2019) and O'Connor et al. (2020) extended professional etiquette to behaviours specifically enacted within social media.

Cusack et al. (2019) distinguished between *professionalism* and *professionalisation*. *Professionalism*, which is sometimes used synonymously with *being professional*, comprises those attributes that nurses should display when acting with clients, whereas

"professionalisation is the process by which a profession grows and evolves over time to meet the characteristics of a profession" (p. 21). Gunn et al. (2019) wrote a similar compilation for professionalisation, delineating the characteristics as gaining expertise, autonomy and recognition; and they included the more historically traditional traits of prestige and status. Gunn et al. (2019) noted significant differences in the ways that the terms *professionalism* and *professionalisation* are used in nursing, but they warned that similarities exist to the extent that they are at times used interchangeably in the literature, a point also emphasised by Evetts (2013). In their own study, Gunn et al. (2019) used both as search terms, even though their review was centred on professionalisation.

To some authors, *professional identity* signifies an individual's identity and how they see themself as a nurse in the context of nursing practice (Burns, 2019; Sabatino et al., 2014). Authors have linked this concept to self-identity (Crigger & Godfrey, 2014; M. Johnson et al., 2012; ten Hoeve et al., 2014), and have referred to it as "the professional self" (Hegney, Chamberlain, et al., 2019, p. 19). Others have used the term to include the collective identity of the occupational group of nurses as a whole (Andrew, 2012; Browne et al., 2018; Burns, 2019; Sabatino et al., 2014). Browne et al. (2018) considered that the collective identity could be understood as the branding of the profession: they clarified this as a branding by those in the profession, rather than by those such as the public who are peripheral to, but observant of, the profession's actions (p. 90). They added that the collective identity influences one's personal professional identity (Browne et al., 2018). McNeil et al. (2014) and Grace et al. (2017) noted that a professional identity becomes more "bounded" when its boundaries compared with other professions in near proximity. Crigger and Godfrey (2014) emphasised that a nurse's professional identity includes not only internalised virtuous attributes such as compassion and integrity but also a socialised element of following codes and standards expected by both the profession and society (p. 377). Despite their work being about *professional identity*, their constructs did not appear to be vastly different from the model of *professionalism* proposed by Cusack et al. (2019). Sabatino et al. (2014) followed a line of both moral attributes and discipline-specific behaviours,

and they skirted the difficulty of defining professional identity by emphasising its development and incorporating everything desirable in a professional. In their definition, the development of professional identity is "an ongoing process developed through the years and involves the acquisition of competencies and capacities learned through continuous professional development, professional autonomy, and decision making, and above all moral integrity as professionals" (p. 667).

After exploring this variety of scholarship to try to understand nurses as professionals, I had achieved a breadth of background about the concept, but difficulty remained in defining what constitutes nurses as professionals. I knew that I wanted more than one's identity and self-reference for a lens to see if actions attributed to professionals were evident in contemporary Australian nursing. In his book, *Theorising Professions*, Burns (2019) provided a useful framework for overcoming the dilemma of definition, and he suggested that "greater modesty in what definitions can do is … a first step to better theory about profession and professionalisation" (Burns, 2019, p. 45). He repeated Dingwall's (1977) caution that "much of the confusion about the notion of 'profession' stems from attempts to legislate its meaning rather than to examine its use" (Dingwall, 1977, p. 372, as cited in Burns, 2019, p. 45). Burns (2019) suggested that definitions of professions may be sociologically useful when used to justify the social power or existence of a particular professional group, but they do not help to explain how and why particular groups have come about and how they occupy the place that they do within contemporary society or work (p. 46). Additionally, he proposed thinking of *profession* and therefore of *professional* as a rich sociological concept. Similar to other rich concepts, such as identity, power and social class, theorising about nurses as professionals requires the same breadth of analysis afforded to other rich concepts, including "attention in terms of complexity and other socio-political negotiation and context and all the literature surrounding these" (p. 55). Burns continued to suggest that building a study on a prior definition does not help with considering whether the political position that the profession currently holds "is a desirable state of affairs," nor does it explain whether a profession should continue in its current form (p. 46).

For a broader understanding of how registered nurses currently function in their roles, both individually and as a professional group, I decided to follow the modesty that Burns (2019) suggested, and to undertake the study by questioning where nurses find themselves, rather than affirming prior definitions or looking to substantiate theory about whether nursing is a *profession*. The review above demonstrates significant overlap in the usage of terms and concepts related to professionals. This rich representation of attributes from the literature, coupled with the theoretical framework and method of study chosen for this PhD study, ensures that the concept of professional and professionalism in nurses will be treated in this study with a depth of analysis befitting a complex concept. Such an approach provides room for analysing the contexts within which nurses find themselves, as well as their depictions of their work.

A THEORETICAL ORIENTATION AND A PRACTICAL APPLICATION

To achieve this study's research aims, discourse analysis provided an appropriate approach to studying 21st century nurses in practice. I approached the theoretical framework and the research methodology in tandem. Each was designed to explore the discourses that nurses were using to discuss their work in direct patient care, and to establish whether this work represented abilities for them to act professionally in their roles. Both the theoretical framework and the research methodology helped me to analyse how the participants in the study referred to their current nursing practices and to their perceptions of the wider socio-political discourses affecting their work.

Several authors have discussed examining the discourses surrounding professionalism as a means of discovering their nuances and use in specific contexts (Atkins & Tummons, 2017; Freshwater et al., 2014). This is particularly useful given that identities and contexts are continually shifting, and that evolution will be necessary to survive in the continually changing face of healthcare (Candlin, 2011). Freshwater et al. (2014) stated that discourses can help frame professional identities into being as much as the roles, values and attitudes that professionals assume (e.g., professional

identity). Unpacking these discourses helps to examine the profession's practices rather than accepting them uncritically (Freshwater et al., 2014). Burns (2019) continued his encouragement of a widely applied approach, and he suggested that, "from within common professional discourse and everyday talk, it is possible to discern deeper themes that require addressing, regardless of what formal definitions or definitional approaches are adopted" (p. 47). With scholars encouraging the concept of a professional being studied through the discourses surrounding it, discourse analysis became an obvious choice for the study's methodology. Additionally, the original anecdote that drew me to the study was an example of discourse – in this case, speaking to a "nurse as worker" discourse.

Central to the focus of this thesis was a study by Stronach, Corbin, McNamara, Stark and Warne (2002), who explored data that depicted nurses' and teachers' reference to their professional selves against the realities and organisational demands of their role performance in practice fields. Stronach et al. demonstrated that nurses (and teachers) in their study were caught between their profession's ideology and the policy-driven measures of their performance. The nurses had to balance this tension by navigating their work to simultaneously answer to the organisation for which they worked and still be true to their own sense of purpose and the profession's assumed charter. Stronach et al. were not just saying that nurses in contemporary healthcare settings are unable to practise the many aspects of work within typologies of professionalism, but they argued that these static categories are unhelpful to the current practitioner living within an audit culture. They looked at "the professional self and its disparate allegiances as a series of contradictions and dilemmas that frame the identity of the professional as an implementer of policy" (p. 109). These ideas, which Stronach (2010) in later writing wished to be considered as *theory*, fitted well with my desire to see just where registered nurses are situated as professionals in present-day Australian practice contexts. Stronach et al.'s (2002) theory of the professional self within the audit culture seems to have been lying dormant since 2002, yet it begged to be examined, especially when the literature referenced above demonstrated an increase in managerialism and an increase in nurses' discontent.

Critical Discourse Analysis (CDA) offered a way of encompassing the contexts affecting nurses. I was particularly drawn to Norman Fairclough's (1989, 1992, 1995, 2003) writings within critical discourse analysis because his approach, within the many approaches that "huddle together as Critical Discourse Analysis" (Smith, 2007, p. 60), included "the practice of discerning elements of the social world affecting the social practices and uncovering these through the research" (Fairclough, 2005, p. 916). Fairclough's works and writings are as much a social theory as a research method/methodology (Blommaert, 2005). This social theory, with its emphasis on contexts for individuals and on the power dynamics behind discourses, aligned agreeably with the aims of this study to examine nurses' fit within the social worlds in which they practise and the dynamics of organisational politics that influenced their autonomy.

CONTRIBUTIONS TO KNOWLEDGE

Fairclough (1989, 1992, 1995, 2003) spoke a similar theoretical language to that of Stronach and colleagues (2002); I elaborate my understandings of this in later chapters. Surprisingly, their work has not been linked in prior studies. Using them together to underpin both the theoretical framework and the methodological approach for this study produces a contribution to knowledge. Stronach's ideas regarding where nurses stood as professionals at the very beginning of the 21st century are examined in the continuing audit culture nearly two decades later. The process of utilising critical discourse analysis, which is introduced in Chapter 3, adds to the use of CDA in nursing research.

A body of knowledge in relation to nurses' work in Australia is increasing, even as this study progressed. This has included ethnographic approaches that examine what nurses do in their day-to-day practice (Ross & Rogers, 2017), and a variety of approaches investigating what they are unable to do when work intensification puts comprehensive care out of reach (e.g. Albsoul et al., 2019; Harvey et al., 2017; Hegney, Chamberlain, et al., 2019; E. Willis, Toffoli, et al., 2015). Nurses' satisfaction with work has been gauged with respect to their enjoyment (Wilkes et al., 2016), or

conversely their moral distress or intentions to leave the profession (Holland et al., 2019; Rodwell et al., 2017; Shacklock et al., 2014; Zuzelo, 2007). The present study adds to this body of knowledge of nurses' work, and it fills a gap by depicting whether nurses can act in their educated, professional role(s), and how their discourses reveal orientations to their profession and/or allegiances to their employer(s).

At the time of the final editing of this thesis, the worldwide pandemic of COVID-19 has affected every healthcare profession and every country on Earth. The health ramifications, ways of doing things, political jurisdictions, moral principles of equity and access, and economic consequences will change the face of healthcare and of nursing. Some insights from this study of nurses navigating their professional selves in the complexities of 21st century healthcare may help with future analysis of registered nurses facing even greater complexities during the COVID-19 pandemic and beyond.

THESIS OUTLINE

Following this introductory chapter, Chapters 2 and 3 provide the theoretical framework and the research design for this study. In Chapter 2, I examine the theory of nurses' positions as professionals from the perspective of the influential work of Stronach and colleagues (2002). I explain Norman Fairclough's (1992, 2003, 2015) situated orientation to critical discourse analysis, and why his work can be considered a theory as well as a method of discourse analysis. Rationale is provided for my use of literature in later chapters to provide insights into the Australian context for similar or contrasting nursing experiences. In Chapter 3, I outline the methodology of this research, which utilised critical discourse analysis to consider the nurses' intentions in their text – text that was generated from minimally structured interviews with myself as the researcher.

An analysis of the discourses that the nurses shared is coupled with many layers of synthesis. Chapters 4 and 5 both provide data excerpts, which in turn discuss the two research questions. This includes Fairclough's recommendations for considering the

data in terms of texts and contexts. A level of analysis regarding the nurses' abilities to employ their professional behaviours begins in these chapters and is augmented in Chapter 6.

Analysis continues in the discussion of Chapter 6. Relevant literature is presented in a necessarily non-traditional fashion, appearing after the presentation of data and the preliminary analysis of the findings. In this study, the literature is considered as part of the theoretical framework and as part of the "orders of discourse" (Fairclough, 1989, p. 29) that assist in interpreting the impact for nurses of wider healthcare contexts. The data generated from other research studies provided further "voices" of nurses, as well as explanations of wider but relevant healthcare contexts for nurses in Australia. Additionally, the authors' interpretations stimulated my own scholarship. The discussion in Chapter 6 illuminates the data from Chapters 4 and 5, and interprets the situated practices of nurses through several different lens, including my own as a nurse and nurse educator, concurrent reference to relevant literature, Stronach et al.'s (2002) theory of professionalism, and Fairclough's (1992, 2003, 2005, 2010) critical yet realist ontology.

Chapter 7 provides a summary of the conclusions drawn, the knowledge generated and the potential uses for this research. Limitations of the study are addressed, and suggestions provided for potential angles for further studies.

NOTES

The study investigates registered nurses' roles. When the word "nurses," is used it refers to registered nurses.

"Patients" and "clients" are used interchangeably to depict the people being cared for by nurses.

CHAPTER 2:
THEORETICAL FRAMEWORK

The previous chapter covered a breadth of literature regarding professionalism with regards to nurses and nursing. I noted that one particular study by Stronach, Corbin, McNamara, Stark and Warne (2002) stood out as a plausible theory for understanding the status of nurses as professionals. This chapter explains the concepts behind this work, and notes studies by other contemporary authors who have arrived at similar conclusions with different nomenclature. I then explain how Norman Fairclough's (1989, 1992, 2001b, 2010) vision for Critical Discourse Analysis supported theory for this study in addition to driving the methodology, which is outlined in Chapter 3. To complete this theoretical framework, I provide a rationale for including published nursing literature that explored nurses' work in contemporary Australia, and some of the influences on those nurses' professionalism within this work.

A THEORY OF NURSES AS PROFESSIONALS

Utilising empirical evidence from their previous studies, Stronach and colleagues (2002) contended that the professional identity of nurses (and teachers) should in fact be considered as *identities* (plural) (Stronach et al., 2002). Contrary to being named or even defined by boundaries, these identities were expressed in the discursive dynamics of the practitioners. In their empirical data, Stronach and his fellow researchers detected discourses of professionalism that became evident as practitioners relayed the pressures that they experienced navigating between the governmentality overarching their performance and the ideology that they held about that performance. Stronach and colleagues demonstrated illustrations where this governmentality, which they coined *economies of performance*, conflicted with the dispositional elements of practising as a professional that they named *ecologies of practice*. They determined that evidence of professionalism evolved from the conjuncture of the two. They proposed that "it was a theory of 'tension' that would identify what was really going on" (p. 125), rather than a more reductive formula to consider professional behaviour.

Collating and criticising published studies of the contemporary professional identities of nurses and teachers, Stronach et al. (2002) argued that attempts to categorise the professionalism of nurses and teachers into types or stages were unhelpful in assisting individual practitioners' sense of identity, particularly as they navigated their roles in increasingly complex workplaces and work cultures. Using a wide variety of literature and research studies, their paper challenged depictions of nurses and teachers by scrutinising (a) the rhetoric used to describe them, (b) typologies of categorisation, and (c) attempts to universalise individuals into a collective species. Rhetoric ranged from presenting the status of the nurse or teacher as a defenceless victim of forces working against them to hyper-inflating their status as a purveyor of "good" for society (p. 110). Typologies included describing professionals with polarities – traditional vs progressive, holistic vs fragmented – or the work itself as either an "art" or a "science" (p. 110). Professionals were categorised by knowledge: practical/technical or stage of development (Benner, 1984), and by type of role: extended or restricted (Stronach et al., 2002, p. 111). Often expressed as competencies, attempts to corral nurses into a collective identity include portraying universal delivery no matter what the type of client.

Stronach et al. (2002) suggested that the classifications have validity and there is accurate depiction within them, but they proposed that "other intellectual tactics may provide more interesting and useful perspectives on 'the professional,' 'professionalism' and the nature of professional performances" (p. 112). To this end, they recommended a construct of the professional as being situated between the competing alliances. In their words:

> We propose a different reading of the professional as caught between what we will call an "economy of performance" (manifestations broadly of the audit culture) and various "ecologies of practice" (professional dispositions and commitments individually and collectively engendered). (p. 109)

Stronach et al. (2002) derived this construct from a premise of two angles of professional: *outside-in* and *inside-out.* Drawing on Dawson's (1994) work exploring professional codes and standards, they explained that outside-in virtue results from

following a set of external beliefs or principles, whereas inside-out professionalism relies on an "Aristotelian philosophy based on the notion of the 'virtuous person'" (Stronach et al., 2002, p. 113). In applying these premises to professional codes and standards, these concepts become a paradox (Stronach et al., 2002, p. 113) because one cannot be fixed to a professional code (outside-in) in the sense that it cannot cover all that nuances of a situation that relies on ethical interpretation (inside-out) to provide guidance for the context and action. The terms *economy of performance* and *ecology of practice,* and the paradoxes that they create, warrant further explanation.

Economies of performance

Economies of performance are those aspects of work where the professional answers to outside measures either of the accomplishments of the individual practitioner or of the achievement of organisational objectives. The accomplishments of the individual practitioner include measures such as competency standards, which Stanley and Stronach (2013) pointed out have inherent inadequacies, including the potential for mistranslation of the item of assessment and the potential for pressures of external control. They stated that it can be a form of power where state agencies act against professionals' work because the subjectivity is removed, and with it the "immeasurable dimensions that constitute professional action" (p. 292). Accountability by the individual practitioner who traditionally answered to their professionally constituted values (Benner, 2011) has been shifted to accountability that can be counted. In this sense, the quality of service still matters, but it is measured in terms that can be quantified and documented (Jefferson et al., 2014). This shift of accountability may in fact hide organisational objectives with wider political agendas whereby healthcare is "reduced to routinised, quantifiable practice driven by utility, best practices and reductive performance indicators" (Murray et al., 2008, p. 276) while parading as professional or personal development (Rudge, 2011, p. 841).

Organisational objectives manifest in many ways, particularly where individuals in the organisation must account for, or answer to, audits of processes that keep the organisation functioning as "a 'well-run' system" (Rudge, 2011, p. 167). Chapter 1

delineated a number of terms for this organisational umbrella of management structures, and a number of terms exist as accompanying vocabulary of processes: *performance indicators, deliverables, targets, devolved budgets, organisational development teams, objectives* and *evaluation schemes* (Jefferson et al., 2014). The agenda for these management structures is to make healthcare services and other public sector organisations more business-like, oriented to measurable costings and efficiency (Collyer, 2020; Jefferson et al., 2014) such as throughput measures. This translates into nurses having greater requirements for organisational training, multidisciplinary coordination (Gaskin et al., 2012) and utilisation of computerised workflow systems (Lake et al., 2015) while managing the high expectations of others in terms of both the delivery and standard of care (Gaskin et al., 2012; Huntington et al., 2011; E. Willis et al., 2017).

Nurses in leadership roles attract particular scrutiny in economies of performance when they attempt to navigate organisational objectives with defined targets such as bed turnover (Gibson, 2013; Shacklock et al., 2014). This puts them in conflict with the priorities of finishing an episode of care for the patient (Hercelinskyj et al., 2013). Although often seen by the rank and file as part of the management forces, nurse managers have been shown by a number of studies to be frustrated by their perceived lack of autonomy owing to the organisational machine (Gaskin et al., 2012; Huntington et al., 2011; Lord et al., 2013; Twigg & McCullough, 2014), with one voicing: "For us to be good leaders we need to be able to change the things that don't work instead of being told[:] 'This is the system, you will work with it'" (Lord et al., 2013, p. 187).

Ecologies of practice

Similarly to the difficulties demonstrated in Chapter 1, Stronach et al. (2002) also found that professional and professionalism are elusive concepts to capture and define for nursing. They utilised considerable journal article space summarising the typologies and classifications of terms used to describe professional aspects of the roles of nurses and teachers (pp. 110-112). Their précis of their own notion of the professional aspects of a nurse's role, termed ecologies of practice, was that they "refer

to the sorts of individual and collective experiences, beliefs and practices that professionals accumulate in learning and performing their roles" (p. 132). Kemmis et al. (2013), in one of the few critical assessments of Stronach et al.'s nomenclature of *ecologies of practice*, judged that the term lacked clarity and precision (p. 147). I argue that this lack of clarity underscores the search for capturing something not quite tangible – perhaps akin to the colloquial term of an elusive "it" factor.

Others have looked for "it" under different names. Benner et al. (2010) did not reference the term *ecologies of practice*, but they described something very similar in their study of nursing education in the United States of America when they referred to the professional aspects of nursing education as *ethical comportment*. Benner (2011) referred to the moral and ethical aspects of the roles and responsibilities of the profession that join content/conceptual knowledge and practical skills acquisition as a triad for expressing integrated practice. In a British study, Carter (2014) identified inferences in nurses' talk to ascertain whether they voiced values of vocational purposes in their work, or alternatively considered their skills a trade level of practice. Traynor, Boland and Buus (2010) looked for keys to professionalism in nurses' decision-making skills, and they concluded that the nurses' "accounts of decision-making created a sense of professional autonomy and demonstrated control over knowledge" (p. 1584).

While Stronach and colleagues (2002) were referring to the ecologies of practice of individual nurses, they highlighted that the notion was also "*collectively experienced"* (p. 123; emphasis in original). This drew further criticism from Kemmis et al. (2013), who stated that Stronach and colleagues did not fully develop this idea theoretically, and that they were only using the term metaphorically – in fact, "poetically" to contrast with *economies of performance.* By contrast, I find *ecologies of practice* a useful term, for just the reason that this sense of salience is difficult to capture in other terms, and in the Australian context it seems a better fit than Benner et al.'s (2010) old-fashioned (and perhaps American) use of "comportment."

Nuances between economies of performance and ecologies of practice

At first, Stronach et al. (2002) painted ecologies of practice in opposition to the economies of performance; after presenting data from their research studies, they suggested that professionalism can be found in the tension between the two. Likewise, they made the point that economies of performance and ecologies of practice do not represent the dualism of good versus evil. They demonstrated that useful improvements in practice can be derived from economies of performance initiatives; they cited an example where an economy "open[ed] up a diverse and 'more' professional response" (p. 127). It is not an "either or," but it is where they meet that the real professionalism is captured. Stronach et al.'s study asked: "How are these tensions expressed and/or resolved by professional subjects in regard to their duties?" and "Are they necessary tensions for professional performances?" (p. 113).

The professional self, then, is a plurality of identities that spill from constant negotiation between "policy, ideology and practice" (Stronach et al., 2002, p. 109). These identities, situated in local contexts, have an indeterminable nature and cannot be pigeon-holed.

Support from other viewpoints

Stronach and colleague's (2002) work has not been significantly taken up in nursing literature in the ensuing years since its publication, which is surprising given that the bureaucratic world that they depicted has grown in organisational and audit practices. In a republishing of the original article as a chapter in a book, Stronach (2010) added a postscript where he looked at the discursive dynamics in terms of the uptake of his colleagues' and his study post-publication. He cited several studies in the field of education that continued the point of interest in economies of performance and ecologies of practice or that appreciated the anti-taxonomic work in terms of highlighting an oversimplification of typologies of professional work. Stronach did not cite in this postscript two additional studies that have been helpful in informing the

present PhD study, and that utilised the concepts of practitioners striving for ecologies of practice within managerialist cultures of economies of performance.

Fisher and Owens (2008) investigated the ecologies of practice for practitioners in two high-profile government health and social welfare initiatives, and they demonstrated that these practitioners often circumvent audit-based economies of performance with more flexible practices incorporating relational and experience-based knowledge to negotiate with their clients and elicit their needs. Stengers (2005) discussed the ecology of practices with a lead-in of lamenting the practice of physics as a discipline and the fear that it will be subsumed into a "mass intelligentsia" (p. 195). She presented the word "ecology" literally, comparing her premises with ecology of nature, and arguing about survival of practices. Her thoughts, post-dating those of Stronach et al.'s (2002) original publication, have relevance to thinking about the ecology of practice in terms of sustainability. This was relevant for this study with its focus on identifying what helps makes practitioners operate, and potentially in helping to inform what keeps them in practice and the discipline in existence. Stengers wrote: "The problem for each practice is how to foster its own force, [and to] make present what causes practitioners to think and feel and act" (p. 195). She considered the ecology of practice as a model for thinking about that practice, and that the point of identity is the divergence of practices from other disciplines – again comparing with nature where no species is the same.

Recent studies or writings in nursing, including Australian contexts, have depicted the tension that Stronach and colleagues (2002) highlighted without drawing from their work or referring to these tensions with the terms *economies* or *ecologies*. Cope et al. (2015) examined the abilities of nurses to enact intrinsically-valued aspects of care, and they demonstrated that this served as a resistance against opposing forces, such as the new managerialism inherent in present-day healthcare. Gibson's (2013) economy of performance was entitled *enterprising rationality*, with an enterprising organisation being one that governs through market-driven enterprises. Gibson demonstrated that not all nurses will be predictably enterprising; many resisted this in various degrees while enacting the relational aspects of care (ecologies of practice). Using Jamous and

Peloille's (1970, cited in Traynor et al., 2010) "indeterminacy/technicality ratio" (p. 1585), Traynor et al. (2010) searched for aspects of clinical decision-making that were more indeterminate (ecologies of practice), and they found degrees of professional autonomy compared with the prescribed processes (economies of performance) that accompany decision-making. In their study, nurses articulated that their experience was the mediating factor of both types of decision-making, and it took a sense of professional agency to harness indeterminacy and to keep technology at a useful but careful distance. Similar to the nurses and teachers in Stronach et al.'s (2002) study, situational factors did impact on the ability to employ the decisions under the more indeterminate category, with workload and bureaucratic institutional practices often standing as impediments to this and to professional autonomy (Traynor et al., 2010).

Value for this study

Stronach et al.'s (2002) work about nurses as professionals fitted the aim and the scope of this study. Kemmis and colleagues' (2013) critique that Stronach et al.'s premise was under-theorised justified a broader framework for this study, incorporating the influences of Norman Fairclough (1989, 1992, 2003) and an interpretation of the current nursing literature. Fairclough's influence highlighted both the context of the situation and the resulting power dynamics.

A THEORY OF CRITICAL DISCOURSE ANALYSIS

Critical discourse analysis (CDA) suited this study as an appropriate framework to investigate how nurses can preserve, adjust or improve their ecologies of practice within the economies of performance that demand attention in today's healthcare environments. Norman Fairclough (1989, 1992, 2003, 2010, 2012), acknowledged as an influential practitioner in the field of critical discourse analysis (Poole, 2010; Smith, 2007; Smith-Merry, 2015), has written extensively regarding the theory and method of discourse analysis. A consideration of what discourse entails, and how Fairclough

has utilised the term, is important for understanding Fairclough's theory regarding the influence of discourse (and language specifically) on the social world.

Discourse

Scholars use the term *discourse* in a variety of ways, which subsequently translates into a breadth of discourse genres that they utilise and promote. Some researchers consider that discourse is the act of communicating information by written words, talk or conversation (Jørgensen & Phillips, 2002; Potter & Wetherell, 2002). Others consider it to be a collection of language acts, or other means of expression pooled together to form a combined communication about a particular topic, including, for example, photographs, art or mass media (Blommaert, 2005; Georgakopoulou & Goutsos, 2004). Understanding and articulating the range is important because the source of data for this study was a series of speech acts that were created in interviews between the researcher and each individual participant, yet the purpose of the research was to uncover a broader type of discourse, a grouped, patterned meaning related to a particular viewpoint or topic. Both types of discourse were utilised to answer the research questions.

Paul Gee (2011) provided a helpful demarcation in distinguishing the meanings of discourse, and he and others provided a broad representation as to what constitutes discourse. Gee described language used in conversation or other types of "stretches of oral or written language" as "little d discourse" and, separately, that which represents patterns of meaning as "Discourse with a capital 'D'" (p. 177). He used language as the definer in each instance, but he elaborated that Big D discourse is also influenced and communicated through other means of expression such as actions, dress, attitudes, values and associations with groups of people (p. 177).

Fairclough (2003) also distinguished two senses in which discourse can be used, with the somewhat confusing terms *abstract* and *count* nouns (Billig, 2008a; R. Henderson, 2005b). His abstract nouns refer to language and other forms of semiosis used in everyday life, and correlate with Gee's 'little d' discourse, whereas his reference to the

broader discourse, as a means of shaping a particular way of looking at part of the world (Gee's Big D discourse), is demarcated as a count noun. Fairclough (1989, 1992, 2003, 2005) explained that semiosis emanates from broad elements of social life, including language, but also radiates from body language or visual signposts that form communication about a particular topic without being speech acts or printed text. He emphasised this in his later writings (Fairclough, 2005, 2010; Fairclough, Jessop, & Sayer, 2004), and he concluded that he preferred to use the term *semiosis* to *discourse* (Fairclough, 2012). Additionally, Fairclough (2003) separated the ways of being to which Gee referred as a third representation of discourse, whereby discourse "figures alongside bodily behaviour" (p. 26), and he referred to the discoursal aspects of this as "style" (p. 26). This third dimension is a valuable angle in terms of looking at particular affiliations with personal or social identities, including professions, and can be picked up in other forms of research complementary to CDA such as ethnography (Chouliarakia & Fairclough, 1999).

Hilary Janks' (1997) study was an example of broader forms of semiosis than linguistic text: she used a photograph in conjunction with the printed word as communication to demonstrate the "Big D" discourses instantiated within a newspaper advertisement with potential racist overtones (pp. 132-133). Wodak (2008) and Wodak and Meyer (2016) stated that discourse can mean anything from a historical monument to a political strategy, and they outlined how notions of racial discourse, gendered discourse and populist discourses can stretch the meaning of *discourse* from a genre to a collective assemblage. In Fairclough's (2015) principles, this is most closely related to his use of the term *orders of discourse*. Georgakopoulou and Goutsos (2004) predicted that scholars will need to continually adapt their philosophies about the nature of discourse and their methods of study, as discourse is continually shaped by modern technologies and future possibilities. They highlighted the changing boundaries of visual text, such as text found on television or cinema screens, and the humour and play of talking electronically with typographical or graphological mechanisms of capitalisation and emoticons.

In Fairclough's (2001b) orientation to discourse analysis, the compass for studying the social world is through language, including the broader signifiers of semiosis outlined above. Language is expressed as a moment in the social process, a social element that then yields ways of analysing language/semiosis in social processes (p. 121). For Fairclough, an analysis of discourse does not begin and end with the discourses uncovered. In his theoretical interpretation, discourse is a practice that not only represents the world but also signifies it, "constituting and constructing the world in meaning" (Fairclough, 1992, p. 65). Uncovering that meaning is influenced by critical social theory.

Critical social theory

Fairclough (1989, 1992, 2003) and others associated with his paradigm (Meyer, 2001; Wodak & Meyer, 2016) share a concern for how language and/or semiosis interconnect with other aspects of social life, particularly in terms of promoting, maintaining or resisting power. Utilising the scaffolding of critical theory, critical discourse analysts consider the discursive aspects of the social world that reveal inequities and disparities in society (Wodak & Meyer, 2016).

These traditions include a particular concern for those in society whom Fairclough (2010) colloquially termed the "'losers'" (p. 22), those who suffer at the hands of power, or those at the lower end of unequal distributions of wealth. With this repertoire, it is of no surprise to find the Western Marxist tradition, including theorisations of ideology, power and hegemony, to be one of the influences of the critical social scientists, such as Althusser and Gramsici, who in turn influenced Fairclough and CDA more generically (Fairclough, 2001a, 2001b). Additionally, Fairclough (2001a) traced influences of critical theory from the Frankfurt School, notably the work of Habermas, and other social theorists, such as Bernstein, Bourdieu, Foucault and Giddens. Foucault's writings about power, knowledge and discourse, and his use of the term *governmentality*, were particularly influential for Fairclough (1992), and they continue to have a far-reaching effect as present-day researchers, including nurse researchers, strive to understand the neoliberal discourses in society

today (Johnson, 2015; McIntyre et al., 2012; Rudge et al., 2011). Detailing the underpinnings of social theory in critical discourse analysis is beyond the scope of this study, but these have been charted well by Fairclough (1992, 1995), and by Fairclough's writing with Chouliarakia (Chouliarakia & Fairclough, 1999). Two points demonstrate the relationship between critical theory and critical discourse analysis: an emphasis on language and a lens of social critique. Chouliarakia and Fairclough (1999), citing Habermas, Giddens and Baudrillard, noted that "a striking feature of recent critical theories of modern social life is the degree to which they focus upon language" (p. 74). Wodak (2014) emphasised that what distinguishes critical discourse analysis from other forms of discourse analysis is the lens of social critique, an attempt to "make the implicit explicit" (p. 304).

The enduring legacy from critical social theory for critical discourse analysis includes researchers' concerns with tensions between oppression and liberation, and the degree of structure versus agency in a particular social world (Rogers, 2014). Those inspired by critical social theory seek not only to critique domination but also to work towards creating "a society free of domination" (Rogers, 2014, p. 20). Fairclough (2001a) outlined this purpose for critical discourse analysis:

> Like critical social science generally, CDA has emancipatory objectives, and is focused upon the problems confronting what we can loosely refer to as the "losers" within particular forms of social life – the poor, the socially excluded, those subject to oppressive gender or race relations, and so forth. (p. 22)

Not all subjects of interest and problems to be addressed need to be dramatic or revolutionary to make transparent what is not apparent. Wodak (2014) wrote that any social phenomena are appropriate for critique:

> The objects under investigation do not have to be related to negative or exceptionally "serious" social or political experiences or events; this is a frequent misunderstanding of the aims and goals of CDA and of the term "critical," which, of course, does not mean "negative" as in common sense usage. (p. 310)

Research provides an opportunity to uncover hidden assumptions, and to challenge aspects that are taken for granted (Fairclough, 2001b; Gee, 2011; Georgakopoulou & Goutsos, 2004). Fairclough (2001b) stated that critique may be considered negative critique in terms of diagnosing a problem to study, but that positive critique can occur in identifying previously unrealised potential for tackling the problem. He recommended a process for closing the loop in the final stages of a research study: the "analysis turns reflexively back on itself, asking for instance, how effective it is as critique, whether it does or can contribute to social emancipation" (p. 127).

Contemporary social world

Fairclough's theoretical influence on this study extends beyond his part in the theoretical development of critical discourse analysis to his research into the contemporary social world, and his consequent writing and theorising. Fairclough is concerned with processes of social transformation that received much attention in his writings around the turn of the millennium (2001a, 2001b, 2005; Fairclough et al., 2004), and that have not abated in the ensuing years (2010, 2012). His themes of neoliberalism, transition, a knowledge-based economy and the information society (2012) align with those that Stronach et al. (2002) outlined for the term *economies of performance*. Fairclough (2001a) noted an increase in the prominence of these elements in social life, which consequently highlighted discourse, language and semiosis as significant features in social theory and research. The knowledge-based economy, for example, means that, as new knowledges are produced, they are circulated and applied, such as a discourse of teamwork or a buzzword of "quality" (p. 27). Permutations of discourses through social practices elevate them to much more than a buzzword; Fairclough (2001a) used the example of higher education, where "appraisal is located within the University's quality assurance/enhancement process" through all levels of the organisation, and is used to measure success in a competitive, market-driven economy (p. 31).

More disciplines are seeking an understanding of where they fit within these discourses of contemporary society. Nursing research is among these, with an increasing number

of studies considering discourse (Clinton & Springer, 2015; Traynor, 2006), or neoliberal influences (Huntington et al., 2011; Schluter et al., 2011), or both (Rudge et al., 2011; Schofield et al., 2012). Fairclough (2012) stated that his overriding objective (and that of CDA) is to give precise accounts of the ways in which social changes are both changes in discourse and changed by discourse. The aim is to identify, through the linguistic and interdiscursive features of texts, how discourse fits with the non-discoursal elements of social contexts (Fairclough, 2012). It is important, then, to understand Fairclough's consideration of discourse in the social world, and the degrees of agency and structure for participants in their social fields.

Fairclough shares with other researchers practising critical discourse analysis within his philosophical school, such as Wodak and Meyer, ontological assumptions about the nature of social life (Meyer, 2001). These include that social phenomena are socially constructed: people construct meaning of the world in which they live, which contributes to replicating and transforming that world (Fairclough, 2005, p. 916). The means of creating these concepts is through discourse (p. 916). Fairclough emphasised that a relationship exists between discourse and social structure: they work dialectically. Maintaining a dialectical focus avoids what Fairclough (1992) described as the "pitfalls" of either: considering that discourse is 100% socially determined and thus a "mere reflection of a deeper social reality," or conversely overemphasising that discourse constructs the social world (p. 65).

Fairclough (1992) was careful to distinguish between *construe* and *construct*, and in doing so he distanced himself from the category of being a *social constructionist* (p. 5; see also Fairclough, 2004, p. 24). He explained that social constructionists emphasise the role of language and text in constructing the social world, to the degree that the social world itself is reduced to discourse (Chouliarakia & Fairclough, 1999, p. 28). He avoided this extreme interpretation: he perceived that potentially there are realities that constrain the extent to which texts (discourses) can construct the social world (Fairclough, 1992, p. 5). In his words:

> We need to distinguish 'construction' from 'construal', which social constructivists do not: we may textually construe (represent, imagine, etc.) the social world in particular ways, but whether our representations or construals have the effect of changing its construction depends upon various contextual factors – including the way social reality already is, who is constructing it, and so forth. (Fairclough, 1992, p. 5)

Likewise, Fairclough rejected a deterministic view of the contextual factors of the social world ruling the social effects. The social world needs to be considered as an open system, whereby aspects of social life, including culture, economics, politics and linguistics, as well as psychological and social determinants, have a generative effect (Chouliarakia & Fairclough, 1999, p. 19), but not a governing effect, on social events. These are not mechanisms in the sense of machinery, but instead involve a complex interplay between them whereby the effects of one mechanism on social life are mediated by the presence or effects of others in the production of social phenomena (Chouliarakia & Fairclough, 1999; Elder-Vass, 2011). This frame of reference influenced data interpretation in the present study in terms of considering the extent of individual agency within structures of the nurses' professional worlds.

Fairclough stated that his perspective on discourse and the social world included a realist ontology (Chouliarakia & Fairclough, 1999, p. 19; Fairclough et al., 2004), a position that is shared by a number of other scholars, including Elder-vass (2011), Jessop (Fairclough et al., 2004) and Sayer (Fairclough et al., 2004), to name a few. Fairclough's realist stance was evident in his earlier writings about discourse (Chouliarakia & Fairclough, 1999; Fairclough, 1989), but he became more explicit in his later works, especially those involved in organisational studies (Fairclough, 2005; Fairclough et al., 2004). This is pertinent given that nurses are influenced by the healthcare organisations within which they practise.

Fairclough (2005) explained critical realism, with acknowledgement of previous scholars, Bhaskar, Archer and Sayer, as a sense of looking at the world, as both pre-existing and being formed along the way. The world exists regardless of our knowledge about it, but the social world differs from the natural world in that it would

not exist without human action. There are aspects of one's social world that are pre-determined, and aspects that exist whether one is aware of them or not. This means that researchers/scholars must avoid confusing the nature of reality with our knowledge of reality; the latter is not the bottom line. Instead, critical realists propose a "stratified ontology" (p. 922) of three properties of social reality. This stratum is separated into: (a) "real" world, which means structures and causal powers that exist in a mode prior to events and subsequent actions, (b) an "actual" social world, which includes human events and processes, and (c) an "empirical" world, which is the reality experienced by the actors involved (p. 922). These distinctions become quite blurred when considering the causal powers within such a representation. Causal powers are not exclusive to the "real" mode, as social actors can also cause change in the world, and the "actual" realm does not simply reflect the "real" in certain circumstances; it depends on the complex interplay and influence of different assemblages.

In Fairclough's (2005) words: "Critical realism claims that mediating entities are necessary to account for the relationship between structures and process/events" (p. 922). These entities are social practices that are reasonably durable expressions of social elements, including discourse, which can be articulated in time and place. These practices are further networked into institutions, organisations and fields, both bounded fields, such as paediatric nursing, and broader fields, such as a political field (Bourdieu, 1990; Fairclough et al., 2004). The important point is that critical realism takes a stance that reality is not conjured by individual perceptions; there is an existing structure within which practices are situated, and these practices can either reproduce or transform this world, from the effects of both structures and human agency (Fairclough, 2005, p. 923). This is consistent with Fairclough's position of a dialectical relationship between discourse and the social world.

Fairclough's theory extends beyond highlighting social practices; his methodological approach of an analytical framework for critical discourse analysis is a further component of his theory for examining social worlds and studying language in its relation to power and ideology (Poole, 2010). Critical discourse analysis becomes a means (both theoretically and procedurally) for examining texts of discourse and the

pre-structured reality with which human agents are confronted (Fairclough, 2005; Fairclough et al., 2004).

Fairclough's conceptual tools, which Wodak and Meyer (2016) stated are important for a researcher to address before passionately speculating over a grand theory, were appropriate for this study. Fairclough's consideration of the use of language for eliciting the discourses of the nurses' everyday professional identity(ies) within their practice contexts provided appropriate conceptual lenses for exploring their inculcated or engineered ecologies of practice against the "social/sociological variables and institutional frames" (Wodak & Meyer, 2016, p. 13) of their situational economies of performance. These tools are explored further in Chapter 3.

Points of difference

Although recognised as one of the most influential writers and practitioners of critical discourse analysis (Widdowson, 2007), Fairclough has also drawn criticism for his social theory of discourse. Understanding Fairclough's CDA is assisted by considering critiques levelled at it in both theory and method. Widdowson (2007) contended that Fairclough was inconsistent within his framework, because he added the use of text to an outline of his demarcation of the influential spheres of discourse, and he drew from but rearranged Halliday's text uses in structural functional linguistics. In a sense, Widdowson performed a discourse analysis of Fairclough's writing, and the discord could be attributed to Fairclough's presentation of his ideas more than to the theory behind them. If taking the crux of Fairclough's (1989) theory that the text works in a dialectical relationship with the other spheres of discourse such as the formation of identity, influence on interpersonal relationships, and construal of knowledge and beliefs, then foregrounding one over the other is not an issue. Widdowson (2007) focused on one small aspect of Fairclough's (1989) collation of theory, which was later given a more measured place when Fairclough delineated in detail how text fits in a discourse analysis (p. 25). R. Henderson (2005a) demonstrated the use of Fairclough as a theoretical framework for her work on literacy, and she outlined methodically his principles of theory for future researchers. Despite her title questioning whether it was

an eclectic approach, her paper reached a conclusion of the positive applicability of Fairclough as theory for research studies. R. Henderson's reference to Widdowson's comment of "a kind of ad hoc bricolage" (R. Henderson, 2005a, p. 7; Widdowson, 1998, p. 137) is misconstrued by Poole (2010, p. 148). Fairclough's use of linguistics for textual analysis evoked criticism from Billig (2008a, 2013), who explored Fairclough's use of certain textual features such as nominalisation. Wodak (2014) magnanimously welcomed the debate that this criticism generated for their school of CDA with the position that debate is part of theory development, with insights and debates from scholars who test it in use. Criticism, she wrote, can keep a field alive and energise it with new questions and the response of new innovations. Her premise, and that of Fairclough (2012), was that the development and use of theory propelling CDA will continue to progress.

Fairclough is a good fit for this study. The critical stance, an awareness of present-day societal and organisational discourses, a grounding in critical realism and an approach to studying semiosis provide an understanding of him as theorist. His interest in neoliberal issues, organisations and the interplay between the discourse and the context are all very applicable for studying nurses' ability to perform nursing in the modern world. Fairclough has drawn on a number of important theorists, but importantly has come up with his own theory, which can be utilised effectively in this study.

Transdisciplinary theory

The appeal of studying within Fairclough's (2001b) tradition is that a wide range of theory can be drawn upon (Wodak, 2014). This has opened the way for transdisciplinary studies in discourse analysis, which Fairclough (2012) promoted to paint a comprehensive picture of a social field when critical discourse analysists work with experts in other fields. Wodak (2001) emphasised that a marrying of disciplines may provide an appropriate approach to situating a discourse study. Organisational studies are one realm where this would be appropriate (Fairclough, 2005) and large-scale historical studies is another (Wodak, 2008; Wodak & Meyer, 2016). Studies designed in a transdisciplinary sense involve a critical discourse analyst working as

the expert analyst with other disciplines seeking answers to their social problems. An example of this was Candlin's (2011) study, where she joined with a discourse analyst to study the professional identities of nurses that surfaced in their discourses with patients during health assessment. Fairclough (2005) considered a study to be transdisciplinary if other disciplinary knowledge is feeding the framework, even if the analyst and the author are one and the same (Fairclough, 2005), as was the case in this study.

Utilising other theory in conjunction with that generated by critical discourse analysts assists as a frame of reference for centring the reading of discourse, which Poole (2010) warned can otherwise be read according to the passion or the "politically grounded 'pretext'" (p. 151) of the producer, a criticism that he levelled at Fairclough's work. Fairclough (2010) acknowledged that multiple readings can occur (see also R. Henderson, 2005a), and Wodak (2014) emphasised that diversity within CDA is one of its salient features (p. 311). In this thesis, adding Stronach et al.'s (2002) work to Fairclough's (1989, 1992, 2003, 2005, 2010) stance has encouraged a reading of the position of the nurses whereby the managerial discourse may have some (albeit minor) positive benefits, in addition to the critique of the contexts within which they find themselves. This has been a practical example of Wodak's (2014) reminder that critique does not have to mean negative criticism (p. 304).

ORDERS OF NURSING DISCOURSE

In this study, I used the insights from published research to inform the discourses found in practice that related to the ability of nurses to enact their practices in a professional manner. Much of the contemporary discourse may be invisible to the practitioners in practice, but for me, as an academic and a researcher, wide reading underpinned my interpretation of the interviewed nurses' contributions to this study. Nurse scholars, researchers and managers have written about the discourses shaped by contextual issues that Stronach et al. (2002) and Fairclough (1989, 1992, 2003, 2005, 2010) highlighted. Crowe, (2000) for example, explored how nursing has been shaped by its

history and discourses, but is also shaped by "more contemporary discursive constructions of healthcare delivery as a business" (p. 963).

These nursing discourses, under many different names, comprised part of the *order of discourse* for the current study. Fairclough (1989) used the term *order of discourse*, which he credited to Foucault (p. 28), to describe the conglomeration of discourses found in a particular social order; they are combined to work together in a distinctive way (Fairclough, 2010). Fairclough (1989) stated that "discourse and practice are constrained not by various independent types of discourse and practice, but by interdependent networks which we can call 'orders' – orders of discourse and social orders" (p. 29). Orders of discourse may be those of a social institution, where discourses are constituted in a particular way, or those in society as a whole. They have fluid boundaries and a constant changing of the structure of discourses, depending on changing relationships of power or control at different levels of the social structure and in larger societal contexts (Fairclough, 1989, p. 30). An example in nursing may be the relationship between convention and practice, which may draw further influences from policy discourses.

Discourses from previously documented nursing studies relate to either my own interpretation or the reader's interpretation, and thus can be considered part of the theoretical influence on this study and an influence on the process of production. Additionally, dissemination of the research results from this study will dialectically feed back into the orders of discourse in nursing and academic fields.

The aim of this study is to provide description, interpretation and explanation of the discourses of nurses working in practice fields, answering the research questions to the degree that was possible within the window of data provided. This will provide one small piece of analysis within the full orders of discourse of the complicated contexts of modern-day health.

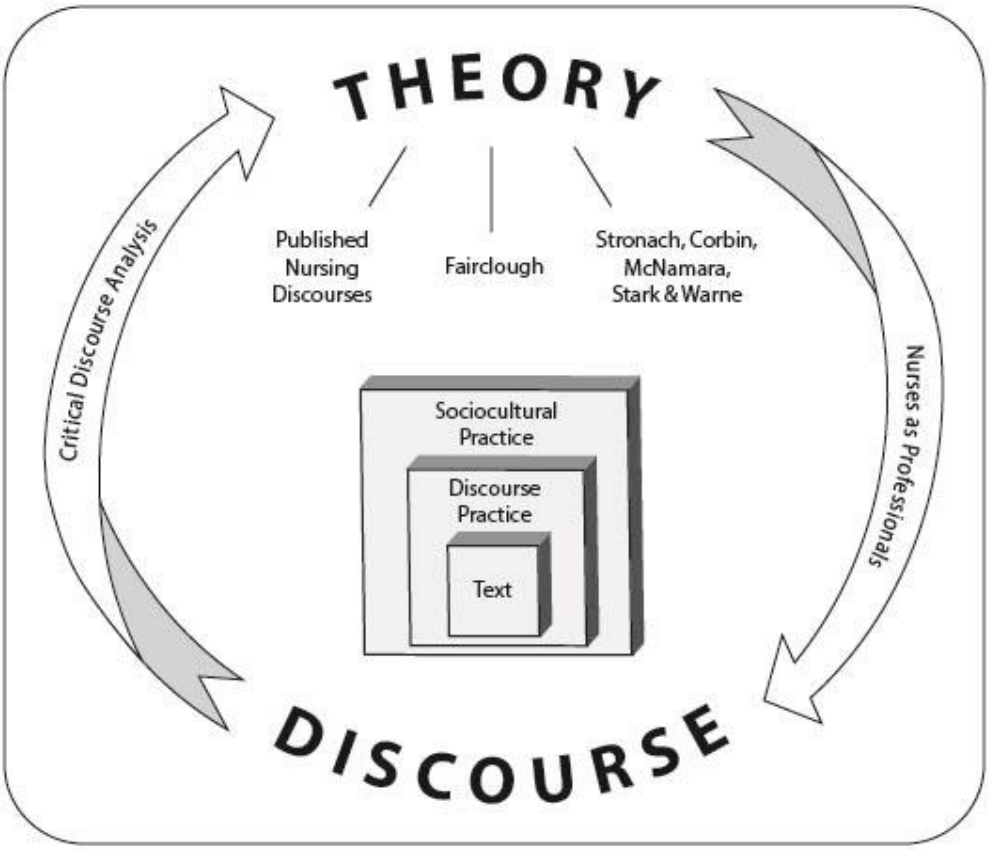
Conceptual framework

The breadth of approaches to critical discourse analysis, and the breadth of theory relating to its application in a diversity of fields, call for clarity in understanding and making explicit the approach (Wodak & Meyer, 2016). To this end, Figure 2 below demonstrates the conceptual framework.

This figure shows the three aspects of theory outlined in this chapter. The discourses of the nurses, will speak to the research questions and be analysed through methods of critical discourse analysis, that is represented by three nested boxes in the diagram. Chapter 3 explains this analysis and the methodological processes. The critical discourse analysis and the theory underpinning this study are shown with arrows to represent the information which moves back and forth in a dialectical manner

Figure 1:

Conceptual Framework



CHAPTER SUMMARY

A concept of professionalism introduced by of Stronach et al. (2002) considered the contexts that nurses (and teachers in their study) navigated while striving to utilise the professional aspects of their occupation. Stronach et al. proposed that being a professional emerges when the nurse is dealing with the complexities of practice. This challenges the nurse's agency for practice, which dovetails with Fairclough's (1989, 1992, 1995, 2005) writings within critical social theory. Fairclough considered the abilities of the individual to act without obstruction within the complexities of the social or occupational world. Both Stronach et al., and Fairclough's orientations work to underpin this study which considers whether nurses can act as professionals within current healthcare environments. These two components are augmented by an analysis of contemporary Australian nursing practice, found in published nursing literature.

CHAPTER 3:
RESEARCH DESIGN

The research design for this study continues in the tradition of discourse analysis illustrated in the previous chapter. Critical discourse analysis (CDA), under the guidance of Norman Fairclough's (1989, 1992, 2003, 2010) writings, frames the design of this study. Within this tradition I have chosen all the methods and processes of research for the purpose of identifying the discourses that participating nurses articulated to consider how contexts influenced their capacities to act as professionals in their work fields. One of the volitional features of discourse analysis is its diversity (Meyer, 2001, p. 30; Wodak, 2014, p. 311), and studies like this one become a bespoke version. This does not imply an ad hoc assemblage, but rather a bounded study tailored to answer the research questions effectively, and to enlarge the body of knowledge (order of discourse) related to present-day professionalism in nursing in Australia.

In this chapter, I explain the methods for conducting the research, and I provide rationale for utilising these methods. This begins in *Shaping the Frame* with an explanation of Fairclough's (1989, 1992, 1995, 2003) orientation to critical discourse analysis which underpins all aspects of the study and which provides tools for collecting, examining and understanding the data. In *Conducting the Research*, I delineate the chosen methods and the scope of the study, including the participants, the method of data collection through interviews, the premises for interpreting the data generated and the logistics surrounding the research process. Following this, I explain, in *Analysing the Discourse,* the techniques that I used for the data interpretation and analysis. A final section, *Employing the Discourse*, notes the potential usefulness of the conclusions from this study.

SHAPING THE FRAME

In the previous chapter, I explained Fairclough's theoretical influences on this study with his views of the social world and the position of discourse within that world. Additionally, Fairclough (1989, 1992, 1995, 2003, 2010) wrote extensively about methods within critical discourse analysis, and he provided conceptual tools to guide researchers. This study was built using these methods, including his continuing methodological philosophy. I consider the entire study to be built on the underpinnings of discourse analysis. I grew to understand and work with this as a comprehensive approach to research, not solely as a method of analysis. Under the umbrella of critical discourse analysis, multiple options exist for researchers to design studies to elicit and examine discourses (Smith, 2007, p. 62) that all centre around operationalising the link between the linguistic and the social (Chouliarakia & Fairclough, 1999, p. 16).

The research design began with a process of gathering insights into the work world of nurses by interviewing 12 nurses working directly with patients in clinical practice. These nurses participated in semi-structured interviews with myself as the researcher. Their interviews were transcribed and the data generated were scrutinised to ascertain several discourses that the participants employed to foreground aspects of their work (Research Question 1) and their abilities to deal with competing discourses within that work (Research Question 2). This began a process of non-linear layers of discourse analysis where I continued to analyse data from these interviews to discern both the nurses' discourses that arose and the influences behind those discourses, particularly in relation to their abilities to enact professional practices. My reading of wider contexts for nursing practice within Australia, and of other researchers' findings of professionalism in nursing, would continue across the timeline of the research. In a process of furthering the analysis, I considered this literature in tandem with the findings from my data, and with the theory outlined in Chapter 2. In this research design, the literature review becomes part of the analysis, and is presented in a chapter following the data presentation/interpretation of Chapters 4 and 5. The study

framework then concludes with my insights from the research regarding the current findings of professionalism, and some recommendations for further study in this field.

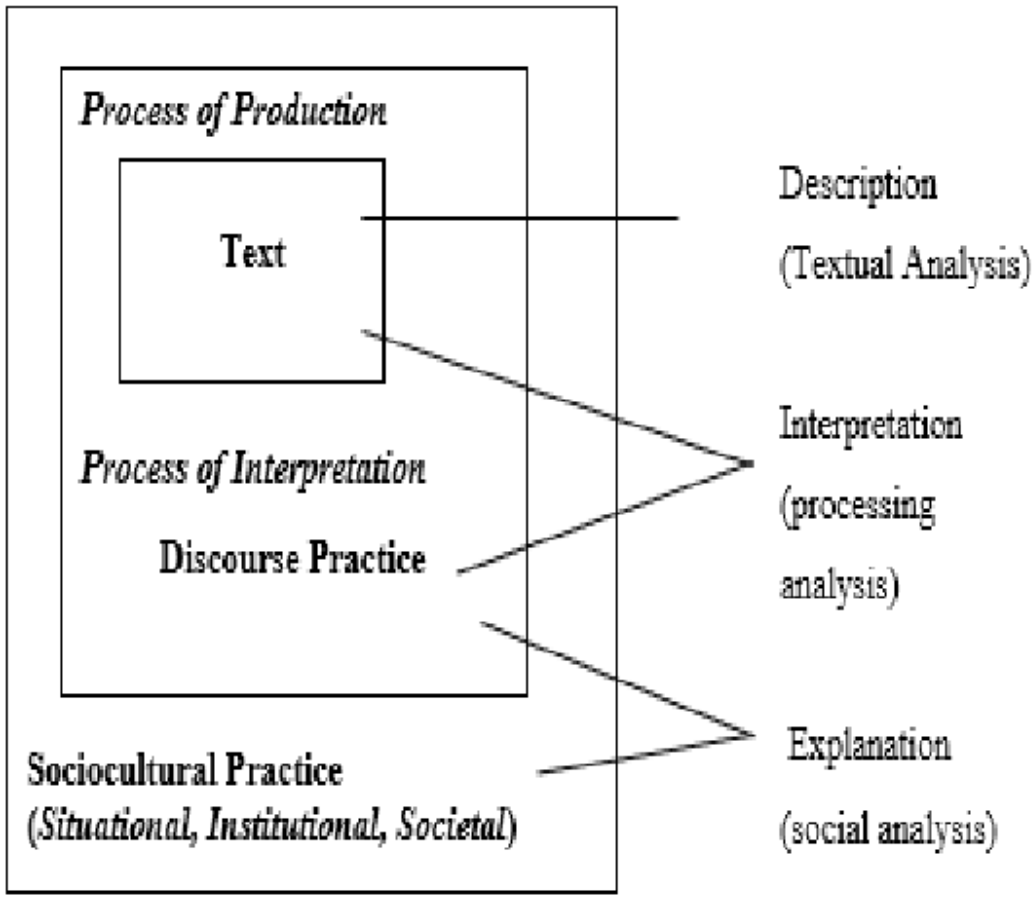
Fairclough's model for enacting research

Collecting and examining the data for this study were based on Fairclough's orientation to critical discourse analysis. Fairclough has more than one recommendation for process. Variations in methodology highlight Smith's (2007) point that individual researchers will conduct their research with different CDA approaches depending on the research question being asked, the type of discursive work and the discursive event under scrutiny. For this study, Fairclough's (1989, 1992, 1995, 2010) early and continuing concept of a trilogy of discoursal representation worked effectively to consider the nurses' language use, the discourses that they revealed from the contexts of their practice fields and the social construction of their discourses, including my own interpretation as researcher.

Fairclough's (1992) conceptual framework considered three primary aspects of critical discourse analysis, which each align with a theoretical orientation to discourse analysis. He wrote that these three dimensions are an attempt to bring together three analytical traditions which he believed are all essential for discourse analysis. The *Text* component includes a close textual analysis which is attentively tied to linguistics; *Sociocultural Practice* involves a macro sociological tradition where social practice is examined in relation to social structures; and the *Discourse Practice* is aligned with the interpretive tradition in discourse analysis, which involves a micro sociological look at how people interpret their social world and make sense of it with common understandings. Fairclough's model provides an anchor for this study to link the linguistic analysis of the nurses' discussions with the contexts that influenced a variety of the discourses that would emerge from their talk. Fairclough visually depicted his conceptual model as three nested boxes (Figure 2), which he labelled: *Text*, *Discourse Practice* and *Sociocultural Practice*.

Figure 2

Fairclough's Model of Discoursal Representation (from Fairclough, 1995, p.98)



The visual depiction shown in Figure 2 is more than a pictorial representation of a process of research; the thinking behind it consolidated Fairclough's theoretical stance regarding the use of language and context. Researchers (e.g., Bergh et al., 2014; Janks, 1997; Maposa, 2015; Rogers, 2014; Schofield et al., 2012) have frequently applied this diagram and the theory it represents.

Fairclough's box labelled *text* centres on the features of the text being studied. He defined *text* as "the written or spoken language produced in a discursive event" (Fairclough, 1995, p. 135). Fairclough's subtitle for the analysis of this dimension of

discourse development is *Description (textual analysis)* (Figure 2). He wrote that any sort of textual feature is potentially significant in terms of supplying material that will be analysed for discourse (1992, p. 74). He based his guidelines for textual inferences on methods from functional linguistics, particularly the work of Michael Halliday (1985, as cited in Fairclough, 1995, p. 139), who showed how the language features of text are connected to its situational and sociocultural contexts. Fairclough (1992) provided categories for text analysis, some of which are oriented to language forms, and others are oriented towards meanings. These range from examining vocabulary and grammar to considering the type of utterance (question, reflection, instruction) and the references to other texts (intertextuality). Examining the minutiae of text, such as vocabulary, or the construction of the passage of text as a whole, allows inferences to be made between the language and meanings beyond the basic word or sentence (Schofield et al., 2012, p. 166; Smith, 2007, p. 63).

The outer box of Fairclough's model is titled *Sociocultural Practice*, and Fairclough refers to the discourse analysis dimension as *Explanation (social analysis)*. For Fairclough (2010), discourse is shaped by social structure in the widest sense, by societal norms, such as social class or other classification customs, and by the conventions of institutions, both discursive and non-discursive. In Fairclough's textual diagrams in later versions, he put the words "situational, institutional, societal" in this box to describe the dimensions of sociocultural practice (Fairclough, 1995, p. 98). This is helpful because social contexts include multiple scales, and researchers can choose which contextual influences can provide discourses for analysis, and thus link the objects of study with the text produced. This variety was evident in examples of nursing studies utilising Fairclough's theory of methods. For example, Bergh et al. (2014), in a Swedish nursing study, concentrated on the organisational level of influence, whereas Schofield et al. (2012) brought in large scale hegemonic influences hovering over healthcare systems within the UK public service. Smith (2007) clarified that the analysis at a contextual level seeks to explain which powers and ideologies inherent in the sociocultural context are influencing the identities and institutions discussed in the text.

In Fairclough's model, the *Discourse Practice* Box (the middle box in Figure 2) has had many iterations by different researchers. This may be because of Fairclough's breadth of explanation for its use, including explanations appropriate to the fields of journalism or politics, where he presented how texts are "produced" and "consumed" (Fairclough, 1992, p. 78). Some authors have brought aspects of the social context into this area for explanation (Janks, 1997, p. 338), which is not inconsistent with Fairclough's diagram (Figure 2) where he groups *social analysis* with arrows pointing to both the middle and outer boxes.

Despite these three conceptual divisions in Fairclough's model, he emphasised that the demarcations are fluid. This stems from an overlap among the orientations represented by the boxes, and because research studies may be suited to foregrounding a particular box. For example, Fairclough (1992) explained that there is not a sharp division between understanding textual nuances and the interpretation of the discourse practice layer (the middle box in Figure 2). He stated: "One never really talks about features of a text without some reference to text production and/or interpretation" (p. 73). He continued:

> Where formal features of texts are most salient, topics are included here; where productive and interpretative processes are most salient, topics are dealt with under analysis of discursive practice, even though they involve formal features of text. (p. 74)

Likewise, he explained overlap between the outer two boxes. The "'discursive practice' does not contrast with 'social practice': the former is a particular form of the latter" (Fairclough, 1992, p. 71).

Fairclough (1992) emphasised a dialectical relationship between the social construction of language and the social determination of discourse, and he frequently reiterated that all parts of the boxes in his model are in touch with one another. Others have expressed their visualisation of this: R. Henderson (2005b) envisaged a stage with three platforms that can be lowered or raised when foregrounded, but remain in touch with one another. Janks (1997) emphasised Fairclough's three boxes as nested, such

as three cardboard boxes within each other, to emphasise that when touching one to use it – it will affect the other two.

Customising the study

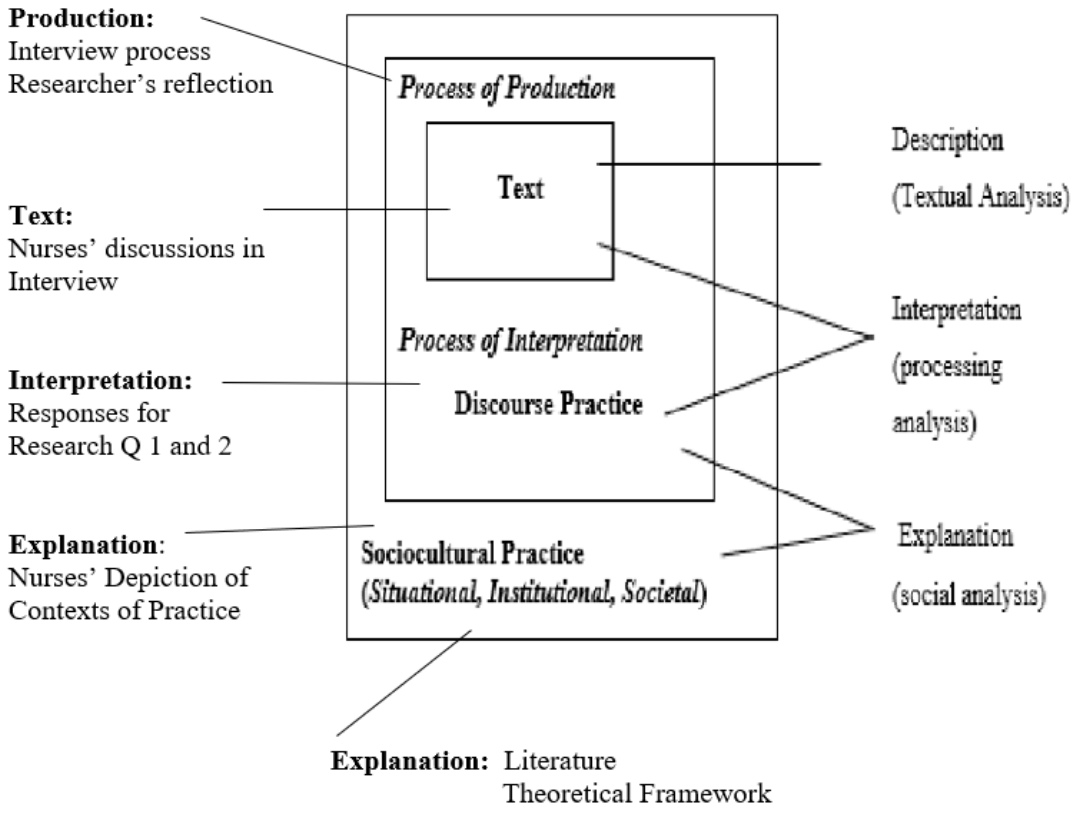
Flexibility in conceptual design also provides flexibility in method. Different research studies foreground one or the other of Fairclough's three demarcations of text, sociocultural practice and discourse practice, depending on what is the object of study or the discursive event under examination (Fairclough, 2003; Smith, 2007). For example, in nursing studies, Berring et al. (2015) examined the nursing notes regarding aggression in mental health patients and centred their elicitation of discourses on the linguistic aspects of these notes, emphasising the text aspect of Fairclough's model. By contrast, McIntyre et.al., (2012) looked at the discourses of their targeted stakeholders at the practice level, and utilised the themes uncovered to examine the occurrences of "thematic patterns of influence in key stakeholder discourses" (p. 41) that showed vocabulary that demonstrated instances of power. Their reported results did not show in-depth linguistic analysis. In a third example, within the field of education, Janks (1997) moved from detailed textual analysis to detailed contextual analysis, with commentary in-between on the discursive production of the piece of text. Janks noted the usefulness of Fairclough's model, in that it allowed multiple points of entry and that it "does not matter which kind of analysis one begins with as long as they are all included and are shown to be mutually explanatory" (p. 329).

Fairclough (2001b) addressed this diversity of approaches; he expressed reservations about the concept of *method* for the process of discourse analysis (p. 121). He stated that the word *method* could be misconstrued for "a sort of 'transferable skill'" (p. 121). His preferred notion was to consider his analytical process as a "tool in a box of tools, which can be resorted to when needed and then returned to the box" (p. 121). He also reinforced the mutual constitution of critical discourse analysis, comprised of method *and* theory that remains in dialogue with other social theories and methods (p. 121). In this study, such a dialogue is addressed in Chapter 6, when the analysis circles back to the theory presented in Chapter 2.

A degree of latitude in terms of process does not give the researcher free rein to design anything and consider it critical discourse analysis simply because it studies discourse(s). In several reviews of nursing research that utilised discourse analysis, the authors noted that a majority of articles lacked a clear explanation to the reader of the processes involved in the analysis (Buus, 2005; Smith, 2007; Traynor, 2006; Traynor et al., 2010). Buus (2005) noted that many studies were theoretically heavy at the front end, but that the density declined, with frequently poor or absent explanations of how the researchers arrived at interpretations or conclusions. To ameliorate this, in the next section of this chapter, I explain my use of the three dimensions of Fairclough's (1995) model for data collection through an interview process, and for understanding that data through analytical processes. It is visually depicted in Figure 3.

Figure 3

Utilising Fairclough's Model: Registered Nurses in Practice Fields (adapted from Fairclough, 1995, p. 78)



Considering nurses as professionals

A further layer of the analytical process within CDA followed the production of discourses by exploring those that emerged, and by considering what purposes were being served by them (Fairclough, 2001b, p. 125). This feeds into broader discourses in nursing: what counts as knowledge in a particular order of discourse is that which is "socially constructed, defined and maintained according to the dominant thinking of powerful group interests" (Schofield et al., 2012, p. 167). While this may seem theoretical and abstract, for nurses in the practical world the discourses maintained are those that highlight what counts as knowledge in everyday fields – what is sustained through everyday interactions and practice routines (Schofield et al., 2012, p. 167).

The discourses of the nurses in this study, their reference to contexts of practice and their interpretations of both discourses and contexts provided a basis for returning in Chapter 6 (Discussion Chapter) to the theoretical understandings from Stronach et al. (2002), Fairclough (1989, 1992, 1995, 2010) and contemporary nursing literature. This stage of the research took the knowledge of nurses' ability to enact their professional nursing practice within their local arenas and conceptually placed it within a broader societal context of contemporary nursing practice.

The aim here was to create a bridge between what was going on for these professional nurses, and what is occurring more broadly in the profession of nurses in contemporary Australia. This is in keeping with Fairclough (2001b), Wodak (2001) and Meyer (2001), who considered critical discourse analysis as a positive tool when used in interdisciplinary studies, be that nursing, management theory or social science.

In a sense, this joins Fairclough's (2003) schema of trying to understand how a social problem arises and how it emerges from the social world. It opens possibilities of looking at the discourses that are shaping nursing practice, and whether others, besides nurses, are being served by these discourses (Fairclough, 1989, 2001b). Additionally, it could open up possibilities for nursing practice in terms of awareness of hegemonic structures or other obstacles to nursing's professional status (S. Springer, 2012).

CONDUCTING THE RESEARCH

In this section, I present the logistics of the research which included a process of interviewing nurses to capture their discourses of practice before interpreting the data that emerged from these interviews using the conceptual model of critical discourse analysis presented above. The research processes include attention to the presence of myself as researcher throughout the study, and attention to research rigour.

The participants

The parameters for choosing the participants for this study are listed in Table 1.

Table 1

Parameters for the Inclusion of Research Participants

Criteria for selecting research participants	*Rationale*
Registered nurses who are practising in roles of direct patient care	*To capture data about nursing work in patient care.*
Nurses who have been in the workforce for at least 18 months post-graduation	*To select participants from the field who have had time to move beyond the huge learning curve experienced by nurses new to practice.*
Nurses who completed their Bachelor of Nursing degree at the University of Southern Queensland	*To select participants with similar backgrounds of nursing preparation. This particular undergraduate degree offered two courses about professional development.*
A variety of healthcare settings or fields within nursing	*To examine discourses from across a range of settings with variable levels of autonomy.*

After receiving ethics approval from the University of Southern Queensland, I recruited 12 participants from a database of graduate Bachelor of Nursing students held by the university. All participants had been employed as registered nurses for at least 18 months post-graduation, and their participation in my research was voluntary. These participants included nurses from a variety of specialities in regional, rural and metropolitan settings, including acute care, mental health, community care, general medical practice clinics, residential aged care settings and theatres. Two men and 10 women, who had each been nursing between two and 16 years, shared their recent and past experiences. The volume of work they undertook varied, from two shifts per week to full-time, and their work status varied from casually rostered workers to employment as permanent staff. Because the data set was obtained from one university, the participants resided and worked in one state, although this was not part of the inclusion criteria. One interviewee was originally educated overseas, but had completed two of the three years of a Bachelor of Nursing degree in Australia. A brief introduction to each participant is provided in Appendix A.

Most of the participants I had known well enough to be on a first name basis with them when they were students at university. Although it was not part of the inclusion criteria to solicit nursing graduates known to me, it seemed to be that the alumni who responded to my introduction by email may have responded because they knew and remembered me. This proved to be an advantage rather than a disadvantage, as the interviews seamlessly moved to conversational status. I also believe that the nurses responding to communication from someone they knew provided a cross section of nurses with a varying degree of professionalism in their ecology of practice. Some of the nurses who responded and volunteered may not have answered an anonymous request for research participants.

Ethics approval

The university ethics committee approved this study before I commenced recruitment of the participants. Each participant received by email a comprehensive written explanation of the research study (Appendix B), which they could read before

choosing either to progress to an interview or to withdraw from the opportunity. They received the consent form (Appendix C) prior to the interview, and they signed this in person at the time of the interview, just prior to commencing it.

The participant was free to cancel the interview or withdraw from the research at any stage up until the approval of the transcript. After the interview, a written transcript was shared with the interviewee by a method of their choosing. If utilising email for member checking, I first checked with the participant that this was a password protected individual email address and not a family one or a work email address that other people could access. All participants were asked to reply to me if they had any issues with the transcripts. I wrote that, if I had not heard from them by a nominated date, I would conclude that this was tacit approval, and I would proceed with the research using their transcript. No participant requested changes to their transcript.

The transcripts were shared with one of my supervisors, which was necessary given my initial lack of experience in the discourse analytic process, and for the benefit of having an additional reader. Transcripts from the study were stored within a locked filing cabinet and in a password protected electronic format with access only by the researcher.

Confidentiality was ensured with an interviewee identifier allocated before transcription. In the conversational data, care was taken to de-identify places of employment and personal details that might identify the participants. This was important as some of the stories had sensitive information regarding anecdotes about patients or staff who might have been recognisable. One critical incident could possibly result in the institution or the individual being recognised, so such situations were omitted from the reported data and discourses.

The interviews

Individual interviews of one and a half to two hours' duration took place with each participant. These were audio recorded. Each interview was conducted in a mutually

agreed place away from the participant's workplace to ensure anonymity and a level of comfort. This was in a private home or a university room, to allow for privacy, confidentiality and recording. Participation, consent and confidentiality were reinforced, and any questions were answered. Most of the interviewees seemed to quickly forget that a recorder was in place. A notable exception was one interviewee who seemed nervous during the interview, and who admitted to being so after the interview; she also appeared to be more cautious in her speech.

The interviews were designed as semi-structured, at the low end of structure on a continuum of interview styles from structured to having no structure. They were closer to "quarter-structured" (my term) than semi-structured. This differs from some other qualitative traditions, and methodological books and articles describing insightful advice on the wording of interview questions that are generated to try to obtain uniformity, or to control for reliability and validity (Abell & Myers, 2008). Appropriately for these interviews in the discourse analytic tradition, conversation was consciously allowed to flow, without trying to pull the interviewee back into a track, as a means of encouraging the articulation of the discourses that had significance to the speaker (Wood & Kroger, 2000).

Although the style was conversational, and many of the interviews occurred across a kitchen table, this was not an equally reciprocal conversation. It included prompts and follow up questions from me as the researcher. Both the interviewee and I were "creating the event moment to moment" (Abell & Myers, 2008, p. 146), but this was still an example of the genre of an interview, not a kitchen conversation. My questions were primarily follow-on questions, rather than a pre-determined script, and they were purposeful and directive. This meant that we were not on an equal footing. Additionally, as I have noted earlier, my impetus to hear the nurses' stories was driven by my interest in the contexts of their situations, their agency in practice and their identification with professionalism. This can be empowering for the interviewee, in that the interviewer values what participants have to say as "experts of their own story" (Cope et al., 2016, p. 117).

In the process of myself and the interviewee creating meaning as we were speaking, my questions were impromptu, but I later discovered, when re-reading the excerpts, an intentionality on my part. In these re-readings, I would find myself mentally asking the next question, which from my notes I then realised I had also asked in the real-time interview. From my perspective, theory drove some of the prompts. Kvale (2007) wrote that this is important: if the theoretical perspective is not considered during the interviews, information needed later for interpretations at the analysis stage may be lacking.

The gap between myself as researcher and the participant as interviewee was advantageous, rather than a disadvantage. My role as a nursing academic had an influence on the interview process, but it was a transparent role, a self-reflective one and a disclosed one. The fact that I was known to the participants and recognised as a lecturer may have led to a possible trigger for their reflection for "What am I doing presently?" against "What is my ideal?" In other words, this re-identification with their university influences occasionally prompted discussions about approaches to care. Additionally, I could use the fact that I was not in current practice legitimately to ask "What is it like out there?" On a practical note, engaging in this research as an experienced nurse and a seasoned academic, I could interpret the language of the nurses and their interpretations of nursing and their role, an aspect of study design that Candlin (2011) highlighted as beneficial.

The interviews had reciprocal benefits. I not only gained data for this research, but also gained an appreciation of the work ethics that clinical nurses hold amongst the many challenges in day-to-day care. Most interviewees expressed appreciation for the opportunity to share their stories. One wrote:

> After our interview I felt like a great weight had been lifted from my shoulders. I felt joyful about my career as a nurse, it was a powerful reinforcement for me. I had begun to doubt myself. I was once again reminded of why I do what I do. The old saying "a real nurse is born – not made" is quite true is some cases. I feel that it is true for me. The best way to truly find yourself is to get lost in caring for others. (Helen, *used with permission*)

Another participant communicated that she realised after sharing in the interview that she enjoyed community nursing much more than the acute care in hospitals, and that perhaps she should listen to herself rather than feeling that she should keep up a hospital-oriented skill-base.

The created interviews provided the text component in this first step of the study framework. Fairclough (1992) considered interviews a genre within discourse types. For this study, they were appropriate for the purpose of formulating research data, given that language is socially created and constructs the social world – in this case, the practice of nursing (Schofield et al., 2012, p. 167). Nurses in practice settings have few easily accessible vehicles for sharing their knowledge of practice; here they were able to share their accounts of nursing. By listening to them talk about their experiences of present-day work situations, I found their language became a means of understanding the social and situational contexts in which their experiences occurred. The discussion collected as interview material became a means to study not only the narrative and illustrative information, but also the discourses these nurses selected, which illustrated those that permeated or dominated their professional world. Additionally, by engaging in interviews (or potentially in other means of semiosis), the nurses were not just reporting on what was pertinent in their fields of practice, but the process of discussion became a discourse as well (Gibson, 2013). In that sense, these interviews extended beyond information gathering. Within the study frame of critical discourse analysis, I also considered them a discursive event. Smith (2007) summarised these layers:

> CDA brings in the multiple layers which shape a text and therefore assists researchers to examine discourse in the context of both the social environment in which the text is produced and the nature of the textual form in which the discourse is presented. (p. 68)

Qualitative interviewing is considered a knowledge-producing activity, one which "can provide us with well-founded knowledge about our conversational reality" (Kvale, 2007, p. 47).

The methods of discourse analysis

The nurses were "text producers" in Schofield et al.'s (2012, p. 167) terms. Through the genre of a conversational interview, they "selectively used discourses (patterns of meaning)" and applied "linguistic rules" to produce their version of social practice, which in this case was nursing (Schofield et al., 2012, p. 167). The data gathered from the interviews in audio recordings were subsequently transcribed into print. The interview and speech act in conversation were the language data to which I refer (not the textual details of transcription), but I maintained the word "text" throughout this thesis as the simplest means of representing these speech productions and of keeping with Fairclough's use of this term (Fairclough, 1989, p. 24).

In this study, I intentionally kept fluid boundaries among the three boxes, which allowed all three of the discourse traditions (Text, Sociocultural Practice, Discourse Practice) to be represented from the language data generated. The nurses' reference to contexts of practice evolved from their discussions, which were designed to inform the research questions. This was different from other studies where the context was gleaned from different sources of data, such as Toffoli, Rudge and Barnes' (2014) study, which looked at institutional texts for the source of the contexts within which nurses were working. The Discourse Practice box is represented by text data as well as my interpretations of this data and what it represented.

Considering text to inform each dimension of Fairclough's model assisted with conceptually and practically grouping the data within each box. Chapters 4 and 5 are each divided into three sections that outline the discourse analysis for text, societal context and discourse practice for each research question respectively. This assisted with assembling the data from the range of interviews and a range of practice fields, rather than following each piece of data through the three theoretical boxes, as might be done with a case study methodology. The latter has been effective for studies that used Fairclough's model for textual analysis of a particular piece of text or talk, such as Janks' (1997) depiction of an advertisement, Rogers' (2014) ethnographic observation and Maposa's (2015) isolated texts from history books. In the current

study, treating each of the boxes as groupings of data avoided a cumbersome litany of linguistic labels that would be unhelpful to the overall aim of the study. An initial reconnaissance with the data prompted me to analyse the contexts for Sociocultural Practice second (the outer box in Figure 2), before considering the middle box, Discourse Practice. The elements of interpretation in this middle box logically flow from the influences of the other two boxes.

Within the Sociocultural Practice box, I continued to look at the texts themselves to see how the nurses' discourses demonstrated the contexts within which they worked, and the meaning that this had for their practice. At times this required moving back to textual analysis of the texts when they signified context. This was a deliberate strategy to manage the assemblage of data, and it also served to keep all three boxes in contact with one another. This was not just a mechanical tactic; it was a theoretical one, because the texts were instances of "socially regulated discourses" (Janks, 1997, p. 329). Janks, who worked in depth with the Fairclough model, wrote that the three prongs of data analysis need to be included and remain mutually explanatory. She emphasised: "It is in the interconnections that the analyst finds interesting patterns and disjunctions that need to be described, interpreted and explained" (p 329).

Interpretation of the Discourse Practice component of this study design relied on the nurses' chosen discourses in relation to their practices and what their language said about their identity, or ideology or social relations (Fairclough, 1992, p. 64). It considered both their production of text and the analyst's reception and understanding of it. This stage in the discourse analysis process involved myself as analyst paying attention to both prior developed boxes while making inferences about the discourses the nurses produced. Chouliaraki and Fairclough (1999) referred to this as positioning between structures and events. In the data analysis chapters this will be sequenced third, but I had been constantly moving between the three. This phase of the research allowed me to consider the texts as discourses beyond the language or anecdotes provided about individual work situations. I took this opportunity to consider the identities the nurses reveal and their clues to professionalism in: their work processes, their occupational relations and in the discourses with which they identify or find

constraining. An example might be a nurse striving for holistic care in an environment emphasising patient throughput.

The Discourse Practice box is where space is possible (Chouliarakia & Fairclough, 1999) to consider factors within the nurses that influenced their identities. This does not mean just a "background" which Fairclough stated missed the point (Fairclough, 1989, p. 141), but a part of their nature, training or potential that affords "compossibles" (Chouliarakia & Fairclough, 1999, p. 32). This includes looking at what the nurses bring to their roles. Fairclough's (1992) term for this was *members' resources*, which he explained in terms of how they can be part of the explanation of the production and interpretation of meanings:

> Production and consumption have partially sociocognitive natures, in that they involve cognitive processes of text production and interpretation which are based upon internalised social structures and conventions. … In the account of these sociocognitive processes, one concern is to specify which (elements of) orders of discourse (as well as other social resources, called "members'' resources) are drawn upon and how, in the production and interpretation of meanings. (p. 72)

A further point about analysis within the Discourse Practice box is that this is a much more subjective analysis than the language analysis of the text box and the collation of the contextual situations from the Sociocultural Practice dimension. Fairclough knew that this was a more interpretative stage; in fact, in earlier versions of his pictorial model, he named this middle box "Interpretation" (Fairclough, 1989, p. 141). One is not looking for literal meanings in the sentences of the text but "rather, interpreters operate from the start with assumptions (which are later open to modification) about the context, which influence the way in which linguistic features of a text are themselves processed so that a text is always interpreted with some context in mind" (Fairclough, 1989, p. 151). For me, this context came from the pre- and continual reading for the study through Fairclough, Stronach et al., nursing research studies, health organisational literature and from an awareness of the nurses' work contexts from the interviews and data analysis to this stage. The analysis here required judgement, which is not only a cognitive process, but also an individualised one,

coloured by my own member's resources. This was acknowledged in Fairclough's statement that "interpretation will depend on what is 'in' the interpreter" (Fairclough, 1989, p. 141); thus reflexivity regarding my role and presence as the researcher was an important aspect of this study.

This continual reading manifests in Chapter 6, where the discussion moved beyond the texts presented and considered them against discourses in circulation within published literature. The critical lenses of Stronach et al. (2002) and Fairclough (1989, 1992, 1995, 2001b, 2003, 2010, 2015) were applied to the findings of the data chapters to assist in critically examining assumptions and making explicit examples and inferences of nurses acting with professional behaviours. This continued the *explanation* from Fairclough's Model, and added to the understanding of the "ways in which texts signify the world and its processes, entities and relations" (Fairclough, 1992, p. 64).

Thus, data analysis in this study had breadth and depth. It included: (a) initial and ongoing selection of interview material, (b) collating and interpreting the data with Fairclough's tools for discourse analysis for each research question in Chapters 4 and 5 respectively; and (c) discussing and analysing the findings against wider discourses in Chapter 6.

The researcher

As the analyst I am a part of this design. The discourse created through the process of interview included myself as the interviewer and the member's resources that I brought to the discussion, and later to the interpretation/explanation. In the explanation phases, my reading of social and nursing theory worked to avoid "untheorised assumptions of society" (Fairclough, 2001b, p. 167), and related the findings from this study to other published theory and research practice.

A reflexive process across the conception, research design and implementation of this study involved multiple conversations with supervisors and research colleagues that

aided the self-consciousness required in the mutually constitutive roles of discourse analyst and nurse-researcher. The self-reflection in the introductory and concluding chapters of this thesis are examples. Rigour from the study extended into other aspects of my life – I see language from the media differently now, and I pick up language nuances in personal, social or work situations.

The rigour

Qualitative research has come of age to the point that establishing the merits of qualitative research and defending it against other traditions are not necessary, nor is it the aim of this section. In fact, continuing these debates long after qualitative research has proven its value (Thorne & Darbyshire, 2005) would be a suggestion of inferiority. Instead, I will outline strategies to demonstrate the fidelity and soundness of this study (Nixon & Power, 2007, p. 74), and of the use of critical discourse analysis to underpin the method of study. There is no claim to being "right" (Nixon & Power, 2007, p. 74). I am instead demonstrating, by making the research process visible, that I have practised sound, thorough, credible and coherent research. My underlying aim was to uncover meaning rather than claims to truth. This involved gathering an understanding of the circumstances in which the accounts were produced, and how meaning was intended to be produced from them.

First I have established the epistemological frame of this work, to be centred in a combination of (a) Stronach et al.'s (2002) provocative study of professionalism in nursing; (b) the writings of Fairclough (1989, 1992, 1995, 2003, 2010) derived from both critical social theory and critical realism, which consider discourse as a means of eliciting power relationships and degrees of agency for individuals; and (c) a number of studies that preceded this one and that looked at professionalism in nursing and discourses concerning Australian healthcare settings that may influence such professionalism. I have carefully measured this frame against Wodak's (2001) statement that a discourse analysis study needs to "consider carefully whether the framework selected makes sense in relation to both the data being investigated and the

theoretical claims and research questions which necessarily guide every analysis" (p. 21).

I have paid attention to the process of analysis to avoid the pitfalls of over-summation, over quotation, using isolated quotations (Antake, Billig, Edwards, & Potter, 2003, as cited in Nixon & Power, 2007, p. 75) or "cherry-picking" (Wodak, 2014, p. 307) the material to use. The combination of using shorter passages to show intertextuality with longer ones was an overt measure to establish breadth as well as depth. Although many of the texts lent themselves to linguistic analysis, Fairclough (2015) stated that some text portions are more opaque than others; not all require a breakdown analysis.

Fairclough (2001b) stated that an extensive background in linguistic analysis is not expected for this kind of research, no more than an extensive background in management theory would be expected to be able to make a comment about management. My learning curve was steep in this regard, but it was assisted by working with my supervisor to test passages of linguistic analysis and to receive feedback in the early, middle and late stages of the process. In other aspects of interpretation, I was grounded with a process of re-reading the material as other sections of the analysis developed and considering points the nurses addressed against something I would read in another study or hear from another practitioner. For instance, I could not figure out why a nurse, whom I thought to be extremely professional in most aspects of nursing, recounted that she had identified a lack of integrity in fulfilling a competency audit. After a discussion with my supervisor where the word "resistance" as a form of power came up, I realised that, although this was not a commendable action, it did fit with her level of autonomy, because she had taken a stance to resist the audit in question.

Chapters 4 and 5 in this thesis are heavily weighted with text representations (transcription excerpts from interviews) to give readers the opportunity to assess my interpretations, and to help them to follow the reasoning process (Nixon & Power, 2007). These interpretations are influenced by both the theoretical standpoint of this study as well as the use of linguistics tailored to the specific discourses elicited in

interviews. This follows Chouliaraki and Fairclough's (1999) premise that CDA should "be open in its analysis to different theoretical discourses which construct the problem in focus in different ways" (p. 93).

Congruity between the ontological and epistemological bases of this work (Nixon & Power, 2007) is grounded in the Discussion Chapter (Chapter 6), which returns the analysis and explanation back to the underpinning theory, a process promoted by Johnson (2015) as part of ensuring rigour. Additionally, as a device for ensuring coherence (Nixon & Power, 2007), I have reflected upon and referenced other exemplar discourse analysis studies in nursing such as Gibson (2013), Rudge (2011), Toffoli et al. (2014) and Schofield et al. (2012). This transparent process answers the concerns of three reviews of nursing discourse studies that identified that the methods became dislocated from the theory (Buus, 2005; Crowe, 2000, 2005). I have also referred to other researchers' reflections on the research process, such as Janks (1997), Rogers (2014) and R. Henderson (2005a), a move that was advocated by Chouliarakia and Fairclough (1999) and Wodak (2014). This has all served to demonstrate the theory, method and analysis of data explicitly, both in this chapter and across this PhD study.

ANALYSING THE DISCOURSE

Text: A language of discourse

The analysis began with a stage of multiple readings of the data and discovering the topics the participants chose to discuss. Bergh (2014) called this a "familiarisation" (p. 193) phase. It was apt to consider these readings as preliminary only. This avoided the criticism of some reviewers who question the difference between CDA and thematic analysis if the processes that follow from a familiarisation phase are not clearly depicted (Buus, 2005; Traynor, 2006).

The questions that are asked of the text are guided by the aim of the research (Smith, 2007), so I naturally focused on discussions that exposed the nurses' perceptions of

their role and of contextual constraints and supports for that role. This stage highlighted the diversity of the fields in which the nurses practised, and produced some unexpected themes such as negativity towards ward work. During this scoping exercise, I moved to manually coding the data into broad categories and colour coding those references with tabs on the transcripts. These were adjusted slightly as familiarity with the entire corpus grew.

I then manually positioned references to episodes in similar compartments, and I worked with an extensive outline of the categories and subcategories. At this stage, I left the data excerpts intact; I wanted to preserve the excerpts within their full transcripts so that the integrity of context and meaning would be pulled across when using and demonstrating these. For each of the two research questions, I created a large pictorial representation of Fairclough's three boxes, similarly to Janks' method (1997), and I began to consider and place the nurses' discourse topics within whichever box best matched their stories. These categories became a strong outline for writing them up and for conveying the text and my interpretation of meaning from this text. Once the outline was in place, headings and styles in Microsoft Word helped demonstrate fit and flow. Some adjustments had to be made; for instance, "a discourse of safety" crossed between spoken aspects of patient care and a category of "paperwork" within an audit culture. As explained earlier, none of the boxes could stand alone from the others.

There were more than a few "aha" moments in this process that are generally now absorbed in this thesis. For example, I kept debating with where to fit the nurses' references to consuming documentation, including electronic and hardcopy (paperwork). It became clear that paperwork, despite seeming a "dry" or "quantitative" entity, has a position in the reality of the audit culture and is not something that can be hidden under more esoteric discourses. For nurses, paperwork is a huge, oppressive burden.

Fairclough (1992) suggested a range of categories for linguistic analysis that were useful in scrutinising the language the nurses used as they spoke. I immediately noticed

vocabulary in the first round in familiarisation, particularly adjectives such as a nurse classing an audit as "stupid," and another depicting patients as "crumbly." Moving up Fairclough's ascending ladder, the grouping of words into clauses (**grammar**) also elicited meaning, with the premise that "people make choices about the design and structure of their clauses which amount to choices about how to signify (and construct) social identities, social relationships, and knowledge and belief" (Fairclough, 1992, pp. 75-76). Mechanisms for foregrounding and backgrounding material, or a punctuated, repetitive list of phrases, were considered in some passages. Pronouns and substituting devices such as near-synonyms were used by participants as well as expected conjunctions to achieve linkages, known as ***cohesion*** in Fairclough's terminology. These longer stretches of **cohesive** text are considered *signs* in discourse analysis, and demonstrate meaning with the rationale that the ways things are lined up are socially motivated (Fairclough, 1992, p. 75). Individual words and groups of words also gave clues to lexicon that is currently used in nursing or healthcare institutions. These at times were signifiers of nurses' attitudes – for example: "It's not right if you want to call yourself a nurse, we're not in the 1920s."

In Fairclough's (1989, 1992) explanations, **intertextuality** can signify a text referring to another text directly or indirectly – for example, when the speaker refers to someone else's speech act, or when nurses in Crowe's study (2005) referred to a diagnostic manual of mental health (p. 59). Intertextuality was evident in this study: nurses referred to written texts such as hospital forms and to spoken texts when referencing what others had said. The linkages between texts were my own, which I often provided by collating similarly themed statements by different nurses and across different fields. This placement and grouping added value to the textual interpretation overall, even if each passage was not marked with linguistic analysis.

The **structuring** of the individual nurses' interviews also gave insights, particularly when their "texturing" (Fairclough, 1989, p. 144) was self-initiated. This was not prompted by the questioning from the interview; the nurses textured their passages by adding to the dialogue without a preceding prompt. Additionally, more than half of the nurses volunteered an incident significant to them – a critical incident that encouraged

their reflection, and that they wished to share. These incidents were revealing about the discourse.

Context: Situational, institutional, societal

To depict the contexts in which nurses were working, the analysis required moving beyond statements or collating themes to use a range of linguistic devices that demonstrated both obvious and hidden meanings. Across the interviews, "the system" often had a faceless reference, which meant uncovering a ubiquitous "they." The nurses depicted managers more personally if they were in a close locus of contact, and, in many cases, these were also positive references. Adjectives and adverbs provided clues, such as a nurse calling a supervisor a "very scary lady" or being "really impressed" when referring to team leaders.

Nominalisation, where a verb is turned into a noun or a noun-phrase, was not seen as often as Fairclough projected for context situations (1989, p. 124; 1992, p. 191; 2005, p. 926), or as often as other researchers have found (Janks, 1997; Maposa, 2015). Possibly this was because these texts were spoken texts. Paltridge (2012) hypothesised that some speech types show less frequently in the spoken vernacular, which is more spontaneous and less deliberately constructed than a written word choice. Interestingly, the nurses often utilised language that demonstrated the opposite of nominalisation – they turned nouns into verbs. This demonstrated entrenchment with audit language that is illuminated in the later chapters. They included that a person could be "risk-manned," or an incident could be "PRIMEd." This nursing colloquial-speak also showed a sense of vocational task work when, for example, a person was "pilled." In searching for a precedent for this, I found that Billig (2008b) wrote of turning nouns into verbs and called this "de-nominalizing" (p. 837), which has more recently been referred to as "verbing" (Gomashie & Stainton, 2016, p. 1/4).

Structures that either support or inhibit what the nurses considered optimal or even appropriate care were highlighted in this section. Identifying obstacles to solving the problem under study is an important phase in the discourse analysis (Fairclough,

2001b), and the nurses were forthcoming in discussing what was difficult. Emotive language was indicative at vocabulary and clause levels, but also in the way they structured their texts – both in sentence cohesion and in the coherence of the overall interview when it foregrounded issues that were often invisible to them.

This contextual analysis was an area where interdiscursivity came through; nurses, for instance, used second-hand anecdotes about colleagues' views when issues such as bullying were discussed. Conflicting discourses subtly emerged, such as nurses valuing a speciality but feeling professionally insecure if they moved their practice too far away from generic ward work. The nurses at times also portrayed, through their language, repetitive sequencing that may demonstrate an institutional propensity for highly regimented practice. Fairclough (1992) stated that this could be a symptom of power (p. 95).

Some of the clues to the nurses' feelings about their workplaces, both locally and institutionally, came through analysing the tenor of the text such as the tone when depicting the use of casual nurses. This was evident from two sides of the fence: from the casual nurses who felt marginalised; and from those working with them who felt resentment in terms of the extra responsibility that they needed to shoulder when working with casual staff members.

The context here was carried through the interpretation, just as it was also depicted in the text box. This demonstrated that the nurses' depiction of their work oscillated between structure and action, weaving through their identities and relationships (Fairclough, 2001b).

Interpretation: The discourse practice

Interpretation of the nurses' texts within the contexts appraised the extent of agency the nurses can employ within the structures of their workplaces. This interpretation afforded indications of the degree of a professional affinity they conveyed when speaking about their roles or when relaying anecdotes regarding patient care.

Discourses that "spoke through them" (Janks 1997, p. 338) surfaced and began to give clues as to some of the orders of discourse existing in Queensland's healthcare establishments.

I looked for linguistic devices that continued to provide insight into the meanings within the nurses' talk. A switch from the use of the pronoun "you" to "I," for example, demonstrated a sense of autonomy.

A further linguistic pattern, which was helpful as a measure of agency, was the use of passivity in sentences that potentially juxtaposed the language with a sense of the nurse's passivity in the life world. I looked for metaphor and found some instances of usage, most often employed to give a heightened view of the structures working against the nurses' ability to deliver optimal care: "We're drowning here" was one example. Cohesive devices such as repetition conveyed repetition in duties, and a task-centredness or a sense of "doing to" rather than "doing for" the patient.

Modality, is a technique that Rogers (2014) interpreted as asserting authority in an instance of discourse analysis. In these transcripts the opposite occurred, as the nurses often showed tentativeness with hedging statements (Fairclough, 2010, p. 216) such as "I think" or "maybe."

Two forms of intertextuality emerged: "manifest intertextuality" (Rogers, 2014, p. 34), where nurses would quote other nurses or managers; and "constitutive intertextuality" (p. 34), which showed interdiscursive features among the other interviews in this study. Looking at the texts in comparison with one another helped to indicate identity, and the expanse of data showed a continuum of demonstrating where nurses saw themselves in their role and thus as professionals. Reading across the texts also highlighted the variety of "members' resources" (Fairclough, 2001b, p. 24) with which they engaged unknowingly. The "tenor" of the text was a helpful indication of the nurse's sense of agency or frustration if agency was prohibited.

The interpretation provided clues for *Question 1*, as to whether nurses saw themselves as professionals in their practice, and clues for *Question 2*, regarding how nurses negotiate practice within competing discourses, and thus how they were "storying themselves" between ecologies of practice and economies of performance (Stronach et al., 2002). Analysis of discourse here examined how nurses were creatively transforming ideologies and practices or "securing their reproductions" (Fairclough, 1992, p. 36). In this box, I could start to expose how the nurses' practices were shaped by dimensions of which they were unaware, such as managerial influences or power constraints (p. 72). Identities, social relations and ideologies – three elements that are constructed in discourse (Fairclough, 1992) – could be elicited through this analysis.

Two other tools related to me as researcher. The first was a consciousness of what I, as the interpreter, was bringing to the process in terms of my own member resources. Fairclough states that "interpretation is sometimes highly reflexive, involving a great deal of conscious thought about what is meant, or what something has been said or written as it has" (Fairclough, 2003, p. 11). This was aided through critical conversations with other nurse researchers and with my supervisors. The other internal resource that I brought was the interdisciplinarity to which Fairclough (2001) and Wodak (2014) referred, including knowledge about nursing practice and healthcare structures.

Explanation: Discussion within Chapter 6

My study cannot demonstrate the full order of discourse that is influencing nursing practice in Australia today, but it does provide some insights. In Chapter 6, my analysis continued as I considered the nurses' accounts of their practice in relation to the macro influences of contexts and the pervading published nursing discourses. This maintained the critical aspects of this research in "the sense of opening up channels and establishing a dialogue between theoretical and wider social practices" (Chouliarakia & Fairclough, 1999, p. 68). The praxis involved: (a) discussing the published literature, particularly but not exclusively articles with an Australian focus; (b) considering Fairclough's premises of discourse as ideological when it "contributes

to sustaining particular relations of power and domination" (Fairclough, 2003, p. 133), or demonstrates "marginal, oppositional or alternative discourses" (Fairclough, 1992, p. 88); and (c) relating Stronach et al.'s (2002) premises that nurses were "storying themselves" between economies of performance and ecologies of practice.

EMPLOYING THE DISCOURSE

Awareness of issues

Critical discourse analysis serviceably helps to critically examine relationships and institutional supports or constraints that manifest in discourse (Nixon & Power, 2007, p. 72). Issues that arose were summarised in the conclusion of this study, with ideas for possible interventions for helping nurses to work within the realities of practice while striving for improvements and for being true to their ecologies of professionalism in nursing. Fairclough outlined this as a further part of the research, which also includes a critical reflection on the prior stages of the research and how effective the research is as critique (Fairclough, 2001b, p. 134).

Feeding into wider discourses

Reflection in the concluding chapter includes looking at ways the study can contribute to awareness of the issues presented in the field of nursing. It also includes positive critique with "hitherto unrealized or not fully realized possibilities" (Fairclough, 2001b, p. 125).

CHAPTER SUMMARY

This research study was designed to utilise critical discourse analysis as a process of research. Interviewing nurses in practice provides an outlet for their understandings of their work world. Through the process of examining their dialogue linguistically and the nuances of their contextual situations a number of discourses would emerge. These discourses were considered against wider orders of discourse in contemporary Australia and in relation to the theory outlined in Chapter 2.

CHAPTER 4:
DISCOURSES OF PRACTICE

Analysing and interpreting the data of the nurses' discourses for this study entailed listening to their descriptions about their real-time world and finding meaning from their talk, expressed in text. The nurses' anecdotal everyday experiences described their desires for optimal nursing care, as well as constraints to implementing their visions for this care. In this chapter and the following one, I provide samples of the conversations with the research participants to demonstrate both the depth and breadth of the discourses that ran through and across the transcripts. In this chapter, I look at how the nurses talked about their nursing and whether these discourses demonstrated a sense of being a professional practitioner in their roles.

The analysis aligns with the framework of three nested boxes, championed by Fairclough (1995) and described in Chapter 3. The discourses were framed to: (a) demonstrate meaning in the texts themselves, (b) examine the context in which the nurses practised, and (c) make explicit my interpretation of these data. Following the scholarship of Hilary Janks (1997), and her rationale that the researcher can commence analysing by entering and proceeding in any order, I began with the box of nurses' text constructing their work world (the inner box), followed by their representations of the contextual environments of contemporary health (the outer box), before exploring the presence and absence of a sense of professionalism through the Discourse Practice box (the middle box). Pragmatically, this box is expressed third in both Chapter 4 and Chapter 5.

The nurses' discourses demonstrated how nurses in this study viewed what they did, the constraints or supports influencing their jobs and whether a professional scope was depicted in their work. This chapter is the first step in answering Research Question 1:

> **Research Question 1**: How do discourses of registered nurses working in direct patient care reflect their ability to enact professional nursing practices in day-to-day work?

SECTION I: DISCOURSES OF NURSING CARE

In this section, I selected material where the nurses foregrounded and described their ability to enact practices of nursing. Through their examples as well as their emotions and tone of examining these, I analysed their choice and use of language, as well as the meanings and emotions that they ascribed to their stories. By describing these within categories (the headings below), the cataloguing of examples of discourses started to show which discourses emerged. These discourses are analysed further in terms of contexts and meanings for the professional aspects of these practices.

Task-based care

I would die of boredom

The nurses' descriptions of their work indicated a tier of basic care, and further tiers of other nursing tasks. Generally, the nurses did not refer to their task-based care with pride; they depicted tasks as a given expectation, a minimum standard. For example:

> **Sophie:** We don't – we're doing anything from basic hygiene right through to medications, procedures, that kind of thing, which is fine[1].

> **Leila:** So, I was in rehab[2] [ward] for about 18 months or so which was really good, like now I would die of boredom there but it was really good because you got to learn how to be a nurse, learn how to do the med charts and the paperwork and just nurse. I worked in a nursing home when I was a student, so I knew the nursing cares but, yeah, with that, I can now care for a sick – like a patient who was unwell, unwell which was really good.

Sophie qualified that it is "fine," implying that she perceived no shame in the beginning aspects of nursing. Leila demonstrated that it was "really good" initially to "learn how to be a nurse," but with a skill set beyond this role she would now (metaphorically speaking) "die of boredom." When she stated that she was learning to

[1] Words and phrases are underlined in the excerpts for the purpose of referencing back to these words and phrases from the explanation that follows.
[2] Excerpts from transcripts remain in the spoken language which occurred through the interview with occasional words added in brackets for clarity. This includes the language of one participant for whom English is an additional language.

"just nurse," she used "nurse" as a verb, which underscored: (a) that everyone should know what nursing is, and (b) the considerable attention paid in the literature to the fact that nursing is difficult to define (Benner, 2015; Birks, Davis, Smithson, & Cant, 2016; Ó Lúanaigh, 2015; Penney, Poulter, Cole, & Wellard, 2016; Shields, 2014).

Frequently, the nurses' language that referred to assisting patients with activities of daily living and hygiene care signified a *lowest* tier of nursing responsibilities. As Harrison explained:

> **Harrison**: It's not uncommon on a shift that the AIN, the EN or whatever will do all the grunt work – like a lot of the showering and helping do the feeds and all that sort of thing. You've got to run around and do all the DD [Dangerous Drugs] - the Schedule 8s and the medications – the antibiotics and all that sort of thing, and oversee what they're doing.
>
> **Harrison:** All that needs doing – like the mundane, menial tasks or whatever – falls back to the nurses.

Harrison called this "grunt work" and he underlined his impression of unskilled tasks because they could be done not only by Assistants in Nursing (AINs) and Enrolled Nurses (ENs) but also by "whatever." Here he dehumanised the tasks, choosing "whatever" over "whoever." Although these "mundane, menial tasks" can be delegated to other staff, they remain in the registered nurses' accountable scope of practice and can be a source of consternation:

> **Harrison:** Well, it's like – yeah – and you're supposed to oversee what the people underneath – what the other grad nurses below you are doing.
>
> **Janelle:** They're helping with our tasks. If something happens,well, technically I'm responsible, but I've had nothing to do with the task.

Other participants would welcome such assistance if their place of employment utilised these roles as part of the designated workforce. According to Sophie and Myra:

> **Sophie:** It would be so lovely to have AINs that would be able to take that workload off of us a little bit.

> **Myra:** Yeah, it's – it is – because my previous experience, we had so much limited staff. We were almost had no AINs because of the recent cuts; they took AINs away totally. So in a shift – no, on a morning shift, we have one registered nurse and one EN.

The nurses described a further tier of responsibilities in their role, including medication administration:

> **Gemma**: When I was in the program, or even before I started my bachelor, I worked as an AIN, and I was sort of seeing things from a different angle, thinking, "I can't wait to get out of aged care and stop having to do showers and toileting people," and then you go out on clinical and realise you never do get away from it [laughs]. I came to the sudden realisation that it's always going to be a part of nursing. It has gotten easier. It doesn't really faze me anymore having to shower someone or clean them up or change their pad.
>
> **Gemma**: Yeah. Seeing things as an AIN – the world is your oyster and there's all these new things, but I think in reality, the way nursing is now, it just goes from showering and cleaning people to showering and cleaning people and giving them their pills and making the doctors happy [laughs].

Retrospectively, nursing had looked exciting with a positive metaphor of "the world is your oyster" but from Gemma's present-day perspective, "the way nursing is now," she painted a negative, repetitive reality. Gemma foregrounded the showering and cleaning as an AIN, and emphasised that it was still in her registered nurse role by repeating the list of these activities before tagging on the additional tasks of "giving them their pills" and "making the doctors happy." Gemma represented giving out pills and following medical orders as further tasks in the repertoire of a registered nurse. Her laugh sealed a "that's the best there is" mentality, but it may also have represented seeking solidarity with the interviewer through an established nursing lexicon of "making the doctors happy."

I've got a hundred more people to do

The research participants' descriptions of nursing as a series of tasks were most frequently aligned with discussions about ward nursing. The task-oriented feeling from the nurses was proverbial:

Sophie: We're just so crazily busy.

Ingrid: I think it [ward work] is all task-focused.

Sophie: Our patients are numbers at the moment.

Sophie: Go do your showers, go do your pills, go make beds, go put them back to bed, go roll them over.

Sophie: Like that's what we have to get done and it has to get done now and this, this, this.

Myra: We spend 25% of our time with the patient. So it's – that's not even therapeutic way, it's just going and do medications and dressings or taking obs and things like that.

Harrison: The priority is definitely on firstly getting the workload done because the workload is the priority. Everybody needs their medications. Everybody needs to be weighed, showered and all that sort of stuff.

Gemma: So I was running around like a silly person, trying to get the medications done.

Continual time-pressure added to the workload, as was evident in the research participants' talk:

Sophie: I still feel our patients are suffering. I – it's just so quick, quick, quick, bang, bang, bang. Is this done? Is that done?

Sophie: It's just, yeah, quick, quick, quick, we'll fix, move on.

Ingrid: I was trying to hold her there while trying to get some assistance and when I finally sorted her out and this buzzer was just going and going and going and going and going.

Sophie: That's what we have to get done and it has to get done now, and this, this, this.

Gemma: Have to do the care plan, tick, tick, tick, tick.

Ingrid: I'll go through them and I'll get the box out, which takes time, but I'm not just going to go pop, pop, pop, pop, "here you go, take your medicine" and running on to the next one.

The fast pace of ward work was reinforced interdiscursively across these excerpts in the repetition of words, used to demonstrate the repetitiveness of tasks which kept firing at them. This pressure was reinforced with phrases of: "Is this done? Is that

done?"; "move on"; "finally sorted her out"; "has to get done now"; "have to do," and "running on to the next one."

Additionally, patients needed time-consuming assistance:

> **Harrison:** The kitchen will come and drop off the meals and you've got three people who need assistance with feeds or whatever and by the time you get everyone set up and you've started feeding the first patient, the kitchen lady has come back to take all the trays away.
>
> **Janelle:** If you're in a ward where you don't have that help, it's very time consuming because some people, especially post knee-joint or something, they're very slow and you're not going to be, "Hurry up, let's get in the shower and let's get out of there," because you know I've got a hundred more people to do.
>
> **Harrison:** If you've got a couple of patients who are difficult and you're not spreading yourself between your other patients as well. That's another hard thing being a nurse on the wards is you have to – some patients are really – are more demanding than others, and there comes a point where you just have to say, "Look, I'm very sorry but I have four or five other patients that I'm looking after and I have to go and see that everything's done for them as well."

These patients, labelled "difficult" and "demanding," exacerbated the workload, which already did not allow for interventions beyond tasks. Janelle's hyperbole expressed the uphill battle of "a hundred more people to do."

When we get deployed

Leila, whose current job is in an intensive care unit (ICU), had outsider eyes when deployed to the wards. Working on the wards for her was not a choice; it was considered "when we get deployed" (Leila). Leila described the patient-care activities:

> **Leila:** When we're quiet, we get sent up to the wards, and it is so frustrating because I feel like – and I don't think I'm alone, like we talk about this, we are so frustrated when we get sent to the wards because, whether it's because they are so busy or because it's the culture of like it was in rehab, they're showered and they're pilled and they're sat out of bed and they're put back into bed and they're washed and they're turned or I don't know what it is.
>
> I remember going up once doing meal relief on a night duty for the specials. I went to special this one person, to relieve this one person

> who didn't like me. He was – I wouldn't want to be nursed by him. He was a very unsafe nurse, lazy. I wasn't the only one thinking that. She [the patient] was obviously specialled for a reason, and it wasn't because she was crazy, like jumping out of bed, like she was obviously unwell. So I asked for a bit of a handover, and he goes, "Oh, she'll be sleeping, I'll be back soon" and left.
>
> So I started reading the chart, and I actually can't remember what was wrong with her. I think she was heading towards palliation, but I can't remember what was wrong with her. Anyway, I saw obs hadn't been done for a few hours so I did a set of obs and her [O_2] sats were 72 or something. Anyway, so I put some oxygen on. They had oxygen next to her, so she obviously had had it, not that that matters, but I put it on her. Then the team leader came in and starts, "You can't put oxygen on this lady, she's COPD, like she's hypoxic, like take that oxygen off her." I didn't know. If you want to take the oxygen off her, go get the doctor and he can come and see the obs.
>
> It was just – it frustrates me that, I don't know, they seem so task driven that they don't look at the patient or the obs and put things together to have a rationale of why they're doing something, and it frustrates me no end. I hate going up there. I feel completely unsafe for a nurse on the wards, like when we get deployed. I hate it. Not because of the work, it's a different type of nursing obviously, it's very busy, but the handovers, even if – you know, you go there for a shift and you're handing over, the handovers are "Slept well overnight, in for this" but not anything of how they're progressing through their admission and where they're going for discharge, or even why they came in. You don't have time to read through their notes.
>
> So the focus is just on getting them out of bed and getting them in the shower, which to me that isn't what nursing is. Sure, people need to be clean and comfortable, but they're there because they're sick, and that to me needs to be the focus of the care, then the cleaning and the showering needs to be done to keep them good, but that's not the focus of the care, I feel. It is what happens on all of the wards.

When Leila talked about patients, she referred to "getting them" out of bed or in the shower. Hygiene care joined a list of other tasks. Other registered nurse level activities were de-nominalised[3] into a verb; such as patients receiving their medications were *pilled.* Leila justified her case, first by generalising to other ICU staff, and then by supporting her impression that task-based priorities were a ward's culture rather than busyness; she substantiated this from her first-hand experience in a rehabilitation ward.

[3] De-nominalised was discussed in Chapter 3.

Leila textured her description by following it with an example, reiterating that there is more that the nurses could be doing than the tasks nominated in her first paragraph of the excerpt cited above. The anecdote provided an example of poor monitoring that reiterated her description of the nurse as "very unsafe" and "I wouldn't want to be nursed by him." Support from an invisible team existed behind her words: "I wasn't the only one thinking that."

Leila ruled out non-medical reasons for why this woman needed one-on-one nursing (a special), and thus she took a set of physical observations, uncovering an unacceptable value in the patient's oxygen saturations. This led to an altercation with the team leader and Leila's unsaid accusation that the team leader was out of date in terms of the parameters for intervention with a patient with chronic obstructive pulmonary disease (COPD). She turned her dialogue into a fictitious retort to this nurse: "If you want to take the oxygen off her, go get the doctor and he can come and see the obs."

This example was sandwiched into the monologue where Leila circled back to the task orientation of the wards. As she said, "They seem so task driven that they don't look at the patient or the obs and put things together to have a rationale of why they're doing something," which not only "frustrates" her; it "frustrates [her] no end." Instead of prioritising the additional observations and interventions required for an unwell person, the task-based care became the priority. Care became hygiene care without higher level nursing care. Leila provided a widely encompassing assessment that "It is what happens on all of the wards."

Other interviewees supported these statements:

> **Sophie:** You get chucked in the deep end.
>
> **Harrison:** You walk into a ward that you've never seen before, and you get your handover of your patient allocation.
>
> **Ingrid:** You sort of feel, "I'm not good enough; I'm not up to speed."

This language demonstrated a distaste for going to the wards. Vocabulary used by the nurses, such as "chucked into the deep end" implied that they had been stripped of agency in the decisions for them to be relocated.

Holistic care

The "whole person" versus the "hole" in the person

Tiered into discussions about caring for patients was a discourse of holistic care. Many of the nurses aspired to this, but their interviews described difficulty in achieving it. The participants referenced holistic care in the following excerpts, but with an overlay of theory rather than practical examples of enacting it:

> **Janelle:** I felt that, when I started out, I was very task orientated. Because I think the tasks in surgical seem to take your time. You were keeping the patient safe, but you weren't doing the holistic thing. I feel surgical nursing, it's very fast paced and it doesn't stress me anymore. But I find that, when I work in other areas, there's more time to actually – to spend a little bit of time – like in a medical ward because it's so slow and you're taking Joe Blow from A to B you can talk. Which we learnt at uni about, while we're doing a shower or we're doing something, we can talk to the patient and establish that rapport. You can identify things that they need help with, or identify what the problem is.

> **Myra:** I get holistic view when I care to patient. Some nurses are very task oriented, but I don't think it's going to work for nursing. It is – I think we have to care the patient or person in holistic way physically, mentally and emotionally, because they are in a vulnerable stage…. yes, stage when they hospitalised especially. They need kindness, care and to be able to listen to and place their concerns and comfortable with doing – comfortable asking things and that sort of thing in patient-centred care.

> **Sophie:** I certainly don't feel that you're there for the whole person. I think that's why I feel quite disheartened with ward nursing because doctors and nurses and allied health are there for the broken leg. They're not looking at what's happening at home. What other issues are happening with that patient? I think they're getting better at looking at the other – the other health issues, but they're not looking at that person as a whole. They're not realising that – an example, 95-year-old lady that comes in. She's been living at home. She's fractured her NOF. They come in and they'll tell them they're not going home, they're going into a nursing home. They don't – they don't factor in how that affects that patient. Their whole life is now changing.

In Sophie's excerpt, the fractured NOF (neck of the femur) was a fitting metaphor for the broken care. Sophie asked a question in her dialogue, and she emphasised that health practitioners should be asking those questions of the patient/family. The doctors, nurses and allied health professionals whom she mentioned became a repetitive "they" as the excerpt progressed, and "they come in" conjures an image of a group in white coats standing over a patient lying in a bed and announcing the verdict of a nursing home placement.

The holistic care to which the nurses aspired included attending to the person's psychological state and assisting with social issues. The nurses wished to provide further psychosocial aspects of care for their patients, as was evidenced by the following statements:

> **Harrison:** Even within your allocation, if you have a patient who's fairly independent and self-caring, but they have – they might have issues that ideally you'd like to sit down and talk to them about. But, because you're spending all your time with the patients who are more dependent – who need feeding, who are not independent or mobile, or who are more demanding – the patient who's independent – more independent – you're not putting their care or level of care that they receive suffers at the expense of the other patients too – maybe.
>
> **Ingrid:** If they start talking to you, and you want to sit on the end of the bed and have a little listen to what they want to say, because it might be they're really frightened about what's happening to them, not understanding or just want to talk to someone. I feel always like I've got to go. I can't spend that time that you'd possibly like to if you could.

These excerpts demonstrated that nurses place value on their relationships with patients. In line with nurses from a multitude of qualitative studies researching contemporary nursing practice (Curtis, 2013; Gibson, 2013; Hutchinson & Jackson, 2014; Schluter et al., 2011), they expected that nursing includes talking with patients and addressing their concerns and those of the patients' families. The nurses demonstrated that this part of their role took a back seat to the patients' physical care needs, such as those "who need feeding" (Harrison).

Building a rapport with their patient was necessary for such a relationship to occur, which then allowed nurses to "nurse":

> **Leila:** I suppose, when you're really busy doing the showers and the tablets and everything, you don't get to build that rapport with people over the four or five days they're in.
>
> **Ingrid:** I think it becomes mainly – unfortunately, a person becomes a job, something that needs to be done. I think there is a little bit of a loss there in the rapport with people. I don't think that's probably going to change much.

To establish a rapport, and to facilitate both the physical aspects of care and the psychosocial aspects of nursing, the nurses valued and desired continuity of care with their patients. Gemma and Ingrid described this as attainable in fields of nursing that are not hospital-based, such as practice nursing and community nursing:

> **Gemma:** Especially in practice nursing, you do get that continuity of care with patients. You can walk out into the waiting room and know their face and their name and their patient history from seeing them every other week, but you also get the time to know them and their families and all that's happening and, from that, I think you can sort of gauge – again, with assessment, if they come in and they're not looking quite right, you can sort of pick it as well because if they're normal and bubbly and they come in and they're not looking so crash hot and they're not talking, and you know something's wrong.
>
> Yeah, there is a lot because they do know you, and you do feel like family when you're there, especially when it's a smaller general practice, but, when it's a bigger one and you're moving around a lot, it tends to be a bit hard, but you're still doing the teaching, and you're still seeing the same people each week, and you see the new ones, and you see the little babies go from little babies to toddlers to bigger kids and yeah. I think that's what I like about it. You get to spend the time and the continual care with them so you get to see them get better and you get to help with – like in wound care, you get to see it from the beginning to the finish when it's healed and they're fine and they're not coming anymore and then yeah.
>
> **Ingrid:** That's one thing I really enjoyed about community [health] is you can set up a rapport with someone more so than in a hospital. You might go in on one shift and that person might be gone the next shift, or you might be lucky and get them two days in a row. You don't really build up to know that person, whereas in community – even for example I've nursed some people – one lady had this horrific ulcer on her leg and they had debrided it and everything. You could see tendon. It was really nasty.

> It took me a long time to heal that wound, with her body's help, obviously, but trying this, trying that. Just the satisfaction of going from "I think she might lose that leg," because that's what I thought, to in the end, I think it was eight months later till it healed, the satisfaction from that was just fantastic, and the fact that I did it myself. I was the one who was managing it, and I'd say, "We're going to use that and we're going to use this. No, that's not quite working so we'll try something else," and it was just a great feeling of doing that.

Gemma demonstrated continuity of care in her description of "go from little babies to toddlers to bigger kids" when a nurse sees the child at each of these points. She built rapport into this: "they do know you" and "you do feel like family." Both nurses used wound care as an example of continuity; the chronicity of wounds that take months to heal was used to demonstrate the longer-term care that can occur in community-based settings. Ingrid used the words "the satisfaction from that was just fantastic," "I did it myself" and "it was just a great feeling of doing that" to evoke a very positive tenor throughout this passage. Both nurses mentioned physical and psychosocial aspects of the interactions; the continuity of care that they depicted allowed the care for all parts of the person. Gemma portrayed a sense of empowerment in picking up a change in the patient from "normal and bubbly" to "not looking so crash hot." Ingrid found her empowerment in driving the wound care from "going from I think she might lose that leg" to a totally healed wound.

Joe Blow

Despite the discourse in nursing literature espousing patient-centred care (Tobiano, Bucknall, Marshall, Guinane, & Chaboyer, 2015; Tobiano, Marshall, Bucknall, & Chaboyer, 2016), doubts were also expressed about whether nurses do represent the patients' voices (Shields, 2014). In the current study, some references to the patients demonstrated a language that was decidedly not patient-centred. These terms may have emerged as conventional lexicon in modern day healthcare. The "Joe Blow" in Janelle's excerpt cited earlier was a conveniently generic name, suggesting an average person, but it was not one that portrayed a sense of the patient as the central focus of attention.

Harrison described medical patients as “crumbly.” In the excerpt that follows, he asserted that resourcing for medical wards was different from what was provided in more acute care wards such as surgical or ICU, and he contended that the nurses’ attitudes towards these patients were also different:

Harrison: Well, in perioperative it's not – the resources issue is not so much an issue – I think it depends on the area that you work in too. Theatres and perioperative are probably – they're given priority for resources and stuff. They have all the latest drains, dressings and all that sort of thing. But then, say if you went to a medical ward, you're not going to have as much variety of choice to provide that level – that quality level of care maybe. I also notice the mentality of the nursing staff and stuff is different too – because in medical it's more “Oh, the patients are crumbly, old and sick.” They probably have – they're probably not going to make that good a recovery anyway.

So you do what you can to manage them, I guess, knowing that they're probably not going to make a – they're always going to be sick. They're not going to make a full, proper recovery. Whereas in other areas of nursing, I suppose, where it's more acute, they get better resource allocation and stuff because – I don't know – the patients are going to respond, they're going to get well and they're going to – yeah. I don't know if you can understand what I'm saying – like there's a contrast.

Interviewer: So you notice a difference in the nurses' attitudes on those two types of things?

Harrison: Yeah.

Interviewer: When you use a word like “crumbly,” do you mean that's what you've heard other nurses say, or that's what you feel that their impression is?

Harrison: A bit of both. You hear – you even hear it in – you do even hear it in theatre, I guess. But a lot of the patients maybe in medical [wards] are a lot sicker. They're older. They have emphysema, COPD or underlying medical conditions, or they're older patients that are waiting to go to a nursing home, and they're just staying there. The nurses are babysitting them basically until they find a ward or – a nursing home placement or whatever for them. That's sort of the – I don't know – the mentality a little bit, I guess.

When Harrison was asked for clarification about his statements as an example of others' attitudes, he expanded by saying that the patients on a medical ward were being babysat while they waited to be sent to a nursing home, or even to an unnamed and therefore inconsequential "whatever." "Babysitting" did not connote patients at the centre of their own care, but as passive recipients of caregiving. Even if being utilised in the intended context of parenting, "babysitting" implies a secondary parent, one who is maintaining and holding the status quo but not executing the role of the primary caregiver. The term implied that the nurses were not moving the patients further on a continuum to wellness or improvement in their health status. The system also reinforced a hierarchy of patients when resourcing for patients on medical wards was below that of surgical units.

Janelle demonstrated an overloaded work situation, and referred to the patients by their diagnosis or their equipment:

> **Janelle**: Well, this was my patient load; I had a trache patient that was very anxious, difficult. He needed a lot of time; I didn't have enough time for him. Another lady she'd had a thyroidectomy. My next patient was a heparin infusion, which you have to chase up the APPT because the doctors overlook that. So that's a part of your care. The next lady – had a young lady of 30 had an abdo-hysterectomy. She had so many issues. She was anxious, she was crying, and I spoke to her husband like I really think she needed a psych review. There were so many issues there which I didn't have time to address.
>
> My next patient was an elderly lady that had a difficult family and the buzzer was going every 10 minutes and – what they wanted for their mother. The next patient was a lady that's had complication after complication.
>
> My next patient was an ICC and then I had a spare bed.

Janelle used a linguistic mechanism whereby the patients became their diagnosis or treatment modality: a "heparin infusion"; "a trache patient"; and an "ICC." Although used occasionally as lexicon in healthcare, this use of language for the condition instead of the patient's name has been recognised as negatively influencing healthcare workers' attitudes (Norman & Ryrie, 2013), and is considered politically incorrect terminology when the patients lose their personhood (Barkway, 2013).

Bumped off the list

The nurses demonstrated empathy for patients when systems provided less than ideal assistance with the episode of care. For example, Helen discussed the frequent necessity to stay back to work overtime to finish the surgeon's list in a privately funded hospital theatre:

Helen: I can give a good example – quite often in theatre we have surgeons that will run until the early hours of the morning, and that's a direct reflection of obviously the financial benefits for the hospital. They're getting as many patients through as they can.

Interviewer: If it's their surgery day, their day extends until one or two o'clock the next morning?

Helen: Yes. Or it can be longer than that, which that's often done because we've got a big, big list book. It's very unrealistic to say that we'll be able to finish by 8:30, nine at night, which is when we usually are expected to finish by. Call staff are called in – everyone – it takes its toll on everyone. Therefore you're short staffed the next day. Everyone's tired. It's – it makes it hard on everyone with that expectation that, because we're trying to get as many patients through as possible, being a private organisation that you will do a 14-hour day. It's – it's not exactly uncommon that – to be asked to do a lot of overtime – to do a 12-hour day or a 14-hour day. It burns the staff out and it's…

Unfortunately, it is not an uncommon thing where I work. For me, it's quite a frustrating aspect because it – you can see the result of that in people being exhausted. It's very hard to turn around if you are asked from your managers or supervisors, "Can you stay? We need people to finish the list." If you turn around and say, "Well, no, I can't finish the list of cases" or – you know, that's going to have an impact on patients. You don't want to do that to patients. It also has an impact on you as a health – a professional because you then become tired and worn down.

Interviewer: Is there a bit of fear that more mistakes might happen as it gets longer and you're tired?

Helen: Absolutely, yeah.

Interviewer: It's not a good position to be in.

Interviewee: No, no, but it's reality. Very much so. I feel quite conflicted with that. Ethically I feel really conflicted with that because I don't think healthcare should be about pushing patients through for the dollar.

Interviewer: How do you deal with that? Tell me about what sort of strategies you might use to marry your ideals with the reality.

Interviewee: For me, it's basically I try and provide the best care I can for the patients that I have – that we see, but I think even within the public system I know that, if you have a list that – if you have a list that has got six patients on it, and you get to patient four, come 4:30, five o'clock and it's not urgent, those patients will be bumped off the list. So, it's – you've got to – two areas where at least the patient in my current position will get seen. It might be at 11 o'clock at night they'll have their procedure. They won't have to come back in two, three months and be put back in the waiting queue again. Which I know does happen in the public system.

However, that's pretty hard on the patient that's been fasting for however long and has been waiting all that time for surgery. The public patients will just be told, "Well, come back tomorrow" or "Come back in two months' time when we've got availability again for you." That's really hard as well. That's such big picture issues. It's…

Her excerpts from the passage showed the difficulty for staff members, and a discourse of managerially-driven processes, but she demonstrated ethical conflict and concluded the topic out of concern for the patients.

Monitoring patients

That's really all it is

When asked to describe their nursing roles, nurses did not remark that observing patient status was something that they did, yet monitoring progress or scrutinising physical/psychological responses for signs of deterioration featured in the fabric of discussion as an automatic occurrence. These practices were taken-for-granted as part of their nursing work. Leila recounted talking to new graduates regarding the importance of learning assessment skills:

> **Leila**: I tell students when they come, and most of them are packing themselves when they come, because they're coming into ICU and they've never seen what – and I remember coming in and being scared. I said all of this doesn't matter; I tell them [university students] the most important tool is assessment; if you assess a patient and are able to interpret that, then you'll be fine. That's really all it is. Then you learn what you have to do for that assessment, but once you can assess and interpret, at least then you have something to give somebody who knows what to do, and they'll learn then.

Choosing to share an anecdote that depicts an educative role ascribes power to the situation; the subject matter weighs in importance because the speaker has foregrounded the discourse as instruction-worthy (Rogers, 2014). Leila's metaphor of "packing themselves," a euphemism for being so scared one tries to avoid defecating on oneself, created a graphic picture of feeling extremely scared. Such terminology has become so well used in Australian vernacular that Leila was probably not conscious of the literal meaning, yet she intentionally used this for emphasis. Leila qualified that it was okay to be scared, as she was scared herself when new in ICU. Confronted with fear, the recipe is simple: Leila told students to learn to assess the person, and to be able to interpret assessment, and "that's really all it is." She provided a learning curve beyond assessment and interpreting, but she demonstrated to students in this situation that these first two steps provided nurses with enough material to initiate review.

Other settings provided examples of assessment and referral. For example, Ingrid described the process in community nursing of assessing a patient's ability for self-management:

> **Ingrid:** If somebody comes in that's new to the service, you might go there and assess their ability to manage their condition. If you think they really could do with a lot more education, then we can refer to our diabetic educator who's a nurse, and then she'd come out and she'd maybe set them up a plan. Then we would work with that client to keep managing that plan, and maybe once a month the diabetic CN [Clinical nurse] might come around and see how that's going and adjust it if she had to. You could ring her up and say, "What do you think we should do with this?"

It was there in the purple and the orange and the yellow

Many facilities utilise detailed observation charts, colour-coded to alert nurses to parameters for when to escalate patient interventions. Nurses in this study considered this charting a significant task to undertake, made more unpalatable by the feeling that such documentation was not assisting patient outcomes.

A particular mechanism for monitoring patients that has grown from safety and quality initiatives, and relates to the deteriorating patient, is the use of early warning detection systems, a system of charting to score and rank a patient's vital signs. The chart is intended to be a guideline for when to call for medical or emergency assistance. Sophie and Leila shared disdain for this system, and gave evidence to support that they felt that appropriate monitoring should be inherent in the nurse's role, and should not be reduced to the common denominator of an audit system.

> **Sophie:** That's something we've only just been chatting about recently actually – if that ADDS tool is not reading emergency and, you know what, it's not actually just junior nurses either. The nurse – well, I've done everything. I'm within this criteria, but there's still things that are not quite right, like on that ADDS tool – we had a patient the other day. She's ticking all the boxes for blood pressure and heart rate and everything, but she had an O_2 sats of 56.
>
> That doesn't actually score as an emergency [laughs]. If you have a look at the ADDS – ADDS tool, now to me I could tell – I called a code, but, to a junior nurse, because it doesn't score in the purple, it only – I think the maximum they could have scored for that was a three. it's – yeah. Have a look next time [laughs]. So, yeah, as long as those boxes are ticked and whatever, some – I guess some nurses would just – I guess some nurses would just – would be happy with that. Then, on the other side of the coin, people that don't feel that they can take things higher or feel intimidated, would – it's okay on paper. They won't take it higher. I guess they're not feeling that their gut instinct is valued. Quite often these things are – they look fine on paper, but there's just that one thing that is not right, but because it's not on paper sometimes it's not – it's not valued.

Sophie demonstrated confidence in her own evaluation that the oxygen saturation of 56 trumped any coding on a chart, and she took an instructional tone to verify this with the researcher: "Have a look next time." She worried that a junior nurse would be happy to delay further intervention if the boxes were ticked. She stated three times that

"some…some nurses…some nurses" would be happy with that. They would feel that "it's okay on paper." Her hypothesis that this may also be a factor if they felt intimidated or perhaps felt that "their gut instinct is not valued" fitted with an excerpt from Harrison's interview where he stated: "Well, sometimes you can pick things up, and then the team leader or the doctor will come and look at it and not be concerned or not act on it or do anything about it" (Harrison).

In Leila's anecdote below, the frustration with this paperwork was linked with a frustration with the calibre of nursing itself: that nurses were haphazardly complying with the numbers requirements and physical charting. instead of providing appropriate monitoring of the patient:

> **Leila:** So, although they're – it's like you think, "How can somebody go – how can someone misread this. It is colour coded," but they do, and that's what happened with these two septic patients. They did them and they scored high, but they didn't add them up and they didn't escalate them and so that's why these people died. It was there in the purple, in the orange and in the yellow, and they didn't write a number there. It shouldn't matter if they write a number; they should know that a blood pressure of – I don't know, 80 systolic with no urine output and a decreased level of consciousness isn't any good, but they did not pick up on it; well, they didn't pick up on it clearly. I don't understand how this could happen. It made me really angry when I heard about this. It frustrates me, frustrates me.

Leila mocked the usefulness of these charts, on one level because the nurse did not complete the charting actions, but on another level because this piece of paper should not stand between whether the patient lived or died. Her commentary "so that's why these people died" was qualified by her opinion that adequate monitoring and escalating a situation where the patient is deteriorating should be an inherent part of nurse-monitoring skills. In her mind, it should not matter whether the nurses wrote a number –it matters what they did. Her emphasis of repetition – "well, they didn't pick up on it, clearly" and "It frustrates me, frustrates me" – paralleled the repetition of the charts themselves: "It was there in the purple, in the orange and in the yellow."

When I asked if the frustration were from a nursing point of view, she continued by using the ultimate cliché of low-level care in nursing, that of changing bedpans, to emphasise her opinion of the nurses at fault:

> **Leila:** From a nursing point of view and from a – it's just not right. If you want to call yourself a nurse, we're not in the 1920s, when all we did was change bedpans. We're not there any more. We do more than that. We're more important than that now.

Her first-person plural repetition "We" to begin the last three sentences was almost speech-like, raising her own passion and reiterating her point.

It was petrifying but cool

In care situations, observations need to be escalated into action when parameters require intervention. Nurses showed rather than told how this occurs, as they narrated events regarding patients under their care. The following excerpt demonstrated a number of processes in Leila's learning curve, but most of all it demonstrated that she had knowledge of the patient's parameters that necessitated medical review and intervention:

> **Leila**: I remember one shift I was TL; it was on a late. So I'd just done a course on deteriorating patients, and then this patient came in. She was an inpatient anyway but her blood pressure was like, I don't know, 160/90 or something, and then it dropped to sort of 115 on something.
>
> I remember calling the – she was like a locum doctor because our doctor was away, and calling her and telling her this has happened; she's got no urine output. I'd just done the course, so I knew what a person going septic was. Then she was like, "Oh, no, her blood pressure is still fine, it's 115." "I'm like, no, it's not fine; she's dropped from 160," like it was really hard to – I was almost like "Okay, okay," but then I remembered that I was the person that was going to push this patient's case.
>
> So she told me to run some fluids and whatever. I ran out the back into the pharmacy, which is this little room the size of a toilet cubicle, went in, closed the door and had a bit of a cry. Then I came back out and, yeah, she

ended up being flown out [to a larger hospital]. She was like really, really unwell. I was still friends with my preceptor who I'd had in ICU, so I called her the next day and asked if she was there, and she was there and she ended up septic and ventilated and everything.

So I suppose after that I was like, yeah, I know what I'm doing, I know what I'm doing and I can do this.

Interviewer: How rewarding because, if she had not been picked up, if you'd taken doctor's initial attitude that 115 was okay, she could have deteriorated so quickly that there wouldn't have been time to fly her out. So you were responsible for that woman getting – living, probably.

Leila: Yeah and so, I don't know, if I start to – and obviously it still happens, it happens to everybody, start to doubt – like I know myself; I've just got to stick with it. It's all simple, really.

Interviewer: So something in that patient was telling you that she could die. There was some intuition going on as well as the numbers, probably.

Leila: Do you know, I think then, I can't remember a lot about what she looked like. At that time, when I hadn't had a huge amount of experience, I actually think it was the numbers, because like and I will, it's something that's cemented wherever I learnt it at, that course, because they said a drop of 40 systolic the patient is in shock, and so she dropped 45. So I was like she's in shock, her urine has decreased, she wasn't tachycardic or becoming tachycardic, but she wasn't a beta blocker. I remember telling the doctor that too, like "It doesn't matter"; I'm like "It does matter."

So at that time I was focusing on what I could tell; I remember that. I don't remember a lot about what she was looking like just because that wasn't what I could tell the doctor and I didn't – it sounds bad; I didn't care about that at the time. I cared about what was on the monitor and what she was looking like as well, but that's what I could tell the doctor, and that's how I could get the doctor to do what I wanted her to do kind of thing.

Interviewer: So in that stage you said, "I feel I can do this." So you felt like a real nurse at that stage?

Leila: Yeah, I did. It was cool. It was petrifying but cool.

In this anecdote, Leila remained firm in her approach; she validated that it was her knowledge of what constituted her patient's deterioration that drove her actions to keep pushing the locum doctor until the patient was seen. She stated: "I knew what someone going septic was." There was more to it than a simple number value of the systolic pressure, despite the doctor stating that 115 was fine; Leila had to push with "I'm like, 'No, it's not fine; she's dropped from 160." She later backed this up from her course learning: "it's something that's cemented wherever I learnt it at, that course, because they said a drop of 40 systolic the patient is in shock, and so she dropped 45." Leila demonstrated pushing the cause: "like it was really hard to – I was almost like, 'Okay, okay', but then I remembered that I was the person that was going to push this patient's case." As the interviewer, I tried to credit intuition and the patient's overall appearance, but Leila negated this, stating she could not "remember a lot about what she was looking like," and she reinforced that she needed quantitative data to make an argument with the doctor: "I cared about what was on the monitor and what she was looking like as well, but that's what I could tell the doctor, and that's how I could get the doctor to do what I wanted her to do kind of thing." Leila emphasised her points that: (a) she knew this was a deteriorating situation; and (b) she needed to portray this to the doctor. She underscored how unwell the patient was, and thus how correct she was in her assessment, with a side-track comment about following the patient's progress at the bigger hospital. The patient was in ICU, "septic and ventilated and everything."

Ingrid discussed the importance of the nurses' roles in monitoring:

> **Ingrid:** The interactions that I've noticed in the hospital, I think the doctors really rely on the nurses as their eyes and ears with things, a change in a patient's condition, or "Hey, doc, make sure," or "This needs doing."
>
> The majority of what I've seen taking place, interaction between the nurses and doctors, the doctors hold the nurses in high esteem and listen to what they've got to say. … I think nurses still hold their ground as being the one that is the protection, the last port of call when you look after someone.

Although Ingrid used the metaphor lexicon that nurses are the eyes and ears for the doctors, her "Hey, doc,….This needs doing" hinted at the position in which nurses find themselves relaying their assessment information and ensuring that action occurs in response to that information. This becomes complicated when the scope of practice for interventions crosses into another health professional's realm – e.g., a patient needs medical intervention – but the responsibility to obtain that intervention is the nurse's.

Sophie narrated an experience of monitoring a patient who had symptoms that Sophie recognised as signs of danger, but she had difficulty working through and around a chain of command to have the patient reviewed:

Sophie: Yeah, so a little while ago, an example, we had a lady who came back – I think she had a total hip replacement as an elective surgery. She was quite well pre-surgery. She came back and she had – obs were stable; however, she had this really bizarre stridor happening. Something didn't sit right with me. I went and consulted my team leader. Something didn't sit right with her as well, so we consulted our resident who was about to go off duty. It was on the orthopaedic ward. He really wasn't too concerned, so I escalated to the reg. The reg was quite happy that the main hip was fine, so that was all okay.

She continued to stride – have this stridor. I noticed that she was actually becoming quite sedated, post – she'd come out of surgery alert and oriented. On return to the ward, I noticed that she was becoming quite dozy. I didn't feel I was being listened to by the reg, so I then took it to the anaesthetics. They came down. They weren't happy, so they took it to the intensive care consultant, who came down and reviewed the patient and then left – didn't give us an action plan or anything.

So a little while later this patient continued to become more sedated. We ended up giving her some naloxone. The stridor was still happening. Otherwise obs were looking okay. I then went through the correct channels of my resident and my reg again. None of them were interested. Couldn't get in touch with anaesthetics again, so I went back to the ICU reg, not the consultant, and we got absolutely blasted. How dare we put ourselves, nurses, consult an ICU reg without going through our correct channels and having the correct – it should have been an orthopaedic reg that

had contacted orthopaedic – ICU reg. They didn't want anything to do with us for two days.

This stridor continued. This patient was still quite sedated. She would rouse, and, yeah, it was – then I got very, very cranky. In that time, we actually got – no, we didn't have an ICU at reg that time. We – I can't remember – we escalated it again with anaesthetics. We did get another ICU consult, and that lady ended up in intensive care for three days; essentially she ended up having a respiratory arrest, and it had something to do with the intubation of her airway. So I wish I'd probably stamped my feet a bit more that first day with the ICU consultant, but I had done everything I could with consulting my team leader and then going higher. Now I've got – I would be phoning that ICU reg until they come down.

If – yeah, I felt I'm not being listened to, I would take it a bit higher, so yeah.

Interviewer: The security of experience of knowing that you were right.

Sophie: Yeah, and that ... That feeling – that gut feeling.

Harrison's dialogue below contrasts with the lengths that Leila and Sophie undertook to have a patient reviewed:

Harrison: In a ward situation – again, I've only had limited ward experience, and only pretty much at one hospital too – it depends on what it is. But, if you're concerned about something, I guess the hierarchy of things is that you notify the team leader. If it needs to go higher, it needs input from the doctors or whatever. You just write it on the ward call, page the doctor, and you've got to wait for the doctor to come and assess and go from there.

Interviewer: But do you feel good about that? That you've picked something up before the patient deteriorated?

Harrison: Well, sometimes you can pick things up, and then the team leader or the doctor will come and look at it and not be concerned or not act on it or do anything about it. Again that might be an experience thing – like I haven't had – like the experience or whatever. But – I don't know, I guess it's sort of like not being acted on in a way – maybe.

Because you've identified something that you're worried about, and it's not followed up on to the extent that you might like it to be.

Interviewer: Okay.

Harrison: But once – it's like, once you've notified the other people as well, it's like beyond your – it's not – it's sort of not your responsibility any more. You've notified the people.

Harrison did not provide a concrete example here, and he qualified that his ward experience was limited, so the excerpt might have derived from his belief system rather than from his actual practices. From a knowledge point of view, though, regardless of examples from practice, Harrison identified that some things necessitate the doctor's input, but that the nurse's scope of practice can finish with the notification. His tentativeness in speech might have mirrored his tentativeness in practice. He attempted to make the point that at times there is no tangible response; therefore the nurse does not have to pursue the issue further. His point was not convincing given his three qualifiers for something not being acted on: "sort of," "in a way" and "maybe."

Nursing by the numbers

If it isn't written down, it wasn't done

The research participants across a number of specialties deal with volumes of paperwork that they stated was increasing, duplicated, unnecessary and intruding on direct patient-care activities (Janelle, Ingrid, Sophie, Harrison, Myra, Toni). This was a tangible and obvious stressor, highlighted by the fact that several participants brought up the subject without prompting. Harrison, for example, initiated the turn taking to encompass this, shifting an existing conversation with: "That's probably a good thing to talk about, is the paperwork" (Harrison).

Nearly all the participants reinforced the copious and increasing levels of documentation:

Toni: I mean, that's another thing that's changed dramatically, is the paperwork. It's just huge. It's overwhelming. There's a piece of paper

for everything. Absolutely everything. If there's not a piece of paper for it, we'll find a piece for it [laughs].

Debra: Sometimes your theatre's nearly over and you're still doing paperwork and computer input if you're the scout. You know, you sort of then still go, “Hold on; don't finish that yet. I'm still going.” I'm not slow on the computer. I'm 16 years in an office; you sort of know.

Ingrid: I know it's everywhere, but the paperwork was just ridiculous. They were just so doubled up with paperwork. You go and do an assessment and you've got all these sheets that are this, that and then the next one. You're basically doing the same thing here and the same thing there.

Sophie: Just in my three – just over three years of nursing, the paperwork is just increasing [laughs]. I was overwhelmed with how much paperwork there was just on a day to day basis with the care plans and their admission tools and wound care pathways and everything that we started – when I started nursing, but I think it's certainly doubled now just in that three years.

The nurses used a variety of adjectives to describe the documentation: “huge,” “overwhelming,” “ridiculous,” “increasing.” Toni adopted the first person to imply someone else prescribing the paperwork: “If there’s not a piece of paper for it, we’ll find a piece for it.” Debra referenced her highly developed computer skills, thus negating them as a cause for slowness in computer input, implying volume instead. Ingrid used “doubled” to describe duplication, and Sophie used the same word to describe volume.

Further excerpts showed descriptions that tried to quantify this paperwork:

Myra: Paperwork is immense … 85% is paperwork.

Janelle: Yesterday I worked in this other ward. I hadn't been there for a couple of days, and they've got this new care plan. Basically, I think it's a four-page document.

Sophie: If they could sit down and do that 10-page booklet.

Janelle: Then they also told me that this care plan if it's approved in that ward it may be going through the whole hospital. I physically groaned. Because we have – every patient that comes in the hospital we had this eight page admission book. I might get five post-opers in that shift. If they've just come in through day surg they have their own

> paperwork down there. But they will come to the ward – every half hour I might receive a post-op patient.

"They" permeated through these excerpts as an unidentified entity to blame, presumably the management introducing the said paperwork.

A timeworn adage in nursing is "If it isn't written down, it wasn't done" (Carroll-Johnson, 2008, p. 331). Debra refuted this convention:

> **Debra:** I just feel that it's the world, though. It's everywhere. You can't have common sense. Common sense is lacking. Accountability is lacking. It's just if it's not there you didn't do it. If you've done it – you know. Same with the writing. I know that that's right with nursing. If it's not written, it's not done. If you go to court [and if] it's not written, you didn't do it. I know I jolly well did do it. Ten years later I might remember it. I think, if something bad happened, you're going to put it in your memory anyway.

Debra mentioned the issue of documenting to protect nurses from litigation, but later she contradicted any necessity of this with her emphasis – "I know I jolly well did do it" – implying an insult to her professionalism. Janelle felt that observations would be picked up from a nurse regardless of the forms, thereby placing more credence in the nurse's observational skills than in a listing on a chart. She commented: "It's the thoroughness of the nurse that would pick these things up anyway." Myra also attributed legal implication to documentation:

> **Myra**: Today nurses very – care about the paperwork because, if it is not documented, it hasn't been done. It's – there's the legal aspect of it. I think everyone sort of care[s] about that because of their registration. Yeah, as everybody knows, it's very time consuming.

Myra used the global "today's nurses" and "everybody" to demonstrate her understanding that the potential legal ramifications were universal expectations.

Nurses expressed repercussions for the next shift if paperwork were not completed:

> **Janelle:** "The blue book," as I call it, is supposed to be filled out. Well, if you've got five post-op patients, half hourly obs for two hours, then hourly. Everything there to physically care for those patients. Well, a lot of nurses just say, "Don't have the time; don't do the blue

> book." So you might come to the next shift, [and] you find all these blue books not done. So Janelle's there doing this.

Janelle resented the others not doing it, but she could not walk away from it herself. In using her first name here, she was almost mocking herself: "So Janelle's there doing this." Myra expressed discontent when others had not completed the paperwork:

> **Myra:** Everyone put the patient into bed, and introduce the environment and like processes, and introduce everything. Then come back and do the paperwork. So, of course, if there's any treatment to be done, they'll initiate it, but thinking of – back of their mind, "We've got to do the paperwork before our shift finishes." From experience I have – I have heard after first shift they haven't been able to do the paperwork, or it's just messy. But we don't know anything about this patient. How do we complete this as the next shift person?

The research participants noted how much time the paperwork took, made worse by a sense that it was busy-work and futile; to them, it did not directly affect patient outcomes, and it prevented them from being with the patient. Qualifying words, such as "depressing," were used to describe the paperwork:

> **Ingrid:** [The paperwork] is depressing. That just makes you think, "If I could spend more time with that patient rather than sitting there ticking, clicking all these boxes" that honestly a lot of the time I don't think anyone ever goes back and reads, and just keep it to a minimum and keep it direct and practical and "relevant" is the word I'm thinking of. Reams of papers that just aren't relevant, really.

Ingrid provided instructions to those sending the paperwork: "just keep it to …". Similarly, Harrison reinforced futility in his assessment that nursing paperwork not only duplicates material recorded elsewhere but also is formulated in isolation from other healthcare practitioners' notations:

> **Harrison:** I find in Queensland Health there's a lot of paperwork. There's a lot of repetition of paperwork and duplication of paperwork. For example, the care plan is supposed to be like an integrated care plan. Yet the nurses are the only ones who ever write on it or fill it out. They have – it depends on the ward you work on too – the pathway or the patient communication board – I mean, if you're going on that for your handover, well, it might not always be updated.
>
> The other allied health – the allied health people, the doctors and stuff don't really – it would be good if it was – if there was like – if it

> was more streamlined, I guess – if there was one thing where the different disciplines or whatever could put – could edit it and put in their little bits so that everybody was on the same page, rather than having to rely on the journey board, the patient's care plan at the end of the bed, having to go to the clinical notes and read what's in the clinical notes – if they need medications, having to look on the board where the medications have been ordered. I guess that would be better, if that was all brought together somehow – maybe.

Analysing this excerpt interdiscursively against some of Harrison's other excerpts, it seemed that he took a comparatively strong stance here. The wording was more confident, because, although "I guess" appeared twice, this was less frequent than in other sections of his interview. He demonstrated in the example of the care plan that the nurses were not aligned with the other professions. He referred to the allied health professionals as "the allied health people," and the doctors were lumped together with "doctors and stuff." He did not integrate the professions together, just as the documentation system that he described lacked integration among professions.

Myra depicted that the paperwork did not always reflect the care given, was not individualised enough to be of value and at times was not completed accurately:

> **Myra:** When I've – when I complete for risk assessment, it doesn't necessarily say – it's not individualised. So we can't get sort of correct, exact picture of the patient who's at risk for falling or not. We can't use that tool to be able to –be applicable to the individualised needs and things like that. We can get rough idea, but it's maybe misleading sometimes, so in a way it's – it's a waste of time sometimes, the – doing the paperwork.

Although risk assessments can underline an audit trail for safety, Myra cast doubt on the usefulness of the tool: the standardisation gave only a rough idea, and the person would still require a re-assessment at further points of contact.

We can get really slammed

The nurses found themselves undertaking a number of audits for quality assurance. Sophie discussed pressure area care, which is a well-known nurse sensitivity indicator (E. Willis, Toffoli, et al., 2015), and a potentially preventable iatrogenic complication that rates highly on an institution's list of quality assurance manoeuvres.

Interviewer: Is there a specific tool for pressure sores?

Sophie: Oh, gosh, yes. We get – we can get really slammed. We have an admission booklet up at the [hospital] now in all [state] hospitals, and it's gone from a six page document to a 10 page – it's 10 pages now, which has the Waterlow score and everything on, but we're now – we're now to document twice a day as to the patient's skin integrity on this Waterlow – on this admission pack, plus we're also to document now – notice every shift patient's skin integrity. Which is great, but we just don't – we don't have the tools all the time or the time to be ensuring that we're providing proper pressure area care. That's just one example.

Sophie used the word "slammed," which demonstrated the hierarchy behind the audits, as the staff can "get really slammed," which denotes higher power over them. She said, "Which is great" sarcastically, and she said, "Oh, gosh, yes" to start her answer. This showed a level of exasperation with the audit tool – not the care being measured, but the frequency of accountability occurring "all the time." Sophie spelt out that this occurs not only for admission work but also an additional two times a day.

Discourse of fear

Packing yourself

In my experience, nurses fear making mistakes for a number of reasons, including that it then requires admission of error and time to follow through with reporting. Beyond the repercussion of dealing with the mistake is a very realistic fear of causing harm to the patients in the nurses' care. A discourse of fear was evident in the data. The nurses in this research were not just scared of potential harm, but, in their own words, they were "really" scared. In the following anecdote, Ingrid walked me, the interviewer, through her mind-set:

Ingrid: One of the first days I worked back – first day back on the wards, I was looking at this medication chart, and it was a squiggle, and I couldn't see anything. All I could see was "subcut" so I'm kind of thinking, "Okay, it's going to be a Clexane or a something in that line."

I went up to the other nurse and said, "Can you tell me what this is?" She goes, "It's heparin; you can see the two and a bit of a squiggle

> there.” I've gone, “How do you know?” “That's Dr So-and-so, I know that.”
>
> I felt really – I really felt quite scared about actually giving that medication because I couldn't read it myself, and I was not a hundred per cent sure that's what it was, and all my bells are saying, “If you don't know – right patient, right drug, all that sort of thing.” Things like that are really scary.

Conscious alarm bells were telling Ingrid that she had doubts about the accuracy of the doctor’s handwriting despite the other nurse allegedly being able to interpret it. After this excerpt, Ingrid recounted a different situation where she discovered that nurses repeatedly did give a wrong dosage of a drug. This second situation pointed to a justification of her own earlier actions in questioning the medical order.

Harrison used the words “fear” and “fearful” to describe the unknown, and the responsibility of assuming care for a patient load on the wards:

> **Harrison:** It's more fear. It's more fear – to be honest. You go in and you get a hand – you walk into a ward that you've never seen before, and you get your handover of your patient allocation. If you haven't done a – if you're not up to date or you haven't done a few shifts on that ward you've never seen – and even people who will go away on holidays and come back, they say it takes them a while to get back into the swing of things, get familiar with the patients and – because things change. But – yeah. It's kind of – it is a big responsibility. It is a really big responsibility to take on that patient load. You go in and it's kind of – well, I feel fearful sometimes because I'm like, “Oh, God, what happens if something goes wrong” and it’s all back on you kind of thing.

Harrison legitimised the fear by telling of staff members whom he perceived to be more experienced than himself: even “they say*”* it takes a while to be familiar with patients. He shifted to second person to deflect some distance from ownership of the fear, choosing “it’s all back on you” rather than owning the first person “me.” Furthermore, he qualified this ownership with what Fairclough (2010, p. 216) referred to as hedging statements: “It’s kind of” and “kind of thing.”

While it may be just an expression of speech, Harrison was not alone in escalating the use of “Oh, God” in this discourse of fear. Similarly, Leila used this expression when

she described her fear of the unknown when waiting for admissions in a rural hospital – "Oh, my god, what if something comes in and I don't know how to do it?" – and later when she recounted a situation where a patient deteriorated quickly: "Oh, my god, I've just killed this patient by not taking that off." Gemma also used "God" as emphasis in her wish for the opposite of continual fear: "I always think, 'God, I wish I could have a work shift like that, where I knew where everything was and who to talk to if something does go wrong.'"

As nurses who worked in a pool, Gemma and Janelle both described a world that frequently evoked a fever pitched activity of trying to cope with sheer numbers of patients when the nurse/patient ratio was stacked against being able to give complete care. This brought a fear that, if anything out of the ordinary happened, the ability to physically attend to everyone else was rendered null and void:

> **Gemma**: It was crazy to think that when you come on and you think, "Oh, yeah, there's 72 people in this area, so there must be like a few RNs on and they say, "No, you're the only RN and you've got two AINs up one end and one AIN down here with you," and you're thinking, "So what happens if something goes wrong?" I knew never being there before, you don't know who you're supposed to contact. … If you do your initial assessment if someone falls and has smacked their head, like you do the neurological and obs and everything, but then do you send them to hospital or are you keeping them there and get the doctor to come out?
>
> **Janelle:** It's harder as a nurse because you're taking on a lot of patients that you know nothing about. You're getting a handover. If you're busy you don't have time to read every chart just to really get the picture. You come on, you've got one patient that's unwell, you must focus on that patient. But are the other eight or nine safe? It's a concern and it's just like it's just part of the nursing role. But it's not an easy job.

Both transcripts provided a litany of repetitiveness that invoked a sense of patient numbers out of control. Gemma used the adjective "crazy" to describe a care-load of 72 patients in a residential care facility. Her assessment of the workload indicated that she was struggling with the large numbers of patients and the responsibility of being the only RN rostered for the shift. The hypothetical patient who "smacked their head" was of concern to Gemma because she feared having to make decisions in an

environment where she did not have experiential answers. Janelle expressed concern if one patient needs more focus, what was occurring with the other eight or nine.

Scares the absolute crap out of me

In addition to the fear of being taxed with too large a load, or the consequences of the unknown, some of the nurses spoke about the more chronic nagging fear of not being up to the task. The participants chosen for this study held at least three years post-graduate experience, which was intentional in the research design to avoid discourses of new graduates who may be unskilled and inexperienced. Although the interviewed nurses ranged from two to 16 years out of university, some transcripts demonstrated that these years did not erase their fear of being under-skilled. New situations provoked fear of the unknown, such as working on the wards after primarily working several years in mental health placements. For example, Jo explained:

> **Jo:** To walk on to a general ward, I guess, because it has only been three years since I did do some – I did my clinicals, and that. Just the busyness of the ward and just being left with 10 patients who are medically unwell scares the absolute crap out of me. I just don't think I – I wouldn't have the – it would take a while. But the first thing, I wouldn't have the confidence to be able to handle it, I don't think. Yeah. I just – yeah, because it's been so long or –since I've done that stuff.

For Leila, the unknown was the emergency room where the mystery of who might come through the door provoked uncertainty and fear:

> **Leila:** There was a two-bed emergency, one resuss and two emergency; there was a 14-bed acute ward and then the 14-bed aged care ward. So when you're in charge, you're in charge of all of it, and I'm like, “Oh, my god, what if something comes in and I don't know how to do it?” I remember the first QAS [Queensland Ambulance Service] call, they were bringing in a girl who had fallen off a horse and hurt her shoulder. I remember completely panicking because I didn't know what to do. All she had was a musculoskeletal injury of her shoulder, and I completely panicked.

Whether that will be a coroner's case or not

The responsibility of having others working under the supervision of the registered nurse came with a fear of being legally responsible for their decisions and their work:

> **Janelle:** So technically, if a mistake is made there next door [by an enrolled nurse or an AIN], I'm responsible for that, even though she [the manager] hasn't consulted me. Even though she's taken another nurse from another area. So I kind of feel – I don't know how to put it into words. But some days I go to work and I feel totally powerless. Then I'm not letting it stress me anymore because I always had this fear over my head that I would be in a coroner's court and I'd have – we shouldn't have to be like that as nurses. But we're taking on a really serious responsibility. Every day we walk in there, we're responsible for those patients' safety.

Janelle used past tense in that she "had" a fear of being in the coroner's court. She quickly moved back to the present tense of "Every day we walk in," which could mean she was still associating the possibility of the coroner's court with her everyday nursing. Janelle said, "I feel totally powerless" when "she" has rearranged the staffing, which increased Janelle's vulnerability to "if a mistake is made there next door."

Janelle also told how one of her patients deteriorated when she was on a break, and a more senior nurse re-positioned the patient incorrectly and the patient aspirated. A series of errors occurred that were not attributed to Janelle, but she returned to the story several times in her interview and appeared to retain a fear that the scenario may be taken before the courts:

> **Janelle:** Yeah, but it's just like a week later I spoke about what had actually happened to some other nurse. I mean this lady didn't have a good prognosis. But exactly a week later I was speaking – I was doing a night shift, and this night nurse that I'd spoken to about this incident came up to me and said, "Do you know your lady in [names ward]? She's gone." "He said, 'They finished her off this time'." She'd been laid flat. She'd aspirated the feed and died. The same thing had happened. Now I still don't know whether that will be a coroner's case or not.
>
> **Interviewer:** How long ago was it, Janelle?

Janelle: It would be in the last two years. So, yeah, it's just like – it's not hanging over my head, but it's just like, well, I did the right thing as a nurse. I just think, "Well, it's happened again." But I think, when you PRIME things at the end of the month, they're kind of – they're discussed in the ward meeting. Which because I'm on nursing support – and it's just like a PRIME is – so I guess it should have been PRIMEd, but it wouldn't have saved that from happening.

But, I mean, it's a nursing – what would you say? It's something that every nurse – you think every nurse knows. But I had no idea that a CN would walk into a room and lay a patient flat. I mean it probably doesn't always happen, but it was obvious to me that this lady had aspirated.

While she did not own any error in the care of this patient, Janelle did state that she should have documented the incident in the incident management system known as PRIME, but she then justified that any amount of auditing would not change the outcome. She shifted the focus back to the nurse who had relieved her and had positioned the patient flat which caused the lady to aspirate. The casual, colloquial speak – "He said, 'They finished her off this time'" – may have served as a conversational technique to purposely de-professionalise the language, perhaps to distance professional responsibility.

I don't want to let her die

The potential involvement of the coroner aside, nurses generally do not wish their actions to cause someone to die. Leila recounted two incidents where she was afraid a patient might die.

In the first story, the patient's parameters indicated to Leila that the patient was septic, but she initially could not convince the on-call doctor of her assessment. In fact, her initial efforts failed to obtain a face-to-face review of the patient. This led to an episode of tears, but her persistence until the doctor responded was successful, and the patient was flown out from their smaller hospital to a major centre:

> **Leila:** I remember feeling scared. I was petrified that this patient was going to die and it was my responsibility. … There were only two nurses on at the time, and when I was with her and a couple of others I felt completely safe with them. So I knew that I was on with her, if something bad happened, I knew I was on with another good team member.
>
> Mostly the crying was fear. I was petrified that this patient was going to die; also like we're sort of a bit removed from it in ICU because we don't get to know the patients because they've got a plastic tube down their throat and they're sedated most of the time. You're sort of a bit removed from it there because you don't know them. Whereas I knew her enough that she was a nice lady and I'd met her family. It was also like I don't want to let her die. I kind of knew that that was the path she was heading down.

Leila walked the listener through the thoughts flashing through her mind, and emphasised that she thought the patient would die, stating that she thought if something bad happened, at least she was working with someone supportive. She ascribed the tears not only to fear, but also to the potential consequence that a *person* would die, someone who "was a "nice lady" and belonged to a family.

In the second situation, the ICU where she worked was trialling a new suction catheter that required a new procedure utilising a valve:

> **Leila:** So last year, about this time last year, I thought I was going to be working at McDonald's for the rest of my life. We had this fellow. He was really unwell at one point. We were t-piercing him to get him off the trachea to get him off the ventilator. We were weaning him off that.
>
> This isn't an excuse, but it may be the reason it happened. We were trialling new inline suction catheters, and they didn't have an exhalation port. So usually it's shaped like that, and there's a cap on this end that you take off so that when the TP [t-piece] is in they can bring it out, whereas with the ventilator they'd breathe out through the exhalation tube and that. These ones didn't have it. They just had the in port and the suction.
>
> So I saw that, and I changed it to the ones that – because we were just trialling those, so I changed it to one of our normal ones that have the exhalation port. By doing that I guess it added an extra step, and so just in the back of my mind I didn't take the cap off and I put him on the high flow – I attached the high flow and got all that ready, and I put him on 50 litres per minute and probably .4 or something and attached it, but I didn't take the exhalation port off.

> It was probably 15 seconds, I don't know, it seemed like about three hours, I think, but it was really, really quick. He went all red, his face went all red, and he sort of panicked a bit and I panicked. I didn't know what had happened, and I sung out to [name]. The other nurse popped over through the curtain, and just a new set of eyes immediately saw I hadn't taken it off. So she took that off and he breathed for a minute and she had her patient; she couldn't leave her patient. So she popped back through the curtain. Then my patient became unresponsive and I had a mask and goggles on because I was disconnecting the circuit, thank goodness, because he went completely unresponsive. I couldn't rouse him. His sats were dropping. I was just like…
>
> Anyway, so people were there very quickly. People were doing stuff, and I just sort of stepped back trying to get things – I was trying to be helpful, but I was [unclear] a mess. So I thought I'd killed him, like he was unresponsive, sats were dropping and I was like, "Oh, my god, I've just killed this patient by not taking that off."
>
> So I did that and then, it's quite funny, it's not funny, but the doctor put in the – like I gave him a pneumothorax, we put in the chest tube and he wanted someone to hold it, and I was just staring at it. So I was holding it, and I was crying. He goes, "Are you crying?" I was like, "No," and he was like, "Go to lunch." So I ran off.
>
> So there's three doctors there, three boss doctors; two of them are lovely, one is terrifying, it was the terrifying one on that day. So I raced off down the hall bawling my eyes out, and the cleaner actually followed me to the bathroom, and called me out of the bathroom eventually, and took me into the NUM's office – Daniel. He was so good, like I was petrified that I was going to be in so much trouble. It was a mistake, anyone can make it. In fact, people make it all the time, and now rules have changed because of that.

Leila recounted the details vividly as though this incident had occurred the day before. She began her anecdote with her symbol of undesirable employment when she felt that she might be "working at McDonalds for the rest of her life." She used the word "panicked" for both the patient and herself. She described herself as "a mess" and "crying," running off and "bawling her eyes out." The doctor on the scene was "terrifying," but so was her fear of harm for the patient: "I was like, 'Oh, my god, I've just killed this patient by not taking that off."

Similarly, Harrison feared that the dose of morphine he had helped administer had been the precipitating factor in a palliative-care patient's death. Consistent with

palliation, the dosages were high, but his inexperience in this field, and the patient's subsequent death, left him in a very anxious state:

> **Harrison:** Another situation when I was working in pool – it was nightshift, so there was me, there was a young nurse and there was a grad nurse. It was a palliative ward – anyway. But I don't know – I think the man may have had cancer, and he may have had brain mets [metastases] maybe. Anyway, one of the young – the girls went down and saw him. His family was with him and he had a headache. So he was written up for – I think – 30 milligrams of IV morphine.
>
> She came to me and was like oh, "I'll just get you to help me sign out this 30 milligrams of IV morphine." From my experience working in recovery, I'm more used to giving doses of 10 or something like that. I said to her, "Oh, that's a really big dose. How about we just start off with maybe 10 or whatever to begin, with and see what happens?" So I went down with her. We signed it out, and we gave him the morphine. Fifteen minutes later his wife buzzed, and she said, "I think – he's not breathing. I think he's passed away." I was straight on the phone to the afterhours nurse manager. "Hello, I think we've done the wrong thing." Have we given him too much morphine? – rah, rah, rah, rah.
>
> The nurse manager was like, "Oh, no, you've done the right thing. It's a – he's a palliative patient. He's written up for 30 to 40 milligrams of IV morphine. If anything, you've probably under-dosed him." But that was just enough to – I don't know – push him over the line kind of thing. I – well, we felt really bad because we didn't know – had we done the right thing? Had we done the wrong thing? Then you've got three junior nurses up there, and you've got his family and everything to deal with.

Harrison's use of "rah, rah, rah, rah" seems out of place trivialising the situation, but he also realised that the full conversation did not need to be reconstructed. Throughout his transcript, Harrison often talked in second person, but here he owned the action: "Hello, I think we've done the wrong thing" demonstrating the discourse genre of a telephone call by including the "hello." He was not convinced of the supervisor's reassurance, repeating, "Had we done the right thing? Had we done the wrong thing?" He then continued to demonstrate a lack of confidence in the situation by texturing the next sequence to be details he had to deal with, including uncertainty in the procedures for post-mortem care.

A very scary lady

Several of the research participants talked about fear of people who were difficult to work with. For example, the final part of Leila's scenario above involved a doctor who was "terrifying." Others talked about similar fears, and this included doctors, but even worse than doctors were scary supervisors. Some examples were:

> **Ingrid:** There's still doctors like that, obviously, and you'd be too scared to do… you think such and such.
>
> **Sophie:** I probably still get intimidated a little bit by consultants, but I will keep pushing other buttons. I won't necessarily keep pushing a consultant, but I will push – I will go through other avenues until I – if I really feel that something's not right or something – we're not being listened to. I may take a few back roads, but – to get – to get us listened to, to get the patient looked at.
>
> **Leila:** In the end I was like, I was trying to talk back to her, but she was a very scary lady. … I remember thinking I wouldn't know how to stand up, like I can stand up to a doctor but I couldn't stand up to her.
>
> **Janelle:** I was outraged because, as with this CN, that was the one that really bullied and abused me, and I was really scared of her.

A fear that may affect how nurses act within the organisation is a fear of retribution:

> **Janelle:** It's not that I'm over it, but I just sort of thought, "Well, okay, if I did sit down and write down a letter about these couple of problems that I encountered. Well, I kind of feel personally there could be a bit of backlash for me. Because I don't know whether your name would be mentioned, and then it's a bit like if I've got to go and work on that ward. "Oh, she's the nurse that reported blah, blah."

Janelle "kind of" felt that there "could be" "a bit" of backlash. She did not want to say there definitely would be such backlash, and she used three hedging phrases in the same sentence and two in the next: "I don't know whether" and "it's a bit like." What she would say is replaced with "blah, blah." This omission of content put the emphasis on herself as the person who would hypothetically have reported the incident.

In summary, when the nurses spoke about their work, they chose to discuss that work with particular emphasis on the challenges of ward work and the workload for registered nurses working in ward settings. Many demands impinged on their visions

for holistic care, and they voiced a desire to be able to nurse more than just addressing the "hole in the patient." The nurses spoke passionately about their role in monitoring and promoting a patient's medical recovery, and they lamented barriers to this, including documentation, audits and occasionally other people. Their passion for appropriate levels of care, coupled with impediments to enacting ideal care merged into a discourse of fear that ideal care was frequently unattainable, with follow-on consequences for patient safety and nurse well-being.

SECTION II: PRACTICE CONTEXTS

The work of nurses in hospital and care facilities is influenced by a range of contextual factors, including government policy, budgets, business goals, models of funding and stakeholders' influence, including their representation in the media. However, the broader system factors that affected nurses' ability to enact their visions for professional roles were relatively invisible to the nurses who worked within them. The interviewed nurses demonstrated that they felt the effects of the system, in fiscal control over resourcing, mandates for audits and concern for risk management, but they did not demonstrate an awareness of how their organisation was managed, or of who was in control. They valued proximal leadership, but they experienced a lack of empowerment to effect changes in conditions, or opportunities to take on leadership themselves.

Fiscal controls

Only so many buckets of money

Nurses referred to systems outside their employing organisation as "government":

> **Ingrid:** Community [nursing]'s pretty good, yes, though I think there's been a lot of changes which I've not been privy to know what's really going on with the government's new healthcare, aged care changes. They're trying to work towards, I don't know, home community care

which people could draw on, and it didn't cost them anything, but I think what's happening is the government wants everyone to go on packages. So they'll be paying so much part of their pension each week to have a package, which might give them five hours care a week, and they can direct how they want that care, whether it's showers or wound care or shopping or whatever.

Interviewer: Do you think that will cut the nurses out?

Ingrid: It's going to cut the nurses out a little bit I think, yes, for sure, but there's also only so many buckets of money. What is happening is, before you used to have a CN to manage packages, and now what I understand from these changes is that the government's not going to pay for a CN to manage a package. They just think someone who's got certificate qualifications in – just like a PC, a personal carer.

Ingrid foreshadowed here that the community nursing she enjoyed may be different for future employment owing to government aged-care changes. Although the list of tasks such as shopping assistance were not all nursing tasks, the plans would remove clinical nurses from a role of manager, owing to their salary costing compared to a less qualified personal carer (PC). Ingrid stated matter-of-factly that this was necessary as "there's also only so many buckets of money."

Jo recounted how changes had occurred in mental health placements:

Jo: We had one patient where they closed one ward down, and they took them into another ward, where it was a different environment, where there were wheelchairs. She wasn't used to that, and, because of that, she had a fall. Unfortunately, she fractured a NOF and ended up having a stroke on the theatre table. Had another one later – actually, she was due to go back to the ward a week later, and passed away.

I think that was directly because she was moved. Some of these patients have been out there for years. It's their home. Basically, they've been kicked out of their home. Some are moving two or three wards because they keep closing them. Yeah, so it's directly because of a government decision to close the facility because of funding, I guess, and yeah.

Jo used “and” to link clauses, with the second clause a consequence of her first ones: “she wasn’t used to that, and, because of that, she had a fall.” Jo did not provide any positive indicators that that demonstrated improved living situations or therapeutic reasons to live in more natural surroundings; she continued with language that “they’ve been kicked out of their home.”

In one instance, Janelle recounted an anecdote where the blame was on the previous state government for austerity measures put in place during that tenure:

> **Janelle:** I arrived at work, and here was this nurse with this big packet full of whiteboard markers. She said, “Here, girls,” and she was handing them out. She said, “We're now in a new era, and we can all” – dishing out the pens as if – well, you know, we can start wasting resources, kind of. It was just like, “Here you are girls”; it was just okay. So that was the atmosphere that I walked into. It was just like, “Oh, well”.
>
> **Interviewer:** Because it was a new financial era?
>
> **Janelle:** Yeah, well, it was just like, “Well, we're not under [name of state premier] any more. Here's resources; we just dish them out” [laughs].

Janelle spoke about this incident as symbolism, with the staff members celebrating a new government. Office items rather than a wound dressing or a mobility aide underlined the end of austerity, which also underlined the nurses’ roles in administration activities.

Getting as many patients through

The government, however, was not seen as the sole culprit for economic rationalism, as was seen in other sections of the research participants’ interviews:

> Helen: I guess I think financially it's – there's always those constraints as well as far as money goes, like in a private organisation. That's understandable being a private business, but it also – I find that frustrating as a health provider, rather than the healthcare aspect of things. I guess as I said it is a business; however, I believe that providing the best service to our patient should be top priority. Unfortunately, you see – if I can give a good

> example – quite often in theatre we have surgeons that will run until the early hours of the morning, and that's a direct reflection of obviously the financial benefits for the hospital. They're getting as many patients through as they can.

Helen faulted the private enterprise and the surgeons for "getting as many patients through as they can," thus highlighting that the "financial benefits" for the company that owned the hospital were sometimes prioritised.

Ingrid discussed the follow-on effect of the pressured turnaround times for patients returning to the community from short stays in acute care settings:

> **Ingrid:** Other times maybe they try and discharge them too early, get them back, and then the community nurses realise they're a lot sicker than what can be managed at home. Then they have to flick them back to the hospital to get them stabilised better before.
>
> I think that's that whole thing of "We need to get the beds; we need to get them out; we need to get them home," rather than having that extra day or so to make sure that the person is well enough to go home.

Her telling word here was "flick," implying that a patient as object can be easily tossed back and forth. This was reinforced in the language of "get them" used four times in the passage, speaking of "doing to" rather than engaging the patient as person. Ingrid switched from "they" to "we": the "we" was unclear but became in this sense a collective "we" – staff, possibly adopting this discourse from management, who in turn were speaking what the governance of the institution desired or mandated.

Leila described an organised audit system for pushing people through:

> **Leila:** So there's this new – I don't know if you've heard about it – this NEAT thing. I don't know what it stands for; I can't remember. It's "N-E-A-T." So we can look on the computer and see what the patients in emergency – what they're in for, and that's just so we have an idea if there's something on the – you know, people coming up. The thing is that from presentation to either discharge home or sent to the ward they have to be done in four hours from ED [emergency department]. So that means that – I'm just going to talk from my ward [ICU] because I don't know what happens on the wards, from admissions. We get a phone call, or the team leader gets a phone call, at three and a half hours this patient has been there – saying,

> "We want this patient up there now" and it's like, "Well, we can't, we don't have staff, we didn't know, we haven't organised, we haven't discharged, we haven't done all this stuff," and it's like they have to be out at four hours.
>
> So then emergency will admit them to the short stay unit at the back, so it looks like they're out of the ward even though like – it's happened, I don't think it happens a lot and I'm not sure why the decision was made, but we had a cardiac patient who was coming up to be monitored taken out of resuss, put around in short stay and not monitored. Then we pick up this patient who's for monitoring because they don't want to go past their four hours.
>
> Of course there are patients who go over the four hours, but there are posters around the hospital saying our emergency is at 83 per cent within the NEAT time for a hospital like this.
>
> It's good in that it gets patients seen because they don't sit waiting. The patients are seen quicker probably, but then things are rushed after they're seen and things aren't done just to get them out. So it's great because it shortens the time from presentation to seeing, but then the rest of it is rushed or not done.

Leila was referring to the National Emergency Access Target (NEAT), which had been introduced in Australian public hospitals prior to this study. Leila admitted that "It's good in that it gets patients seen because they don't sit waiting," but then the patient is rushed out, and "things aren't done just to get them out." She gave the example of a cardiac patient who was taken out of the resuscitation area and "put" in a short stay area, which qualified as being separate from the emergency room in terms of the four-hour target time. The patient was not monitored during this time despite being unstable enough to eventually warrant an ICU admission. Leila's frustration was for the patient but also for the ICU nursing staff, given that the deadline for the emergency room had implications for the accepting ward. This was accentuated by the short sentences with the collective pronoun "we": "we don't have staff, we didn't know, we haven't organised, we haven't discharged, we haven't done all this stuff."

We get nothing

Funding significantly affected the contexts of patient care. In Toni's excerpt, the insurance companies drove fiscal constraints to wards in instances when patients overstayed the standardised time allotment:

> **Toni:** This is the other thing that's changed dramatically to affect – what I see all the time is that now the private health funds, they will only fund – say you come in with a stroke, the private health funds say, "Well, typically, the statistics say that a stroke patient should spend 10 days as a – well, seven days acute and then 14 days as inpatient, then they go to rehab or they go nursing home or they go somewhere else." So, if we got a stroke patient who, say, was 90, who's had a massive CVA, is full nursing care, needs speech pathology, has renal failure, has all the other comorbidity that come in.
>
> They might be a diabetic. They could come in with pressure areas. They could then develop pneumonia, and then they could go on to – oh, God knows what else. That health fund will only fully fund that patient for acute for seven days. Then after the 14-day period, the doctor has got to justify why that patient is still being treated in hospital. So they have an acute care certificate that they have to fill out. Then after that 21 – if they – they can fill out the acute care certificate, but, after 21 days, depending on what's the patient's come in and for medical, it's your popular ones, your COPDs, your CVAs, your MIs, that sort of stuff, we'll get nothing for them. Absolutely nothing.
>
> So the funding for our nurse hours has dropped dramatically. So I've probably seen – even though we've reduced our patient load over a period of eight, nine years, we've actually increased our workload, because we have heavy – typically heavier patients. We don't get the funding, so we don't get the specials, the nurses to come in and sit with the confused patient. We don't get all this fancy equipment, because our funding for that patient is primarily coming out of ward funding. … Funding for things like mobility aids, like beds, and I know some of that comes out of the hospital budget, but a lot of those smaller things, like trollies and shower chairs, come out of the ward budget.

This passage continued further; its length along with the highlighted negatives demonstrated the passion and injustice that Toni felt: "they will only fully fund"; "we'll get nothing"; "so we don't get"; "we don't get all this fancy equipment." The flow-on effect of lack of patient funding was seen in Toni's ward with requirements for "trollies and shower chairs" to be funded by the ward.

Constraints on physical resources were also linked to frustrating rebound effects on time management:

> **Harrison:** Sometimes you do find, I guess, the quality of care or the level of care that you would – might like to provide sometimes isn't

there because of the system – the pressures and everything that are put on you by the system – like having to push so many people through, and having to do what's required with – because I was thinking about this. You've haven't always got the resources and stuff that you need available to you to do a quality kind of job or the job that – or the level that you would like to do, I guess.

For example – well, for example, you might have to do a dressing or something on someone. But yet you go to the treatment room or whatever, and the dressing that you need isn't in stock, or you have to go and borrow from other wards or do that sort of thing. That adds all these extra sort of – it slows you down, it takes extra time and – so, yeah, I don't know if that – but where it's coming from.

Sophie: We do have trouble getting stock. Sometimes it's as simple as the incontinence pads and stuff; we're having to ring other wards. For a public hospital, that's not great. Dressings, that kind of thing, so we've got a really big thing on pressure ulcer prevention at the moment, but we're having trouble getting Mepilex, that kind of thing, or we're running out, yet we must be making sure that we don't have any pressure – pressure areas that develop.

Harrison blamed the system for impeding optimal care: "the pressures and everything that are put on you by the system." Sophie talked about "a really big thing on pressure ulcer prevention," which she referred to elsewhere as a risk management audit. She claused her sarcasm after the statement that the wound dressing, Mepilex, was hard to obtain, "yet we must be making sure that we don't have any pressure – pressure areas that develop." She did not hide her opinion of this: "For a public hospital, that's not great."

Institutional management

The toll it takes

In the earlier discourses depicting workloads in the wards, the nurses expressed concern regarding the human resourcing for their fields of practice. The nurses referred to an obscure "they," who set the staffing. In Helen's case, the expectation emanated from the private organisation; it was portrayed as an expectation and not as an option:

Helen: Call staff are called in – everyone – it takes its toll on everyone. Short – therefore you're short staffed the next day. Everyone's tired. It's – it makes it hard on everyone with that expectation that, because we're trying to get as many patients

> through as possible, being a private organisation, that you will do a 14 hour day. It's – it's not exactly uncommon that – to be asked to do a lot of overtime – to do a 12-hour day or a 14-hour day. It burns the staff out.

She felt obligated to join "everyone" in staying for the overtime and then paying for it with the toll that it took.

Gemma also discussed patient/nurse ratios, and blamed a "they" for the staffing levels:

> **Gemma**: It's a [private] hospital. and the way patient care and nursing workload is spread between the hospital and the nursing home, they're not the same staff, but the way management takes into consideration how many nurses to patients in the hospital to the nursing home where it's not really a priority to have nurses' workload in a safe range. I think the other night I had 72 people who I was looking after.
>
> **Interviewer**: You're joking.
>
> **Gemma**: With three AINs with me. So that was spread out over three areas, and then in the hospital you have nine to 10, but 72 is just crazy, and that's – when you're asking AINs and ENs who work there, and they're saying, "Oh, they've told management that it's too much to have just one RN to all these people overnight." Nothing's really been done about it because they don't want to get the extra staff in.

Gemma used an interdiscursivity here where she shifted her statement to refer to dialogue from other more permanent staff who provided the second-hand rationale that "they don't want to get the extra staff in." An "us versus them" was expressed in relation to staffing as an affront to the nurses: "it's not really a priority to have nurses' workload in a safe range." Despite her indignation, Gemma demonstrated disempowerment with the staffing arrangements. She referred to the fact that the AINs and ENs had already told management that it was too much: her dialogue gave the impression that the situated rested there.

Likewise, Ingrid's excerpt demonstrated acceptance of the status quo:

> **Ingrid:** I don't know whether making the amount of patients you look after smaller would help, because if you get a group of eight patients that's a lot. In say a surgical ward or a medical ward, that's a lot of patients. Probably six would be ideal, but then again can they afford to run it that way cost-wise?

Ingrid's point was in reference to nurse-patient ratios. Although arguing for a better ratio, she immediately answered herself rhetorically and in doing so validated a managerial discourse: "but then again can they afford to run it that way cost-wise?"

A time-wasting load of rubbish

Audits such as TrendCare, which is used in the public system in Queensland are used to measure staffing. This had an impact on how many nurses would be staffed in subsequent shifts. Leila and Janelle demonstrated this as an exercise imposed by management:

> **Leila:** They're got TrendCare, but TrendCare is a time-wasting load of rubbish. It's for staffing, but it's so stupid. I don't ever do it. I just get in trouble for it. I think it's the stupidest idea in the whole world. So they staff like maybe 12 patients to two nurses, I guess. I'm not completely sure what the ratio is on the wards because I don't do it often enough, thank goodness. It's really busy … You can't assess 12 patients and you can't do your – you can't do what you need to do for the findings of those assessments on six patients in eight hours. It doesn't happen, and you can't do it as well as doing the nurse care.
>
> **Janelle:** Because it was one of the managers that sent me to a ward – it's the transit ward, which I probably worked three shifts there, and he said, "You're going to be the TL [team leader] tonight." My first reaction was, "I don't accept that role." But they're basically saying, "You have to accept that role because you're there."
>
> Anyway it's sort of like – well, so the patients are coming, and I thought, "Well, maybe I can do it. I've never had any tuition in doing the extra – the stuff that the TLs do on the TrendCare. He just said to me, "Well, don't worry about doing that." I did it, but I didn't really want to accept that role.

Janelle's excerpt here discussed her experience of being told to team lead when she had not been trained in that role, but the pertinent aspect of this discussion was that the manager said not to worry about doing the TrendCare. In both nurses' excerpts, TrendCare was considered time-consuming, irrelevant and expendable.

What are we, accountants?

As discussed earlier, nurses attributed the potential for litigation as a source of fear when care did not proceed as expected. They identified litigation as the motivation for the audits and documentation imposed by the system.

> **Ingrid:** It is a fear of litigation for sure, because we have audit scheduled at [community nursing agency], and you'll hear the auditor's coming, "So bring the charts in; we want to make sure all the charts are – " and they've got a checklist of this, this, this and this and this, that would fail the audit because this isn't done. It's like what are we, accountants?
>
> I know you have to have certain things in place to protect everybody, but some of the paperwork, do you really think this is relevant? If that box wasn't ticked, you'd fail the audit. It just does not reflect what's going on with the actual person. I think there's a lot of wasted time and effort with that sort of thing.

Here Ingrid made her point that the churn of audits was for the purpose of getting them completed, and that completing them and all the boxes that comprised the documentation was the measure of completed care, regardless of "what's going on with the actual person."

I'm going to Riskman you

Nurses had adopted the organisational "safety speak," to the extent that they had de-nominalised the title of the institution's safety procedure into a verb for utilising that procedure. Toni had an injury while manually handling a patient, and was told by her supervisor to "Suck it up. All nurses have bad backs." She added: "But I did Riskman it; that's our reporting system." She again used this term as a verb in describing the kitchen staff member's criticism of a new graduate:

> **Toni:** Grads get upset easily, because they're so anxious anyway and, like, a little grad the other day did – said something to one of the kitchen staff and the kitchen staff said, "Well, I'm going to Riskman you." This poor grad becomes so upset and, like, it was only nothing.

Janelle used her institution's system of "PRIME" (a computerised clinical incident system) as a verb to show the action of filling out a PRIME sheet, something about which she was conflicted in this re-telling:

> **Janelle:** But the guilt that I feel about that was that, all right, well, this is the team leader. It was a PRIME – I should have PRIMEd that. But I'm not the queen of PRIME because I thought, "Well, a team leader…"
>
> **Interviewer**: What do you mean by PRIME, sorry?
>
> **Janelle:** A PRIME – you don't know what a PRIME is? If something happens on the ward, it's a mistake or something happens, there's this computer program which I struggle with – it takes me forever to do a PRIME. I should have put in the incident, and how that the patient was put at risk.

Each of these excerpts also gave some clues as to the culture of safety, or indications of a lack of a positive culture. A staff member utilising "Riskman" as a threat impeded the principles of identifying near misses or mistakes. The action clearly left the new graduate unsettled, with a take home message of other staff members reporting one's actions, rather than learning to proactively report errors that could be rectified. Janelle's anecdote showed a lack of organisational culture of self-responsibility because she felt that the onus of documentation rested with the team leader. Additionally, she noted that the interface was not user friendly, and thus staff uptake would potentially be affected as it took her "forever to do a PRIME."

Here's another nightmare for me

The nurses portrayed vague management entities who prescribed the copious documentation expected of RNs in daily practice:

> **Sophie:** That's what I find – management are just so hell bent on making sure those boxes are ticked and everything that nothing else – well, it's my opinion – that nothing else really – really matters.
>
> **Janelle:** They used to have a more complex care plan in the cancer ward, which is – they had their own care plan – which is where this has been implemented and trialled. But then, if they decide that's a good thing, we get that all over the hospital.

Sophie blamed the demands of paperwork on a specifically coined "management," and Janelle referred to an obscure "they." In several passages, Janelle spoke about documentation with rhetorical questions, presumably also directed to this faceless management:

> **Janelle:** But now it's just like, well, what criteria have they got in here now? I've got to get used to that paperwork all over again. It's just like – and the care plan – it's just like here's another nightmare for me. So I kind of feel it is relevant, but I don't know who is creating these changes. Are they necessarily the best? I think things – there's going to be things – it's probably – it's the thoroughness of the nurse that would pick these things up anyway.
>
> **Janelle:** The paperwork is changing, which is creating challenges for nurses. Are all these changes really necessary?
>
> **Janelle:** I mean, with this new care plan, I mean – but I don't know who has created it, but I would like to go to that person and say, "Well, why have we got this?"

In the final excerpt, Janelle's points demonstrated the divide between those using the artefacts and those producing them.

Relationships/culture

People impact on the nurses' ability to deliver what they conceive as quality care. This includes managers, team leaders, co-workers, other health professionals or ancillary workers and patients/families.

I've got KPIs to meet

Nurses in this study referred to managers in both a supportive light and in less than glowing terms if they deemed managers to be out of touch or less than helpful. As either a negative or a positive influence, managers impacted on the nurses' work-contexts:

> **Sophie:** The ward that I work on, along with the other wards that I've visited with nursing support or worked on with nursing support, quite often from the nurse unit manager they may have come out and done a couple of years of clinical nursing or working on the floor, but then they've taken managerial roles. I think they forget what nursing

> entails. Some of them don't realise – I don't think they realise that it has changed. Those that did have clinical – that were working on the floor many, many years ago, I don't know if they've realised how much it's actually changed. While they're there directing, they haven't actually worked under those conditions as such.
>
> I feel, yeah, that right from our nurse unit managers up, and then above those nurse unit managers, no, I don't believe that they have real, on-the-floor ideas of what is going on. Myself and others will quite often approach our nurse unit managers and explain that we're having difficulties in whatever area, and their solutions to those problems are not practical. It's most likely – it's "Here's my answer and then go away" kind of thing. "I've got my KPIs to meet," which I find very disheartening.

In discussing nurse unit managers and the higher managers above them, Sophie demonstrated a lack of confidence in their clinical abilities, either because of the brevity of service: "done a couple of years"; their lack of currency: "working on the floor many, many years ago"; or a doubt that they had much clinical background at all: "those that did have clinical." In a relatively short passage five different phrases stated that she did not believe that the managers had an understanding of how much working on the floor had changed: "I think they forget what nursing entails"; "some of them don't realise"; "I don't think they realise that it has changed"; "I don't know if they've realised how much it's actually changed"; "no, I don't believe that they have real on-the-floor ideas of what is going on."

She talked of trying to bring issues to the manager, then moved to the first person to simulate a parent dismissing a child: "Here's my answer and then go away." She also poked fun at the managerial requirements: "I've got my KPIs to meet."

In contrast, Helen discussed her managers in a more sympathetic tone, trying to understand their constraints from management above them:

> **Helen:** I think a lot of times their hands are tied from what does come from higher up in the hierarchy. They're told that this is what will be done, and it's what's to be followed through with. It [support] does seem to have disappeared to a certain degree. We don't seem to have the same amount of support that we used to.

Interviewer: How do the managers feel?

Helen: I think to be honest they do feel quite conflicted.

Interviewer: Are they nurses or are they neutral sort of administrators?

Helen: Our theatre managers are both nurses. However, they're not – they haven't been clinical nursing for a number of years. However, as I mentioned, you do have being a private organisation it is about the money, to some degree. They've got the executive telling them to – we've got to put all these patients through. It is really hard for them because they can see the staff are tired. We've just got to keep going.

This interchange was reflective of Helen's opinion about how others (the managers) were feeling. Like Sophie, Helen stated that the nurses were removed from nursing "for a number of years," but she accepted this and demonstrated affinity with the managers in saying: "It's really hard for them because they can see that the staff are tired." There was a level of solidarity expressed, not in fighting the organisation, but in a feeling of resignation that this was the way it was in a private organisation where the purpose was "about the money." In the final sentence, she linked herself with the managers, and she demonstrated this solidarity: "We've just got to keep going."

Several nurses were positive in their summation of managers. Janelle, for example, appreciated when a manager helped with hands on care:

Janelle: But I remember being really impressed one day with one of the managers, because she was there on the ward and I was there. I suppose I was a bit snowed under. She just went and got a bowl, and she brought it out, and then I remembered what [a particular lecturer] said once in one of the tutorials here. He was saying, "Well, sometimes the best thing that we can do for a patient is just to show that we care." Just for her just to bring that bowl of water just to give this patient a wash just to help me out. It was just like, "Well, look, there's a good nurse." You're a – you could be a manager, but it's not beyond you to take on a menial task to help on the ward.

In this passage, Janelle used the analogy of how to demonstrate care to patients, in that the manager demonstrated care to her, by practically and physically pitching in. Her choice of words, "to take on a menial task," reverberated with some of the earlier

discourses from the nurses in this study regarding their opinion of hygiene care and other activities of daily living. It was notable, though, that the respect came when the manager did ward work. It was not a respect for managerial duties.

In the next two passages, Leila discussed both positive and negative examples of nurse unit managers and her choice of words, as well as her choice of phrasing show contrast in the difference:

Leila Excerpt: Manager A

Leila: It was so nice – like the NUM would come around – like where we are in ICU – come around, and just have handover in the morning with everyone at the desk, and then he'd go do his thing. You could plan your day, and that was your day, you can do it. You knew what you were doing, and if you had a problem you just went and found help. You weren't judged for asking for help.

Another time, I was wailing in his room. It was quite embarrassing actually, thinking about it now. He was so good. I feel very lucky to have a leader, a NUM, manager that – because I've had a couple and I haven't worked under one that is any good yet. He's very good, like he talked through it, and he was like, "I don't want you to –." I think he was worried that I was going to be so traumatised I was going to leave. I was worried I was going to get the sack.

Leila Excerpt: Manager B

Leila: At [place], the DON [Director of Nursing] would lurk around and just – if it was a bit quiet – it was kind of sometimes we'd be run off our feet, we wouldn't get a break for eight hours, it's super busy, and that's fine because when it's quiet you should be able to have a bit of downtime; no, we'd hide if it was quiet because otherwise she'd get us doing audits.

The night the lady arrested…the thing I remember about that night was that I was oxygenating her. The DON was telling me to bag harder and faster to get her CO_2 levels down. I was like, I didn't want to do what she was telling me to do, but she was my DON, and it was terrifying. It was like she's my boss, and I have to do it, but I don't think I should. In the end, I was like I was trying to talk back to her, but she was a very scary lady.

Even though I knew that she had a lot more years' experience, she'd spent almost all of her time in aged care. Obviously she had the qualifications to be a DON, I don't know what they are but it was, it was really scary. The ambo came and took over from me because he

> wasn't – she wasn't in charge of him, and he could do what he knew was right.
>
> I remember thinking, “I wouldn't know how to stand up, like I can stand up to a doctor, but I couldn’t stand up to her.”

The attributes that Leila respected in Manager A were his trust in the staff members, the autonomy that he awarded to staff members and his support in a crisis situation. One can perceive a sense of a motivational talk from him in Excerpt A: “You can do it.” The nurses were left to plan their day, yet they were free to ask for help if required. In a crisis, this manager demonstrated psychological support when a mistake occurred. Leila used the words “embarrassing,” “wailing” and “worried.” As embarrassed and traumatised as Leila felt, she felt also a sense of personal support, in that “he talked through it.” Twice she said, “He was so good,” and “he’s very good.” She stated that she had not worked under “one that is any good yet,” which was underlined in her second excerpt about a previous manager. Leila talked about Manager B, a DON, as “lurking around.”

Leila doubted Manager B’s clinical abilities, but she was intimidated about defending her own practice in an emergency situation. The conflict that Leila felt between her actions and the directions from the DON was clear in her words “she’s my DON,” “she’s my boss,” but her instructions conflicted with Leila’s own judgement. She started to say “I knew,” as though she knew that she was right, but then she moved to explain that she had to defer to this DON, given her years of experience, and because she was “a very scary lady.” She expressed doubt about the qualifications needed to become a DON. In Leila’s opinion, the ambulance officer’s actions confirmed her own perspective.

Scared the daylights out of me

In addition to the manager roles, many nursing areas also have a team leader who supervises the shift and who carries a patient load. Some of the nurses provided opinions of the skills required in team leading, and of the attributes that were helpful (or not):

> **Leila:** Well, I didn't ever team lead in rehab, but there were some team leaders there who were great, and some that weren't so great. I remember the really good ones. I knew what I liked about them, and I knew what they did – I didn't know what they did, but from my level looking at them I knew what they did to make a shift run well, and to make the rest of the staff work well and feel like they're supported.
>
> When I had to act as a team leader in the country hospital when still a fairly junior nurse, I suppose I just tried to remember the couple of team leaders in rehab that I worked with that were really good, and trying to take on what I learnt from them. It all made sense in my head, but scared the daylights out of me when I went to do it.
>
> **Debra:** I can team lead in a theatre. I don't team lead the floor or anything like that. I suppose I will one day, but I really – you see the people that progress and they're more in the office, more in the office, more in the office. That's not why I became a nurse. I don't want to be in the office. While my feet hang on and everything else works for me, I'll stick it out. Maybe later on I may have to think about becoming more that level. No intention of it at the moment.
>
> **Janelle:** The APPT [blood test] was slightly late, but that was really not my problem. But, had I more time, I should have chased up the doctors earlier. Normally, the TL would have done that for me, but that didn't happen. With all these other issues, the TL did not even walk in my room all day. At ten past three, "How are you going, Janelle? We're leaving, we're going home." Out the door.

Leila did not give specifics about how the supportive team leaders worked to make things run well, but her favourable language "who were great," "really good ones," and the outcomes they achieved to "make a shift run well," "make the rest of the staff work well" and make "the staff feel like they're supported," demonstrated that they were a positive influence on the shift and on the ward. Leila stated that acting as a team leader when still classified as a junior nurse "completely scared the daylights out of me," which demonstrated that this was not an easy role to fulfil. Debra's excerpt reinforced this, as she described the role as one to be avoided.

Janelle described a lack of support from her team leader. She implied that the late blood test was the team leader's fault, because normally the team leader (TL) would have "done that for me." She provided a statement that mocked her situation when the team leader said, "How are you going, Janelle?" but she did not wait for an answer

before going home. Janelle finished the excerpt with “Out the door” as her synopsis of the team leader’s lack of support.

Who died and made you Level 2?

Teamwork can make or break the contexts within which the nurses are practising, and several of the nurses spoke about this:

> **Debra:** A good day is also when you've worked with a really good team. I'm a bit of a team sort of person. There's always two scrub – two nurses in theatre. Twenty doctors or whoever else is there. [Laughs.] You've got your theatre tech, and you've got your porter guy or gal. I just tend to think it's a good day if everyone works together. It's been a good outcome for patients, and just everything's gone smoothly.
>
> **Leila:** So the AINs over in [name of ward] were really – they'd done all their work, and the last hour they don't do anything anyway. We were really busy. I think we had a lot of discharges and admissions, and the place was a mess. The team leader asked me to go and do something, make a bed or something, and then she said, “We'll see if those AINs from the other end will come and help us.”
>
> So I thought, “I'll just go grab a couple of them and see if they can help me make the beds.” Well, that was the worst thing I ever did in my entire life, I think. Yeah, so I went and got them and asked them if – “Would you mind go making these beds, and I'll make these beds.” The team leader was sitting at the desk doing paperwork or something. She went off her nut: “Who died and made you level 2, blah, blah, blah.” I was like, “I was just trying to help.” Of course I started crying because I cry all the time. This is at the nurses' station, and there's people around.
>
> **Janelle:** I remember one day – because you've got things back then that the EN couldn't do. It's just like, “Look I'm overloaded, I'm” – delegation. But it's not in their vocabulary. Anyway, this one day I remember saying, “Could you just please shower Mrs so and so for me?.” You just get a flat “No.” So, I mean, I guess I should have been more assertive; I definitely wasn't assertive. It's just like “Well, I know that I'd do a better job anyway,” so I'd go and do it because I wanted the patients to be looked after properly.

The language in these three separate incidents clearly took a positive or a negative spin. Positively, Debra reported teamwork as making their day in a theatre environment. The difficulties of teamwork for registered nurses are compounded when delegation is involved; this was clearly refused in both Leila’s and Janelle’s examples.

Workload shared invokes a feeling of teamwork, but disappointment when it is not reciprocated. For example:

> **Janelle:** This other nurse piped up and said, “I'd have him on 15 minutely obs. It's just like “Well, yes, you've been sitting in that chair for the last hour while I've been running around looking after my patients and keeping them safe. If you come to my area to help” – because, with team nursing, if I'm finished and I am okay, you go to the next area if they're struggling and you help them out. This is what team nursing is all about. But sadly it doesn't happen a lot.
>
> **Ingrid:** That was just me, I think, because I'm that sort of person. I think, “You're going to ask me to help, I'm going to ask you to help and I'll help you somewhere else.” It actually backfired on me one other time, and I ended up doing a whole heap of things for this other person that somehow, I don't know how I ended up with it, but she was “Well, I had to do that.” I was like “Okay, you've got to choose your person that you want to ask to help.”

In Janelle’s excerpt, the first couple of sentences textured the passage. The issue was not simply that the other nurse did not help her as the scenario unfolded; it was that the other nurse ventured an unwelcome opinion regarding the care decision for Janelle’s patient. The sarcasm was evident: “It’s just like ‘Well, yes, you’ve been sitting in that chair for the last hour while I’ve been running around looking after my patients and keeping them safe’.” Ingrid felt that reciprocity backfired when it was disproportionately in one direction.

The lack of teamwork could also become personal if horizontal violence was involved. Janelle talked about horizontal violence from the team:

> **Janelle:** It's just like – I don't think I would have survived if I didn't have [a person’s name]. She was the coordinator, and there were just so many challenges, and I could talk to [a person’s name] about them. Things that I'd heard about which I didn't believe were in nursing. Like bullying and just some of the things that went on that were just horrific. I personally experienced it. It's just like – but it's there – but I kind of felt – how would you say? When you're being abused, you feel that you're inadequate as a nurse, and that I'm reflecting, “Well, this is what I did.” But it was really wrong. Do you know what I'm saying? It still exists.

In this case, Janelle did not give an example. She referred to having heard of bullying before experiencing it, and confirmed not only that "It still exists," but also that she personally had experienced it. She then foregrounded how it made her feel by moving back from the nominalisation of "bullying" to high impact action words of "being abused." This action on the part of others not only was a noun that has become a cliché, but also was "horrific" and made her feel "inadequate as a nurse."

Despite this example, across the interviews there were notably few transcripts where the term "bullying" among peers was used. There were instances of not being treated equitably, such as the teamwork mentioned just above, and behaviours from management in relation to critical incidents that could be called "bullying," but the need to discuss current workplace behaviours was not one of the dominant discourses from the research participants in this study. This is worth mentioning because there is a proliferation of studies examining horizontal violence as reasons for dissatisfaction in nursing (Huntington et al., 2011; Hutchinson & Jackson, 2015; Hutchinson, Vickers, Jackson, & Wilkes, 2010), or as intentions to leave (Cope et al., 2015).

The eyes and ears

The nurses in this study portrayed their professional rapport with doctors in a reasonably positive light, which was a contrast to the tradition in nursing literature to refer to subservience and power domination (Browne et al., 2018). Some frustration was highlighted previously when conflict occurred for nurses when trying to initiate a medical review of deteriorating patients, or to obtain written orders from doctors to allow nurses to enact therapies or other prescribed interventions for the patients' healthcare plans. For example:

> **Ingrid:** The interactions that I've noticed in the hospital, I think the doctors really rely on the nurses as their eyes and ears with things, a change in a patient's condition or "Hey, doc, make sure" or "This needs doing." They seem to take it quite well - not like, I think, quite a while ago the doctor was sort of on this high pedestal and how dare a nurse ever challenge anything he says?

There's still doctors like that, obviously, and you'd be too scared to "Do you think such and such?" but I think nurses have got very clever in how to approach a lot of doctors. They'll put it into a way where they might suggest something, and that doctor will take that on board and think "Okay, yes, that might be a good idea." There's a lot of space there to be proactive with a patient, I think, if you're a good communicator, and if you're a good negotiator sometimes.

The majority of what I've seen taking place, interaction between the nurses and doctors, the doctors hold the nurses in high esteem, and listen to what they've got to say.

Debra: Look, most of the doctors are pretty good…

Early on I had one of the doctors throw something and say, "Don't they teach you anything?" I handed him the wrong instrument or something. I said "Well, you know, I'm a bit slow." It's all right. I think that's few and far between these days. Some get a little bit superior.

Very few doctors are intentionally horrible to you. Some will be abrupt or not quite with it. You know they've got a big responsibility. Big job, so I don't expect a doctor to have light conversation with me every time I see them. It's not realistic. Most of them are good.

Gemma: and making the doctors happy [laughs].

Gemma's dialogue included other cliché statements about the doctors thrown into the conversation, possibly unconsciously to seek solidarity with the researcher with statements about the supposed common enemy. Of note was that she never provided any specific examples, and these statements were unsupported, even though they may be still appearing as part of established nursing lexicon.

The last port of call

Nurses work within a complex system of people who are also providing treatment to patients. The nurses mentioned the allied health team occasionally, generally in relation to liaising with them over patient care. Some examples included:

Ingrid: Between the physios and things like that, it seems not too bad working. I think nurses still hold their ground as being the one that is the protection - the last port of call when you look after people.

Harrison: Everything falls back to the nurses, I notice. That's something that other nurses say. I've experienced that myself. Anything that needs doing – like the mundane,? menial tasks or

> whatever – falls back to the nurses. If forms need filling out or something, it falls back to the nurses. Care falls back to the nurses. It just seems like the expectation or the workload of nurses is – yeah, a lot – well, bigger. I guess the other allied – I mean, I don't really see a lot of what the other allied health professionals, doctors and stuff do behind the scenes.
>
> So I'm just going on – I mean, I know they see people, have consultations and stuff. But I've been in the situations where, for example, a dietitian has come to the ward or whatever, and you've got a patient that's elderly. They're a two patient transfer and they're in the bed. It's morning shift. The dietitian or whatever will come. They haven't had their weekly weigh, their daily weigh, or whatever. They'll say “Oh, this patient needs to be weighed.” It's like “Oh, okay.”
>
> Then they wait there while the nurse has to organise to have the patient taken out of the bed, and there's no one to help. They've got all that – the nurse has got to weigh the patient and – that takes away from the other tasks that they're having to do too. So that's again adding to their workload. I just think it's supposed to be allied health, and it's all integrated and everything. But yet the nurse is the only one who can do a weight kind of thing.

Although Ingrid worded this positively, nurses had a role as the patient’s protector, in Harrison’s reference to allied health the nurses were portrayed in a subservient role to the other professionals. Harrison pointed out that, although there should be an interprofessional approach, dieticians could ask nurses to perform tasks for them.

Staff are just numbers

In some instances, the nurses gave evidence where the hegemony of the modern hospital has shifted from nurse versus doctors to nurses *and* doctors versus the bureaucratic system under which they are working. Some of the nurses talked about this. For example:

> **Myra:** Because earlier nurses under the doctors, all the time. Right, this, do whatever they been told. Not being able to think, and not being able to point out any mistakes or anything. It has changed now, but again now management is controlling, yeah.
>
> **Sophie:** My opinion is it's coming from – it's coming from management. They've got quotas to meet. They've got budgets to meet. I feel that we're just being pushed to make sure that their paperwork is looking up to scratch for – for their – for further up and for the government, right down to the doctors. However, I guess the

> doctors actually have management on them as well saying, “This must only be the length of stay. This must be the approximate length of stay. You're not getting them out fast enough. They need to – you need to be getting them out quicker.” I think that's where it's coming from. I might have said before I just – I feel that patients are just numbers.
>
> I also feel that staff are just numbers as well. I don't just mean nursing staff; I mean all of us.
>
> **Leila:** Our doctors are actually refusing to do it in ICU, like “I'm not doing it. I spent 25 years training; I'm not doing a tick and flick on a computer.” Everyone has to do it, nurses, doctors, everyone, this tick and flick thing.

The excerpts demonstrated both a controlling management and a continuation of the faceless “they,” particularly in the excerpt from Sophie. Solidarity with the doctors was evident.

SECTION III: INTERPRETATION OF THE DISCOURSES

In moving to Fairclough’s (1995) middle box of interpretation for Research Question 1, I looked at the discourses with respect to the contexts and across the genre to ask, as Fairclough (2010) proposed in his later writing, why the discourse is like it is. Here my interpretation considered conduct recounted or thoughts/emotions expressed in the process of interview (the discourse practice event) that could be indicative of a professional role. Choices of data to use and interpret integrated my own lens as the researcher. This lens was influenced by Fairclough’s (1989, 1992, 1995, 2010) writings on social theory and by considering agency for the individual within the social context.

In each of the categories below, some discourses emerged that showed significant tension between the participants’ own desires for more professional nursing and the thwarting of their actions by institutional overlays. Conversely, different examples in

these same categories recounted care as institutional expectations of what measures as nursing care and nursing formation, with seemingly little professional expertise, agency or accountability portrayed. These are considered collectively at the end of this section.

Independent nursing actions versus routine care

Everything goes out the window

Sophie talked about patient education, which in nursing theory is considered an established part of a nurse's professional role (Lima et al., 2016), but it is not one that is easily visible or counted in audits or nurse sensitive indicators:

> **Sophie:** Yeah, yeah, I think education is a big – is a huge thing, especially in orthopaedics. If you can take that time to educate a patient, and that's not necessarily, "Okay, now we're going to sit down. We're going to talk about this. It's that communication – it's talking to your patient while you're doing something, or it could be something – you're standing there waiting for the obs to finish, but you're fixing up their TEDS – their TED stockings. Then educating the patient as to why they've got those TEDS on, and what we can do to prevent blood clots, that kind of thing. I think we educate – most – I don't know about other nurses, but I try to educate constantly. It's – why we're doing your exercises, why we're doing pressure area care. How you can prevent pressure sores from forming, that kind of thing. Ensuring that you're taking your medication – it's a constant – yeah, I think that we – most of us try and put that into our whole – our whole shift – our whole patient contact time.

Sophie easily described this recount of constant patient-teaching during other activities as a part of what nurses do, not as a separate activity of now "we're going to sit down," "We're going to talk about this." It was woven into "our whole patient contact time." Sophie did not display this as anything extraordinary, and, although she indicated that she did not speculate about other nurses, she assumed that other nurses had the same vision for care: "I think that we – most of us – try and put that into our whole – our whole shift."

Sophie demonstrated frustration with the status quo of current practice workloads that rarely allowed for aspects of professional nursing practice; she showed in the following

excerpt that autonomously enacting immeasurable psychosocial care came with the cost of time management going "out the window":

> **Sophie:** I try every single day – I try to make sure that I'm looking at the whole person. Unfortunately, when I do – really try to make that effort to look at the whole side of things, that's when the time – I find that my time management and everything goes out the window. To me, though, it's more important to be able to go home and know that you sat and listened to a patient, or you've spent time listening to the family's concerns, than making sure the boxes are ticked on the paperwork – that kind of thing. I – like I say, I try to do it every shift. Unfortunately, I'm not able to attain that every shift because we're just so crazily busy. I guess that I don't go home feeling satisfied as much as I'd like to.
>
> I don't go home and think, "That was a really good day. I made a difference in someone's life, or I made something easier. I found out something for someone, or whatever." Those days are becoming few and far between. I find that a shame because that's why I came into nursing. It's – it's becoming very, very hard to achieve these days.

This was quite a reflective piece, and Sophie's texturing of her monologue became more sombre in each line. She started with stating the ideal and the importance of her ideal practice, but then she moved to stating that, although she would like "to try to do it every shift," "unfortunately I'm not able to attain that every shift," eventually admitting that she did not feel as satisfied as she would like to feel. In fact, she realised that "I don't go home and think that was a really good day," and then that "those days are becoming few and far between." She then recognised that this was not fulfilling her ideals of nursing, and that fulfilling those ideals was "becoming very, very hard to achieve these days."

Doesn't leave a whole lot of time to initiate things

In Section I regarding nursing work on wards, I demonstrated how the nurses' descriptions of this work read as a recitation of tasks, literally listed and accentuated with repetitive words. It was challenging, even after prompting the nurses, to find in some of the nurses' talk activities that extended to nurse-initiated interventions for improving a patient's recovery, health status or comfort. In contrast to Sophie's excerpt

just above, Harrison had difficulty imparting a vision for a scope of nursing practice beyond minimal institutional expectations:

> **Interviewer:** Are there elements of driving nurse – good nursing care that you also are able to do?
>
> **Harrison:** From – well, from my experiences – the priority is definitely on firstly getting the workload, done because the workload is the priority. Everybody needs their medications. Everybody needs to be weighed, showered and all that sort of stuff. I guess – yeah, it doesn't really leave a whole lot of time to initiate things. Then I don't know whether – well, there's very few medications that nurses can initiate anyway. I mean, I did – I have started someone on incentive spirometry before, just because they were a bit chesty or whatever. But I didn't really know whether what I was doing was of any real benefit to the patient. But I sort of thought, "Well, it's better to do it than not do it" – maybe. This is from my experience – like my time in medical, which has been not very much.

This excerpt illuminated categories that could characterise a professional role, including independent nursing actions, knowledge for practice and a sense of autonomy. When considering interventions that nurses could initiate, Harrison moved to comparing scope of practice to what a medical team initiates such as medication prescriptions. This may have been what came to his mind first, that a doctor would be the one to initiate actions related to patient care, but this demonstrated a bias towards thinking medical treatments were the crux of patient care. When Harrison realised my question referred to nursing interventions, he surfaced a vague example of initiating an incentive spirometer for a respiratory patient. He then showed a knowledge gap, questioning whether it would be beneficial treatment. His tone seemed to be saying "Why bother?," because nurses do not have time to initiate things, and he did not know if it would be beneficial. He may have been influenced by my presence as a nurse educator, and thus he tried to produce knowledge related to university nursing course content in the realm of independent actions.

The participants' excerpts earlier in this chapter demonstrated that they consider a desired part of a nurse's role includes addressing patients' psychological or social issues. Gemma was prompted by me to discuss this:

Interviewer: Do you find yourself working on mental health or social issues with your clients in the general practice setting?

Gemma: Yeah, yeah, it is too. Patients come in, and they have family problems, work problems, and I think you're the one who bears the brunt of most of it. A lot of them, you can sort of – not that you always do it – sort of veer them away from it, to stop them getting extremely angry or upset because, well, they'd be there forever if they're crying, and that just holds up everything.

The nursing intervention provided by Gemma was to "sort of veer them away from it." Her first reason was to keep the client from getting upset, but the second was related to answering to throughput issues that "holds up everything."

Taking responsibility versus shifting responsibility

It's up to me what happens to that patient

Examples of independent nursing interventions emerged from the transcripts, such as the previously detailed excerpt where Ingrid demonstrated her case management role in wound care. The following words from Leila demonstrated her autonomy in enacting patient care. The final paragraph was analysed previously, but it is included here because the sequencing is important as contrast:

Interviewer: That's very rewarding to hear that you like it, and also that they treat you as an adult. Once you do get that handover, and then the patients are yours for the day, do you feel like you're using independent decisions or that you're doing ideal nursing in any way?

Leila: Yep, it's really good.

Interviewer: What kinds of things?

Leila: I'll get my handover, and then we start. We check all the emergency equipment at the back of the bed, and check all the alarms, and whatever. Then we do the head to toe assessment. Then depending on what's

> happening with the patient but then just do the plan for the day. We do 12 hour shifts mostly, so just do the plan for the day. No one comes and fiddles with you, it's your patient and it's your little space. It's up to me what happens with that patient, you know, within reason, what happens with that patient; when they go down for CT then I organise it, when the x-ray comes it's my – like I have to make sure they're ready for that x-ray and for that CT and for whatever they're having.
>
> I like it.
>
> When we're quiet, we get sent up to the wards, and it is so frustrating because I feel like - and I don't think I'm alone. Like we talk about this. We are so frustrated when we get sent to the wards because, whether it's because they are so busy, or because it's the culture of like it was in rehab, they're showered and they're pilled and they're sat out of bed and they're put back into bed and they're washed and they're turned or I don't know what it is.

In the first paragraph, Leila's one sentence after she described manual tasks carried three phrases related to autonomy: "No one comes and fiddles with you"; "it's your patient"; and "it's your little space." She then moved from second person to first person to demonstrate a personal responsibility and accountability: "It's up to me what happens with that patient." She stated "I organise it" and "I have to make sure."

In the second full paragraph of this excerpt, as was mentioned previously, the tasks became short phrases and nouns became verbs as the patients were "showered" or "pilled." Notably, in the first and happier recount, the patient was mentioned as a patient, but in the second turn the patient became not only a pronoun but a plural one: "they're."

The buck stops with me

If acting with autonomy is a vision for ideal nursing, for nurses with a more visible professional focus, such as Leila, the autonomy also comes with a level of accountability. Leila and Sophie demonstrated such accountability in their discussions of the persistence required to have their respective patients medically reviewed. Both

incidents also demonstrated that the responsibility rested with? them. Idiomatically, "the buck stopped with them."

Conversely, a statement from Harrison is repeated here:

> **Harrison:** But once – it's like once you've notified the other people as well, it's like beyond your – it's not – it's sort of not your responsibility any more. You've notified the people.

He suggested that reporting information was enough, and reporting to someone else was where his responsibility ended.

Knowledge for practice versus standardised procedures

If you want to call yourself a nurse

In previous descriptions by Leila and Sophie, where they told of managing a deteriorating patient, even though the experiences were challenging, both nurses indicated that they had grown from those experiences. They added to their experiential knowledge, including interpersonal skills as well as theoretical knowledge in a life-threatening situation. Later in their overall transcripts, each had a reference chain with anaphora. Each had examples of subsequent references that demonstrated their growth from the highlighted experience. Leila described to university students the importance of gathering assessment data and of passing this knowledge on to someone, and Sophie said she would stand up and down more.

> **Leila:** I said all of this doesn't matter; I tell them [university students] the most important tool is assessment; if you assess a patient and are able to interpret that, then you'll be fine. That's really all it is. Then you learn what you have to do for that assessment, but once you can assess and interpret, at least then you have something to give somebody who knows what to do, and they'll learn then.
>
> Sophie: Communication. It comes down to communication. Trying not to be scared – I know that, when I started nursing three and a half years ago, you'd only have to look at me the wrong way, and I would run away crying probably, but now I've grown a real backbone, and it doesn't bother me if I – I probably still get intimidated a little bit by consultants, but I will keep pushing other buttons. I won't necessarily keep pushing a consultant, but I will push – I will go through other

> avenues until I – if I really feel that something's not right or something – we're not being listened to. I may take a few back roads, but – to get – to get us listened to, to get the patient looked at.

These two nurses' abilities to implement what they saw as best practice were buoyed by knowledge and the associated confidence to stick up for that knowledge: "you have something to give somebody" (knowledge, Leila) and "I've grown a real backbone…I will push" (confidence, Sophie).

Leila castigated other nurses who did not demonstrate inherent nursing knowledge. In an example displayed earlier, she expressed anger and frustration about how nurses could miss something that was "there in the purple, in the orange and in the yellow," and then she added her perspective of nursing in this situation:

> **Leila:** From a nursing point of view and from a – it's just not right. If you want to call yourself a nurse not in the 1920s when all we did was change bed pans. We're not there anymore. We do more than that. We're more important than that now.

The text elements of Leila's words were analysed previously in this chapter. The importance of returning to this point here lay in Leila's linking this knowledge with being part of a nurse's role, a role beyond the audit that is meant to safeguard against deterioration of the patient, and that could be considered a lowest common denominator for practice. Leila challenged the nurses from the anecdote: "If you want to call yourself a nurse." To her, nurses were educated professionals who did more than completing tasks of emptying bedpans. She said: "We do more than that. We're more important than that now."

Ingrid discussed knowledge and confidence in tandem as she embarked on a role working on wards, which was new to her after several years of experience in community nursing:

> **Interviewer:** Even that confidence to ring doctors cold, and all that kind of stuff are skills, that a lot of people aren't comfortable with, but your experience in the community is huge on that.

Ingrid: Yes, it helps a lot because it's quite daunting sometimes to ring them up. Then, if you don't, they go – I've been a couple of times with patients and I've noticed say their blood pressure's quite low and because I'm agency I don't know, am I able to ring the doctor? What I generally do is go talk to the NUM and say, "This is what's happening: I've put the bed down, I've done this, I've done that, I've gone back, I've done it manually, the blood pressure's still really low. What's the protocol, because the hospital's going to be different."

That's the other hard thing being an agency; you're not really sure where the protocol parameters are sometimes. Usually she'll give you a direction, "da-da-da-da-da," come back and then, if it's still low, then she will generally ring the doctor. That's good that way because it's a bit hard when you're an agency. You don't know.

Some of this passage showed a tenor of lack of confidence, and of feeling tentative in a new situation, but, as Ingrid reflected through her experiences, she was able to answer herself that she did have an arsenal of skills, and the ability to learn a new skill set for acute care nursing.

Two short excerpts, from Sophie and Gemma, demonstrated a contrast in attitudes towards accountability in knowing what was right compared with following a procedure:

Sophie: I'm within this criteria, but there's still things that are not quite right, like on that ADDS tool – we had a patient the other day. She's ticking all the boxes for blood pressure and heart rate and everything, but she had an O_2 sats of 56.

Gemma: Being in a different place every day doesn't enable me to always know policy and procedures.

Sophie delineated how she could be within the criteria of an audit – "She's ticking all the boxes" – but the patient was compromised in her physical presentation. Gemma divulged responsibility for her knowledge base – i.e., that it cannot be possible when being in a different place every day. Additionally, she was insinuating that her practice was driven by the policy and procedures.

You've got people's lives in your hands

Additional to upskilling in their institutional settings, the nurses all had a professional requirement for continuous professional development (CPD). The nurses provided insights into their attitudes towards professional development, with some embarking on advanced degrees to further their knowledge base. Others felt that it was the institution's responsibility to provide what they called "training," not "education."

The following comment from Gemma emerged after she described a shift (depicted previously) where she was assigned as RN to care for 72 residents:

> **Gemma:** I was an agency. So I didn't know anyone. I didn't know policies. I hadn't been trained in their fire safety. Like I have general, general fire safety and manual handling training, but not specific to that area.

Gemma admitted that, in accepting this shift as an agency nurse, she did not have training from that facility in basic safety procedures. She depersonalised herself, referring to herself not as an agency nurse, but as an "an agency." Using the passive voice that she had not "been trained" placed an onus of responsibility on the facility and, in doing so, she took a step back from professional self-responsibility.

One would expect that confidence in emergency interventions was a non-negotiable bottom line in theatre, so it was a surprise to hear this from a theatre nurse:

> **Debra:** The training is really up to us. You know, CPD points and all that sort of stuff. We have in-services and that sort of thing, where they get company reps and show you how to use stuff. You've got your mandatory training and all that sort of thing. I think a little bit more could probably be done on the emergency side of things maybe.

Debra was tentative about emergency training, using the hedging words, "I think" and "maybe." By mentioning it, she demonstrated a perceived need for this training.

Apart from any judgement regarding healthcare facilities' responsibilities, these discussions demonstrated the attitudes of the nurses in terms of knowledge

development as part of their own professionalism. Jo interpreted my question about continuing her mental health education with an answer regarding mandatory compulsory training:

Interviewer: Do they upskill you, because I'm fascinated, because I haven't done mental health nursing separately. I mean, I think we're always doing mental health nursing. But being casual, do they help upskill you or - ?

Jo: No, not at all. That's actually been a little bit disappointing, because the only training that I am provided for and paid to do is OVP training, which is occupational violence training. So we are taught to defend ourselves, and take down patients if they're – in a safe way. As a casual I don't get paid even to do my CPR training any more. I couldn't believe it. It's not part of my mandatory training. if you're a permanent staff member, it's provided. I do have access to it, but I have to go in my own time. I was dumbstruck.

Jo related her answer to bottom line training such as OVP and CPR as opposed to speciality upskilling in mental health nursing. Her focus concentrated on financial renumeration rather than on professional development.

In contrast, Leila placed mandatory training below the lowest common denominator of what was acceptable for nurses to maintain their professional knowledge:

Leila: So apart from having to do the 20 points with AHPRA registration, which is stupid, because I don't think that gets anyone anywhere; I don't think that – if people don't want to do their development they're not going to do it. You can easily get those hours doing nothing, just the mandatory training. They need education.

Interviewer: Do you feel that that should be a nurse's personal responsibility rather than something delegated by AHPRA, to stay up to date and proficient in your field?

Leila: Absolutely. I think if you want to be a nurse it's important; you've got people's lives in your hands. Although you might not be a doctor or a surgeon and doing that, you're the one that's going to bring the issues to the doctors, because they're not there. It's your responsibility to - , like this person, their entire trust is in you. There's a few in little hospitals around

> [this city], I'm not sure where, two people have died from sepsis, deteriorating, not picked up and they died recently. So the nurses then are put through AHPRA, and they'll do whatever.

PROFESSIONALISM AS A CONTINUUM

By considering the transcripts of the interviews collectively, I was able to identify a categories of professional behaviours, as presented above and summarised in Table 2.

Table 2

The Extremities of a Continuum of Professional Behaviours

Nursing Practices	
Extended Care	**Routine Care**
Interventions beyond routines	Litany of tasks
Time with patient	Fleeting through
Patient-centred: doing "for"	Task-centred: doing "to"
Improving patient's health	Keeping patient safe
Nursing Responsibility	
Embraced Responsibility	**Transferred Responsibility**
Personal accountability	Audit standards
The buck stops with me	Passing the buck
Autonomy/Empowerment	Disempowerment
Nursing Expertise/ Proficiency	
Professional Knowledge	**Dictated practice**
Knowledge for practice	Policies and procedures
Professional development	Mandatory training
Reflection/Frustration	Language of acceptance

Although my analysis across the breadth of the participants' interviews revealed that there were some nurses who were strongly on one side compared with the other in relation to these professional categories, others exhibited thoughts and behaviours with elements of either side. The data suggested that professionalism, then, should be interpreted as a continuum rather than as a series of opposites. The ends of that continuum are presented in Table 2. This demonstrates a wide range of professional behaviours and attitudes which emerged from the nurses' discourses.

CHAPTER SUMMARY

By examining the data from nurses' interviews through the three angles of critical discourse analysis, I could formulate a collated response to Research Question 1. Narratives showed tiers of patient-care objectives that competed for the nurses' time, energy and focus. Discourses of fiscal rationalism, mandated procedures and an audited safety culture evolved from their talk and spoke to the expectations and culture of their workplaces. The nurses shared emotions, including a discourse of fear and a generalised lament that they had difficulty fulfilling their ideals for nursing practice. The nurses portrayed the institutional management as operating far from their workface, but they noted superiors who could positively affect their work experiences.

Interpretation showed behaviours and attitudes from these nurses that could be considered professional. They utilised knowledge for practice, and they critically appraised events and critical incidents. They demonstrated variable degrees of agency within their roles. The nurses showed a spectrum of professional capabilities in their nursing interventions, their use of knowledge for practice, their responsibility within the clinical situations portrayed and their knowledge for practice.

CHAPTER 5:
COMPETING DISCOURSES

Chapter 4 provided data and data analysis that related to Research Question 1. This chapter addresses Research Question 2, which asked:

> **Research Question 2:** How do nurses say that they (and other nurses) deal with competing discourses in their practice fields?

The analysis for Research Question 2 began with selecting the nurses' interview discussions that provided an indication of how they were managing the competing discourses in their practice fields (Section I). The nurses' ability to do this was then examined through the discourses, which arose, that demonstrated the contexts they were navigating (Section II). Finally, I examined whether this afforded the nurses a sense of agency or professionalism as they dealt with their situated contexts (Section III). As with Chapter 4, the three sections of this chapter consider Fairclough's (1995) inner, outer and middle boxes respectively.

SECTION I: NURSES' TALK

The data indicated that some nurses in this study were choosing jobs, or a combination of jobs, that allowed them to experience aspects of what they wished for in an ideal nursing role. These nurses sought specialties that offered expertise, and thus nurtured their confidence. Other nurses preferred to remain in roles as casual or pool staff to keep their nursing as a manageable job, or to safeguard their family time. Some expressed that they were also learning to draw boundaries to avoid advancement and extra duties.

The nurses demonstrated mechanisms for dealing with the competing demands of their workplaces. Nurses employed strategies that ranged from staying back in unpaid overtime to purposely not completing everything, including paperwork. They outlined strategies for distancing themselves, protecting themselves against stress and

recognising burnout. They spoke of nurses who dealt with the demands of audit by falsifying paperwork, routinely and almost unconsciously.

Building expertise

I have a specialty

In Chapter 4, the nurses indicated the expertise that they had acquired or were acquiring. The following excerpts showed that the nurses valued this expertise, and that they intentionally worked to carve a niche for themselves, such as the specialty of mental health nursing or the operating theatre. The nurses chose specialties as an avenue for practising more idealised aspects of nursing, which often included: passion for the subject matter, building their expertise in an area, fostering their own autonomy and experiencing a better patient ratio.

Ingrid, for example, relayed the expertise she had developed in palliative care in her role as a community nurse:

Ingrid: Palliative care. I've done a lot of palliative care. I really enjoy that as well. That's where you find families can be – if there was conflict prior to the person being sick, it will be double conflict quite often until they resolve it. A lot of the time the actual person that might be dying, they hang on and they hang on and they hang on, and you say, “I think they're waiting for you to get back together,” and quite often when those people do the person passes. It's like a relief to them. It's like, “I can go now; I know everything's going to be okay.”

Interviewer: Did you find that that palliative care fits with some of your ideals of nursing?

Ingrid: Yes, definitely. … Good palliative care at home if that's what people want. I'm really passionate about that too.

Interviewer: You see a place for nurses within that?

Ingrid: Yes, actually. That's our forte in there, I think, with palliative care, because you can manage the syringe drivers for people. If you can get good pain control, not everyone has pain when they're dying, but good pain control, good family support, after hours number who they can ring and say, “This is happening; what can we

do?" and just knowing all the stages that might happen in that palliative care journey, educating them about – a family member might say, "Dad's not drinking," so we need to put up a bag of fluids.

Managing the symptoms as they arise at home is great if you can do that. Then maybe, if they have an acute episode where they need to go to [name of a particular ward] and get managed for a bit, and then back home, that's great, but again it can cost. It's cheaper having people at home being managed by nurses than it is in a ward in hospital. That would be something I'd really enjoy is to be able to help people stay at home if that's what they want to do.

They do need good family support and you can quite often have to sit down with them and be the mediator as the nurse and the educator and all that, so I think there's a big role for nurses.

Interviewer: Educating them on that, what to do and when and how to get some relief.

Ingrid: Yes, we even train – if someone's on a syringe driver, we can have say a breakthrough morphine drawn up for them and show the carer how to administer this, and make sure they're happy to do that, or they can ring us and say, "Should I give it?" Everything's there for them. If they're not confident, they don't have to do it, but in the middle of the night, at three in the morning, you know, "What do I do?"; if you can teach them what to do and managing.

Also I've had some feedback from families that have said it was really good to be able to manage with support, to be able to manage dad or mum because that's what they wanted. They really wanted to stay at home, and I've done my job. I've had so many people saying that's what they wanted, and that's happened, and now I feel a relief.

Ingrid demonstrated both knowledge of palliative care nursing and a number of autonomous actions she employed within her role. Her description of her role in palliative care conveyed a calmness, an ease about it. She used positive phrases to demonstrate her passion for this aspect of community nursing: "really enjoy" and "really passionate." She stated that working with syringe drivers is "our forte," and that the nurses can make a difference to achieve "good pain control," "good family

support" and to divulge information that empowers the family to be well-educated: "just knowing all the stages that might happen in that palliative care journey." She expressed actions of psychosocial care: to "sit down with them," being the "mediator as the nurse and the educator and all that." Her desire to help people manage their family member at home was reinforced when the families voiced that this was what they desired.

Three of the research participants worked in theatre and they valued both their acquired expertise and the adrenaline of the fast-paced environment:

> **Debra**: I think it's just something I've always wanted to do. I'm basically where I wanted to be now.
>
> **Helen:** It's – I enjoy theatre nursing, but I also enjoy … getting that buzz.
>
> **Harrison:** I had the basic experience and skills where they didn't have to go right back to scratch and teach me kind of thing. I was at a certain level where I could come in and do some stuff.
>
> In theatre you've got a team of people all focused or working on one patient … It's a different situation where, if you're unsure of anything or you need support, backup or anything, well, we've got people like an anaesthetist, a surgeon – other nursing staff – that can collectively have an input.

Harrison expressed gratification in knowing how to do what was required, maintaining a palatable patient ratio and having support on hand.

The nurses demonstrated that they valued their knowledge base in specialties to the extent that they looked for experiences for growth, beyond mandated competencies from their employer or the nursing board. Some of the nurses also used their expertise as *expertise capital*. Debra, for example, explained that her speciality in theatre work offered some security, because there was always a demand in theatre:

> **Debra:** I have a speciality. I suppose because I'm not permanent. I'm there all the time, but I'm not permanent. I'm contracted from Nursing Support.. Realistically they could pull me from theatre and pop me anywhere in the hospital.

Interviewer: Has it happened?

Debra: No. I don't think theatre would allow that to happen.

Interviewer: They need you and want you when they roster you.

Debra: They're always short of staff. It's not something that you can pull someone else off of Nursing Support for. Even to scout, you've got to know where everything is to be the scout.

In contrast, Sophie and Ingrid equated their medical/surgical skills with employability, and they feared losing these skills if they remained in their other specialties. Sophie said she was afraid of her skills stagnating at a junior nurse level if she remained in mental health nursing, and Ingrid used agency work as a means of maintaining her skill base beyond community nursing:

Sophie: I was terrified of being a junior nurse, and I wanted to get back out, pick up those clinical skills again.

Ingrid: I do like to get out of the comfort zone, and I don't want to be where I'm too frightened to go and do the nursing job that I love. I feel I need to keep challenging myself that way.

Each of them used a fright word, "terrified" and "frightened," to describe a mounting fear that they would be deskilled in ward work if they remained solely in the specialties of mental health nursing and community nursing.

Medical nursing is often considered a catch-all, considered as generic nursing in a general ward. Toni, however, worked hard to delineate that it also is a specialty; to her, this identity as a nursing specialty was part of the reward of working on a medical ward:

Toni: I mean, lots of patients you don't like, but you have to love looking after the patient, whether you like that patient or not, you know? So regardless of how cranky or sarcastic or nasty that patient might be, you still need to care for that patient, and it's very hard to do that for someone abusive; they just can't do it. That's fair enough. They just can't do it, because they're not that sort of person, but a lot of our nurses in the medical wards have to do it, because that's who we get.

> Especially you – we get our patients who come back who are very narky or get crabby very easily and expect a certain type of service, because they pay for it. You just have to deal with that. You've got to be good with dealing with that. Otherwise it just beats you down, you know? Quite often you'll have new nurses who have never done medical come out, oh, in tears, saying, "That person has just abused me because I hadn't done that." So I'll go in and say, "Now, Mr Smith, you've been here before. This isn't a motel. You're here because you're in hospital, you know?" That's all it takes, but it just – yeah.
>
> I think that's what sets us apart from surgical, emergency and rehaband all of that. We – because our patient comes in with so many problems. It's not just one.

Toni tried to capture an altruistic sense, and may not have supported this in her choice of the word "love," but she used it more of as a phrase: "you have to love looking after the patient." Although she described the patients as "cranky, sarcastic or nasty," and later as "narky" and "crabby," it was actually said with affection; she was emphasising that medical patients come back through a revolving door, and that the staff come to know them personally. She underlined this with her use of "Mr. Smith." Toni maintained that a level of pride distinguished the medical nurses from those working in surgical wards or emergency rooms because they knew the patients and knew their levels of comorbidities: "*Our* patient comes in with so many problems" (*emphasis added*).

I don't plan to be a ward nurse forever

A number of the nurses interviewed pursued or were pursuing graduate level education in nursing. Their goals included consolidating their knowledge for specialty fields or positioning themselves for opportunities in the future. At the time of this study, Julian, Leila and Helen were studying masters degrees in nursing education, critical care and public health/tropical medicine respectively. Myra had completed a graduate certificate focused on rural and remote area nursing. Toni was enrolled in a graduate degree in pain management, purposely positioning herself to be considered when a new medically-driven pain management facility would be opened at her hospital. She explained:

> **Toni:** Well, they used to have a clinical pain management nurse specialist at [this hospital]. I don't know what happened. It must have been a – I can't even remember there being one, but there was, and I guess the finance like that got in the way, but, yeah, I don't know. But I'd like to be in on that. Not just – I don't plan to be a ward nurse forever. We all age, and we all need to have our plans in place. So ultimately I'd like just to either specialise in a certain area of pain management, or just pain management in general as a consultant, or working with a pain specialist on pain management and taking it further.

Toni suggested the possible economic rationalisation of the previous position of a clinical pain management consultant. She mentioned the need for longer-term plans in nursing due to the physical demands of ward nursing and the reality that "we all age."

Preserving autonomy

Quite a contrast

For Helen, the decision to work in general practice nursing while maintaining shifts in theatre was a conscious choice to score for herself both sides of nursing: the buzz of theatre, and the continuity of care that a general practice environment afforded, including autonomy in practice and continuity of care with clients:

> **Helen:** I am currently working two nursing jobs and two very different types of nursing. I'm still working theatre. I work as anaesthetic scrubs scout and recovery nurse, which is what I've done since I started nursing. I'm also working in general practice as a practice nurse. So very different aspects of nursing, which is quite a contrast. The practice nurse job is only fairly recent. I find they do complement each other as well. The thing that drew me towards practice nursing was the opportunity to provide some continuity of care to patients, which is something that you generally don't get to do in theatre.
>
> We have the patients come in, and as a scrub nurse or an anaesthetic nurse you really don't even get to see what's happened before and after as such. You only have that interim whilst they're in theatre, whereas the patients I'm having come through general practice are long-term patients, from little babies up to the elderly, which is wonderful – a different skill set.
>
> It has been quite interesting having that certain degree of autonomy within practice nursing, which has been absolutely wonderful. To make your own decisions to a certain degree, and say, "Look, I feel

> that we should do this for the patient," and can make recommendations.

Using synonymy, Helen highlighted the contrast between the two types of nursing, with "very different types of nursing," "a different skill set," "so very different aspects of nursing and "is quite a contrast" all appearing in her excerpt. She justified her choice to take on both types of nursing – "you really don't even get to see what's happened before and after" in theatre – to disclose her rationale for adding a new speciality. She highlighted that her choices were deliberate, not simply for scheduling or lifestyle gain, but also to make nursing rewarding for her, and to ensure a breadth of her nursing skills. Helen cited autonomy as a desirable feature of this field; she chose the words "absolutely wonderful" to describe this.

Julian positioned himself in two jobs, firstly taking a job in the cardiac catheterisation lab as an alternative to shift work. He stated in his interview that it is rare to find a non-shift work job in nursing without pursuing management or nursing education. He combined this with a job in intensive care, when he found he needed more challenging stimulation and the opportunity to be more autonomous:

> **Julian:** I think it was also that I was learning a new skill set as well, and it was also that I got a break from doing shift work. I finally got to work normal hours.
>
> I got to go home and be involved in more family things. Having weekends off: I think that makes a huge difference. Ultimately, it wasn't challenging enough, and so that's why I started going back into intensive care. Now, as a cath lab nurse, there are three roles that you have; you can be a cardiac tech, you can be a scout or you can be a scrub, working with the cardiologist.
>
> Really good to do those things, but they're very repetitive tasks, and I guess I missed the autonomy that was in intensive care, and the challenges that [were] in intensive care. I'm somebody that needs to be kept busy. So what I've done is, I'm actually – I'm working half-time in a cardiac cath lab; I'm working half-time in an intensive care, and that seems to be the right balance at the moment.

Julian's speech patterns offered certainty about his decisions, in a sense punctuating how thoroughly he had thought everything through. He moved to the second person only when talking about generic roles in cardiac catheterisation labs, what "you" can

do. His phrases about these roles were short and repetitive, perhaps not unlike the roles/duties he listed. His sentences about his two current job roles were very balanced. When talking about half-time in each, he provided two equal sentences: "I'm working half-time in a cardiac cath lab; I'm working half-time in an intensive care.

Daddy you're always sleeping

Several of the nurses intentionally worked in casual positions to provide autonomy, particularly but not exclusively in terms of shift work and hours. It also afforded them boundaries, which was another tactic that these nurses utilised to deal with competing discourses. For a couple of the research participants, the shift work was about the flexibility; for others, their expertise could be used as capital, a sale card.

Julian, in returning to theatre and intensive care work, returned as a casual staff member:

> **Julian:** So it's marrying two different rosters, and also working with two different managers that both want your time. I've gotten very good at saying, "No," though. At the same time, I'm very aware that I could potentially be burning my bridges, but I guess at the moment I'm very – I'm more interested in being a casual worker.
>
> I think I'm good at what I do, and I can provide that service for eight hours at a time. If people want me to do more, we'll have to look at that later because I think that's what burnt me out in my previous jobs.

He provided a very telling anecdote as his rationale:

> **Julian:** I remember – this was – in the midst of all these things that were happening, I picked up my son from kindergarten, and he drew a picture of the family. So he drew a picture of his three brothers, mum and the three-legged dog that we have outside. He drew a picture of our house and he drew a picture of the bed with a person in the bed.
>
> I said – it was pretty obvious – I said, "Who's that?" He goes, "That's you, Daddy, you're always sleeping." I thought, "Well, here I am beating myself up about this job, and my children see me when I'm sleeping. What am I doing?" At that particular time, I wasn't feeling very valued in my job. So I'm probably doing it – I'm a lot more selfish now.

> I do it for me, because I know I'm not going to get this time back. I can provide very good care for that period of time, but after that time I have to look after myself, and I think that's something that will ensure the longevity of my career.

Julian demonstrated his bargaining chip, which was that he "can provide that service for eight hours at a time," and "I think I'm good at what I do." He acknowledged that he had to keep different stakeholders happy, and he used the idiom of being careful not to burn his bridges. A more permanent roster came with the downside of night duty and sleeping during the day, which became an arresting mirror in his three-year-old son's drawing. His inclusion of "Daddy" in the retelling demonstrated that the picture was not in keeping with his image of being a good dad. This was reinforced with "I know I'm not going to get this time back." His question, "What am I doing?" was used in the first person to underline the mental questioning he underwent to decide to leave his previous permanent job, one that he was justifiably "beating [himself] up about." Interestingly, though, although he was positive about the boundaries he was setting, he focused on a negative to describe his actions: "I'm a lot more selfish."

Gemma chose night duty as an ability to work around a toddler:

> **Gemma:** I think I work agency more because I do what I have been trained to do, and what I want to do, and it fits in around my family. My husband works during the day, so I work nights, and it means I don't have to put my son in day care and pay for day care on top of everything else. So agency works for now, but I think when he gets older and he's in school and I can have the opportunity to work during the day while he's at school, it'd be more suited to do something like that.

She foreshadowed that this situation was temporary. Her phrase, "something like that," referred to a specialty that might be possible later in her career.

Likewise, Jo worked in nursing support for family reasons; she added that it helped her circadian rhythm and with holidays:

> **Jo**: Yeah. I pretty much just work afternoon shifts, yeah, which – that suits me too as I'm not a morning person. It just works for us. I can work weekend shifts as well, which – it's a little bit more money, and that means I don't have to organise babysitters either because my

> husband's home. So, yeah, just work. I can have holidays when I want. Generally, you speak to other nursing staff, and they don't have a say when they get the holidays, whereas I can just take whatever time I want off, and I don't have to worry about anybody.

She underlined the flexibility of obtaining holidays, by comparing that other nursing staff did not have a say when they took their holidays.

In addition, nursing casually allowed a distance from the work environment:

> **Jo:** Sometimes you don't feel part of the work environment. But, in saying that, sometimes I find that's a good thing. I actually find that I don't get involved in staff politics, or staff relationships, I guess.
>
> **Julian:** I think there's a lot of nurses where predominantly an older workforce with people that have been working in it a long time, and there's a lot of burnt out nurses, and I think that – in terms of the younger people coming through, I think that's affecting them, too. Stepping away from that and coming in, often as a casual employee, is a lot more enjoyable, because I think also, as a casual employee, you're working with the floor, not having to manage people as well, which can be very difficult.

Jo stated that working casually allowed a distance from workplace politics. Julian suggested that casual employment provided distance from negative ward cultures, and avoiding team leading kept a distance from having to manage people.

Janelle recounted that her initial purpose for choosing casual support work was for the flexibility it afforded, but her excerpt hinted at other reasons to maintain her employment as a contract worker:

> **Janelle:** I thought, "Well, look, I need to be more flexible," and when you are contracted to a ward there's not the flexibility. If something crops up you can't – you've got to find someone to change your shift with, and there's not the flexibility. So now going to nursing support I think is a really good thing for me. Because I finished my grad program, I was in surg for two years, which was a huge challenge.
>
> A lot of things went on. If I didn't have the support program and had [name of person] to actually talk about my problems, I don't think I would have survived. It was very challenging and, because I'm not a quitter – it was a bit like I really couldn't leave nursing feeling that I would feel a failure. So I really thought, "No, I've really got to come to terms with this."

> Then we got a really good nurse unit manager. It was just, well probably only maybe three times in that year I just sort of – it was by chance; he'd come and say, “Another contract?” Every time I'd say I'm not doing another contract. But it was just like I kept accepting the contracts. I'm glad I did now because I didn't want to be beaten, if you know what I mean. I sort of wanted to feel that I was a good nurse.

A number of issues occurred for Janelle in her two years on “surg” – her nickname for the surgical ward. Janelle moved from stating that nursing support “is a really good thing for me” to recounting the words and phrases of the challenge of two years in surgical nursing, using “I’m not a quitter,” and “I really couldn’t leave nursing feeling that I would feel a failure.” Janelle hinted at dealing with some of the other competing discourses for nurses besides schedule challenges and shift work. She indicated that working casually in support provided her with a distance from some negative ward experiences and the opportunity to prove to herself that she was a good nurse.

Sophie utilised a support position to maintain her freedom, although she acknowledged that it was not quite the niche for her. She expressed enjoying mental health nursing, but she was not currently pursuing this:

> **Sophie:** At the same time it's also nice to have a little bit of a familiar surroundings. I just found that personally that's where I sat the best. I have been pushed and pushed and pushed to take on more orthopaedic training and to stay there. To be honest, my heart's not in orthopaedics. I – I'm happy to work there at the moment, but it's not something that I am clinically interested in.
>
> I think there's a couple of reasons. Unfortunately, it doesn't represent my ideal of nursing. In saying that, I'm finding that that's in most areas. The other side of things – we get quite an array of things that come through. It's not all just fractured NOFs and little old ladies that are falling over. We get some big traumas and that that come in for – they either come back from Brisbane, a step down, or we have them on the ward from ED. All that's quite fascinating to me, but I just don't feel that I'm being fulfilled in orthopaedics. I don't – I actually really don't know exactly what area would fulfil me, but I'm not sitting there saying, “Oh, yeah, this is really me.”
>
> Like I said earlier, I love mental health, but at the same time I like to keep my clinical skills up to date, and that just doesn't happen in mental health.

Sophie's excerpts here provided a story of positioning herself as best as currently possible, but with a sense of transience. She mentioned that the support position fulfilled current family obligations with school aged children. She stated that it did not "represent my ideal of nursing," and then qualified, "In saying that, I'm finding that that's in most areas." Her discourse had a tenor of doubt: "I don't – I actually don't know exactly what area would fulfil me, but I'm not sitting there saying, 'Oh yeah, this is really me.'" She concluded that her nursing support position was a means to fulfil the purpose of upskilling herself in clinical abilities.

It was a very unproductive and unfulfilling role

Earlier interview excerpts from Julian mentioned how he controlled his current positions by keeping boundaries in his work shifts. This strategy also provided control over his level of involvement. He purposely avoided higher-level positions that came with high expectations of fulfilling extra duties:

> **Julian:** It was an expectation. I was a clinical nurse, and we were given portfolios. So I did policy and procedure. So I was doing a lot of it at home. We got one day a month to work on policies and procedures. It wasn't enough, and often if it was busy we'd be called back onto the floor on that day. I found that it was a very difficult place to do policies and procedures.
>
> There were many committees that you had to pass things through. So it was a very unproductive and unfulfilling role. Then I did rostering, and I had two days to roster 52 staff for accommodation of eight- and 12-hour shifts, 24-hour rosters. So two days wasn't enough. So I ended up doing another two days at home on rostering as well.

There is repetition of "so" in this excerpt. It has a singsong effect: one can visually match arrows where the sentences start with "So." Julian showcased two different expectations of his clinical nurse (CN) role: progressing his dialogue to demonstrate that neither policy/procedure duties nor rostering staff were possible in work time. He used numbers to help quantify the difficulty, describing the number of staff and the complexities of schedules with differing denominations of length of shifts.

Debra stated she was happy to leave management as someone else's headache:

Interviewer: You just said because you've been in senior positions. Does that sometimes frustrate you when you could see how things can be done better? Or can you keep that distance where you look at what you need to do?

Debra: I'm sort of happy that the headache's someone else's now.

Interviewer: So that's one of your strategies. Keeping that distance in a way.

Debra: I can team lead in a theatre. I don't team lead the floor or anything like that. I suppose I will one day, but I really – you see the people that progress and they're more in the office, more in the office, more in the office. That's not why I became a nurse. I don't want to be in the office. While my feet hang on and everything else works for me, I'll stick it out. Maybe later on I may have to think about becoming more that level. No intention of it at the moment.

Interviewer Why would you? You've just said all the happy things. You just said a few sentences ago, "I'm where I want to be."

Debra: People ask you, "Do you want to [do] this? You should be doing something else." I'm, "No, I shouldn't. I'm just happy." I don't want to go there really. You're doing the practical stuff. You're doing the hands-on stuff. And why did you become a nurse – not to sit in an office.

Debra not only discussed her own situation, but also included how she thought that others perceived it. Although the words "stick it out" were used, these seem more related to physical health and to her prior medical history whereby she was unable to work for several months due to an ankle injury. She provided a hypothetical interdiscursivity dialogue of "You should be doing something else" that she answered with, "No, I shouldn't. I'm just happy." Her move to the second person may have been because the "you" demonstrated a stepping back and completing a full circle of questioning and answering herself.

Finding rewards

That was a day when I kind of felt good

The research participants provided insights into strategies for dealing with everyday situations in the frontline aspects of delivering healthcare to vulnerable people. Pride in one's work varied with the individual, and could be as simple as the satisfaction of picking up a problem that was previously undetected. For example, Janelle noticed that a particular drug prescription was incompatible with a patient's shortened digestive tract:

> **Janelle:** So if there's something like that that I don't know, if I don't have time I have a little notebook and I write it down, and I look it up when I go home. I found out that this particular medication has to be absorbed in the stomach. He'd been having it for weeks and weeks on end. I took it up with the doctors, and I just said, "Well, this drug has a potential to block the tube, and this is probably why the tube has been blocking. Why is this man having this medication?"
>
> Then this surg reg got back to me and said, "Oh, we've ceased that." He said, "Thanks for picking that up." So they'd all just been prescribing this medication which he couldn't absorb it in his duodenum, which is where his tube was going to. So they ceased it. So that was a day when I kind of felt good that it's a bit like what I don't understand I look it up.

Although in written form this sounded confrontational, Janelle's speech intonation from the audiotape was more questioning than accusing. Her point, although highlighting a mistake and the costliness of that mistake, also emphasised the "thanks" and a positive feeling for taking an issue a step further and looking it up.

Reinforced feedback, such as thanks from patients or their families, also helped the nurses feel a purpose in everyday care. Harrison, for example, reflected on his work in aged care, and he felt reward in the form of recognition that a family years later remembered the care he had provided:

> **Harrison**: That's one thing about theatre is you don't ever get to see any of the follow-up. The patient comes on the day, they have their operation or you see them during, and then they go home or they go back to the ward. You never ever know what happened to them or anything.

> Aged care is – from when I was an AIN working in aged care, I looked after a lady. Her daughter used to come in every day and help out at dinner time – feed her mum and whatnot. I bumped into her daughter a couple of months – last year I think – and – yeah. I still remembered her, and she remembered me. She thanked me for everything that I did for her mum, and introduced me to all her family and everything. So that was nice to get that recognition or – yeah, to know that they felt like you'd made a difference or helped.

You try and do everything you can for your patient

In everyday care, the nurses buttressed themselves against competing demands by depositing more effort, even if the effort came at the cost of overtime or unpaid overtime. Helen demonstrated this in Chapter 4 in her justification of the overtime for private theatre patients.

A passage from Toni's interview confirmed that she found reward in navigating competing discourses by putting in extra effort for the situation:

> **Toni:** I think that that's part of what you eventually come to accept as being maybe the private system, maybe the hierarchy, the politics of it all, and down on the coalface of nursing you try and do everything you can for your patient. So that's, like, you know, whether that means you stay back for 20 minutes, because that patient needs to talk to you and you don't get paid for it; I don't think that's right. But I think as a nurse you have to. Especially if you've got a special bond with that patient and you're the only – you're the one they've asked for.
>
> That's what medical nursing is. It's just giving of yourself, as opposed to just – as I said, I've done surgical. Just doing obs, pulling out drains, see you later, go see your doctor in two weeks. It's not like that. We get our patients who ring back. Go home; a fortnight later ring up and say, "I'm a bit short of breath. Do you think I need to take my nebs or something?" [laughs]. So we don't just get them on the ward. They trust us, and it's that trust relationship and love that we have for each other really. They trust us enough to want to come back to us, and they know us.
>
> The doctor trusts us enough to have that patient in our care, yeah, most of our physicians will request [particular ward] as opposed to somewhere else. There's a lot of medical overflow that goes to surgical, maternity, rehab. It goes to a lot of other places in the hospital, but, if there's a patient that they're concerned about, they will specifically ask for us. So that's pretty good, you know? Yeah.

In this passage, Toni normalised the situation by admitting the politics up front and weighing in that injustice existed in the politics. Despite the institutional politics seemingly stacked against them, she stated that at the coalface of nursing "you try and do everything you can for your patient." She considered medical nursing a specialty and distinguished it from other wards (such as surgical) by the nurse/patient relationship: "it's just giving of yourself." She used a number of emotive words over the next few sentences, emphasising the "trust" in a nurse-patient relationship (on a medical ward), and utilising the emotionally powerful word "love." She shored up the premise of trust, stating that it was not only the patients but also the doctors who valued the medical ward staff and "trusted" them. Although medical patients may sometimes be out-lied to any wards, when physicians were concerned about someone receiving comprehensive medical nursing, then they would "specifically ask for us." She left no doubt that this was a positive quality: "So that's pretty good, you know? Yeah." She was asking the listener to buy in with "you know?" and she did not leave this as a rhetorical question but instead answered herself with "Yeah."

We can do that on behalf of the patient

Advocacy was valued by the nurses, but sometimes it required treading carefully around the system. In talking about palliative care in the community, Ingrid had stated that a key support was when the person's general practitioner (GP) was on board with keeping the patient at home and would be willing to make home visits. She was asked if she ever had to advocate for a change of doctor:

Ingrid: I think being able to get hold of a GP and have that on board, and there's some good GPs here in [city] that do a really good job.

Interviewer: And the opposite?

Ingrid: Yes, there's some that just won't do home visits. Not that they're not interested, just probably time constraints or family constraints or whatever. That's hard for a person too having to get a new GP that they don't know to be able to do home visits for them.

Interviewer: Have you ever had to advocate that somebody needed to swap?

Ingrid: Needed a new doctor?

Interviewer: Well, needed to swap to somebody that could help with that end journey?

Ingrid: Yes, I've had to sometimes without being – you have to be careful of the words you choose, but knowing that a certain doctor would not maybe be that supportive and maybe say to them, "Do you realise what's required?" Go and have a chat to your GP, and if he or she says that they're not going to be able to do that, well, let's look at other avenues.

I've actually rung a few surgeries trying to find a GP that will take on a new patient. Sometimes that's hard for them too because, if it's a patient that's on their palliative journey, it, it can be quite time demanding.

She demonstrated that she approached the dialogue with the patient in regards to the patients' expectations and knowledge, diplomatically being "careful of the words [she] chose" while avoiding comment on her knowledge of previous support from individual doctors.

Myra gave an example in a rural setting of assisting patients with relaying their concerns or with helping them to understand information that had been conveyed to them:

Myra: Yes, well, it is – what else – like, as I said, we can be helpful in so much ways. Talking to and getting their [patient's] concerns heard, and advocate to the family and the doctors or whoever – the specialist, or their – and we can suggest thing. If they have concerns, they might not wanting to discuss with the doctor because of communication barrier. Sometimes, for example in rural areas we get sort of more migrant doctors. Some patients don't understand what they're talking about. Sometimes they use medical terms most often, but not necessarily thinking of if the patient could understand what they are talking about. Nurse can facilitate that and things like that, I would say – yeah.

Interviewer: Educating them?

Myra: Educating and giving a more explanatory way: "But he meant this; are you happy to do that?." Sometimes people … back off from the doctors because they think

> – because of respect or something. They don't raise their concern – "I should have asked the doctor, or I was a little bit not comfortable with it" – that sort of thing. Then we can facilitate … and we can do that on behalf of the patient.

Here Myra stated that the nurses with whom she worked were "getting their [patient's] concerns heard" and circling information back to the family, or to their doctor or specialist. She cited communication barriers, including doctors with English as an additional language, who may have been difficult to understand, or who may have held back on information with "thinking of if the patient could understand what they are talking about." Her talk showed a higher order of involvement than just imparting information when she asked, "But he meant this; are you happy to do that?" This moved to a level of interpreting the information in two ways: clarifying for the patient; and taking the responsibility to bring information back to the doctor. She explained that "we can do that on behalf of the patient."

Upon reflection, Harrison interpreted advocacy as part of a nurse's responsibility to care for the person, and he put it in the category of respecting the patient's dignity:

> **Harrison:** But I've come to realise too – people think about the theatre setting and everything – like people say, "Oh, that'd be really good. The patient's asleep. You don't have to talk to them or whatever." But I've come to realise too the longer I'm in theatre too is that, maybe even more so, you take on more of a patient advocate role because that patient's – they're completely dependent on the people around them to speak on their behalf and do things for them like maintain their dignity, make sure they're positioned correctly and make sure that the procedure – only the designated procedure or whatever is being done. Because they're not awake, and they can't speak for themselves, I guess as a nurse you have to maybe advocate for what's in their best interests.

Harrison was particularly concerned for protecting patients' dignity if they could not advocate for themselves. He worked with patients in theatre when they were under anaesthetic and were therefore particularly vulnerable.

I become very emotionally attached to patients

Toni discussed the rewards in palliative care nursing, and explained that, even though it is sad, it is also very meaningful. After discussing palliative care generically, she gave the specifics of a particular patient's end of life journey:

Toni: I love one-on-one with my patients. I love palliative care. I love it. I mean, when I first – when the hospice first opened, I worked as an AIN, there and I loved it. I think I become very emotionally attached to patients, so nursing's about giving yourself. It's not about, "Oh, I'm your nurse. I'll look after you, but that's it." To be a good nurse, I think you need to give of yourself.

So I've had lots of palliative patients. I think one that really sticks with me is we had a nurse who used to work on our ward when I first started. Jackie [pseudonym] was her name, and I worked with her, and she was a very good mentor to me, and we had her periodically throughout her whole diagnoses. She had CA, and she eventually came back and I'd nursed her quite a bit through all that. We all knew it would be her final admission when she came back that final time, she said, "Toni, I want to stay here. I want to stay here with you." It was so beautiful [crying]. Yeah. But, look, it was a long – it was three months with us, I think.

Interviewer: But even your sad times are beautiful?

Toni: Yeah. Look, we got to spend time with the husband, with her son. We got to be able to do things for her that she wouldn't have been able to do at home by herself. We cut her hair. We put her make up on. We dressed her every day. She – and we tried to take her outside and, even if we didn't have the time, we would have stayed back. Yeah. It was good. So that's special [crying].

Toni's choices of examples to include in her soliloquy reinforced her sense of proximity to the patients. She verbally drew the circle closer and described getting close to patients, one in particular. She candidly described the intensity of the relationship over repeated admissions, and she provided details of the individualised care, calling it "beautiful" and "special," and evoking her own tears in the memory.

Rewards from relationships with patients and families were not unique to Toni. Julian, for example, spoke of a patient whom the staff had nursed over a long period of time, and who managed to be discharged on a home ventilator in the care of his wife:

> **Julian:** He was told that he wouldn't survive, but, in saying that, it was her that advocated for him, but it was also – there was an intensive care doctor at the [Hospital] that also pushed really, really hard for a home ventilator, and to get them to keep him for that period of time. That was really special, too.
>
> Yeah, there was a particular day there where we were – because he was in over Christmas, so he was sitting up in his motorised wheelchair, and we all sat there on the floor and opened presents with his children. So there are some pretty special memories there. Maybe not getting to spend Christmas Day with my own family, but getting to spend it with someone else's family is pretty cool.

"Pretty cool" affirmatively expressed something special, something unique, in this case participating in other families' close moments, in Julian's role as a nurse.

They can talk … with the clique

Teamwork was previously mentioned in Chapter 4 as a positive influence that helped nurses to deal with day-to-day challenges. Camaraderie for the purpose of social gains on work time, though, can be construed as negative and oppositional to teamwork. It was another mechanism used by the nurses to deal with work situations. For example:

> **Janelle:** I've realised, okay, there's the nurses that are there – it's a job to them. They'll do what they have to do as quick as they can to get out to the nurses' station where they can talk with their – with the clique.

This excerpt was an example of discussing how other nurses coped, a negative tone highlighted by the word "clique."

Nurses don't "eat their young"

Many of the interviewed nurses demonstrated concern for the new graduates, and expressed a desire to take them under their wing, to assist these newer nurses in navigating a flawed system. Debra took a sympathetic attitude towards the skill set

that new nurses may or may not have at their disposal, and Ingrid reflected on how she saw other nurses treat the graduates:

> **Debra:** I quite enjoy training the young ones. They're normally young ones. Although we've had a couple come down from other surgical wards. They come down, and they're good. Sometimes you can see a little bit of immaturity. The lack of thought. It's just an age thing. It's not a personality issue.
>
> **Ingrid:** I've seen two little sweet grad nurses when I've been doing some agency work, and they're really trying their hardest, and you might hear a comment by one of the nurses, "That didn't get done but that was the grad" or something like that. They do expect a lot from them at times, and they do try their hardest. Sometimes I think, "Give them a break."
>
> Instead of nurturing them and saying, "Let's try and help you as much as we can" – there's plenty of nurses that do help them, but you still get a lot of "My shift was handed over from the grad, and this wasn't done and that wasn't done." Some of these kids have been out a month or two. The amount they're learning in that short time, they're not always going to remember to tick that box or do something.

Ingrid demonstrated concern that experienced nurses were quick to point out what the graduate nurses had *not* done. She verbally accepted newly graduate nurses under her wing with the words "these kids," and she provided an alternative narrative: "Let's try and help you as much as we can."

Harrison and Leila highlighted that more education and skill development should occur to assist the newest nurses:

> **Harrison:** It would be good if there were experienced people – or the organisation would invest in working with the new nurses to bring – to equip them with the skills and knowledge to perform their task, rather than just chucking them in, and – that's the experience that I've had. You're just chucked in, and it's sink or swim kind of thing.
>
> **Leila:** So they need more education and not in-services once a month. They need someone there that they can go to that they know, and who knows them – well, not necessarily knows them, but it does help.

Both Toni and Janelle provided excerpts that demonstrated empathy for how new graduates were feeling emotionally within the huge learning curve that they experienced when first working as nurses:

> **Toni:** Especially on our ward. Grads get upset easily, because they're so anxious anyway and, like, a little grad the other day said something to one of the kitchen staff, and the kitchen staff said, "Well, I'm going to Riskman you." This poor grad became so upset and, like, it was only nothing. I said, "Look, there's not a person here who hasn't made a mistake. It's certainly not a big mistake. It's nothing to worry about. Don't worry about it. We're all here. We'll look after you." That's the type of environment we have now. But it wasn't like that before.
>
> **Janelle:** Which – it's a bit like well how do other people – how do other – I'm thinking about the new nurses that come out. How do they feel about that? How is that impacting on them?

Toni discussed a staff member de-nominalising[4] the noun "Riskman," utilising it as a verb and a threat: "I'm going to Riskman you." She empathised with the graduate, and provided several sentences to appease the graduate, who was "so upset." These included: "It's certainly not a big mistake. It's nothing to worry about. Don't worry about it. We're all here. We'll look after you."

Spectacular failures as social outings

The nurses stated that they dealt with competing discourses in their practice fields by keeping other aspects of their life enriched, including family life and pursuing education, which were mentioned previously. They also used mechanisms for de-stressing, such as talking to a trusted person or meditating.

Some nurses, including Janelle, Leila and Harrison, spoke of having a supportive person with whom to talk. Julian questioned whether this should be more formal, as occurs in some other professional fields:

> **Julian**: My [friend] is a social worker, and, whenever they have difficult clients, and they have lots of difficult clients, they have a process which they call "peer review," where she actually talks to

[4] De-nominalising was discussed in Chapter 3.

> other professionals, and they're very astute at picking up when a team member's not doing well, and they'll actually organise meetings.

In contrast, Helen said simply: "I meditate."

Toni explained that distance from work can be intentionally enabled by maintaining a boundary between professional and personal life:

> **Toni:** I know other wards often have monthly get-togethers, or go for a drink, or have barbecues. We don't do that. We've tried to do that [laughs], but I think we give so much of ourselves while we're at work that we don't want to meet up with each other afterwards. We've had spectacular failures as social outings, because no one wants to go. It's not because we don't like mixing with each other. I think it's our time at home is very important, because that's our de-stressing. As soon as you see your work colleagues, as much as they're your friends, it's work.
>
> I think that – yeah, it's very much a separate thing. I don't know whether that's just a medical thing, because I know everywhere else in the hospital are very much sociable type of wards, but we're not. I'm not sure why.

This passage read as something that Toni had thought through previously. Even though Toni's words and ideas were constructed in a spontaneous interview conversation, they were well-formulated, particularly in the phrase "We've had spectacular failures as social outings." She underlined the separation of work and home lives amongst the staff as a strategy for de-stressing. She explained that, if one were to see colleagues, it became work. These comments also demonstrated the headspace that nursing can occupy. It is not just the physical work day, but it can consume nurses' thought processes, which can be triggered by seeing the other players.

Lowering standards

I don't ever do it

Contrary to examples of extending themselves, the nurses from this study discussed other nurses who dealt with competing discourses by pulling back – sometimes as a mechanism to demonstrate that they could not fulfil the workload. This was disconcerting if the nurses felt the offender was obviously not pulling her weight, such

as the nurse whom Leila described earlier as "very unsafe…lazy" (Chapter 4). Gemma used the same word to describe coming on to a shift with many things not done by the previous staff: "That's just laziness" (Gemma).

In other cases, missed care was not considered careless, but a strategy to be happy with a job *reasonably* well done, but not *perfectly* well done. Sophie, for example, explained:

> **Sophie:** I think I'm starting to mature as a nurse in realising that it's okay if you don't achieve all those things, even though you've got the pressure on you: "Well, why wasn't this done?" … Nursing is a 24 hour a day job. I don't like handing things over, but I'm not beating myself up as much any more over it.

Toni used the same terminology in referring to the 24 hours:

> **Toni:** You have to leave something. You've got to realise nursing is a 24 hour job.

Janelle spoke of nurses who were quick to refer issues to other health professionals rather than stretching themselves to follow through on issues for patients:

> **Janelle:** I mean, we've got this huge team; it's not just the nurses' team. We've got the psychologist, we've got the dietician, we've got the diabetic educator.
>
> So, really, I think today the nursing role – what is my role? Because, okay, I see nurses that identify problems. But it's something that I think that we can sometimes even deal with or help. Maybe that other resource is perhaps even not needed; it's something that we could do. But I don't know how to put this into words. But it's a bit like, "Well, if you're looking for a shortcut – to get to the nurses' station to gossip," if I could put it that way.
>
> Well, okay, I can fix him up, refer him to the dietician, refer him to the diabetic educator, whoever. So we don't really even take on the role of trying to help that patient. When I think as a registered nurse it is part of our role. We don't – we're quick to refer, but it's making our load lighter. Do you know what I mean?
>
> I think that's good. I think it's really good that that's there. But sometimes it's a bit like as a nurse that we don't just put that on to someone else to make less work for us. Do you know what I'm saying?

Janelle stated here that the nurses she works with were not recognising that it was within their scope of practice to act on things. She stated overtly that she felt that it was part of the registered nurse's role to "take on the role of trying to help that patient," and more covertly that she felt that some nurses were quick to refer patients to other health professions, to provide shortcuts that afforded them time "to get to the nurses' station to gossip." She was tentative in this passage, completing points with "Do you know what I mean/I'm saying?" (twice) and "if I could put it that way." Her hedging could be related to her criticism of others and a feeling that she was exposing something, but there was also tentativeness in what the nurse's role really was; nurses can identify problems, but Janelle was asking if they could also work harder to solve those problems rather than taking shortcuts.

They don't go in and see the patient

One way to deal with the pervasive discourse of audit responsibilities was to ignore them or to falsify them. Myra spoke of nurses ticking audits even though they had not checked the patient for the underlying skin condition:

> **Interviewer:** What did you mean before? You said the paperwork is fake. You said, "It's like fake when we're doing it."
>
> **Myra:** For example, pressure – pressure area risks, and you have three columns there to fill – to review. Sometimes … the nurses have no time to do that review, but, with the accreditation time coming soon, they come; they don't go in and see the patient. They don't ask, "Have the circumstances changed from the first admission?" Then they tick it sometimes, if you know what I mean?

She added that the nurses, while listening to handover at the beginning of their shift, were ticking the care as completed for their shift to follow:

> **Myra:** Another example, even though they go to bedside, these grads [new graduates], sometimes, they pretend [to be] listening to the handover. They go and – sign the care plan when somebody is talking to them, to give them handover about the patient. They sign the care plan.
>
> **Interviewer:** For the care to follow?

Myra: Yes. I said, “Girls you put that away; just listen to the handover and then – then this is your last thing to do, whether you have met this or whether you have done this in the care plan.” That's again come to the paperwork. They were very concentrate[d] on paperwork.

Interviewer: That's false.

Myra: Yes, it is. I was so – so cross with that.

Leila spoke of an audit where the ICU staff were given a computer-based knowledge assessment regarding the deteriorating patient, in response to incidents that occurred where registered nurses did not implement appropriate actions when the patient was showing signs of sepsis:

Leila: The stupid hospital; so we all had to do this stupid sepsis awareness training before the end of June, changed it to July now because no one's done it. It's just this online, stupid tick and flick going through. It doesn't teach you anything, but once you've done it you're sepsis trained. That's the kind of thing that the training – now we've got this [healthcare region], online learning or something. You've got your mandatory stuff like your cultural awareness and things like that, but then it's got actual clinical stuff there like sepsis awareness. You didn't learn anything on that. You might read a sentence or two that makes a bit of sense.

So that's the training that they're giving people for these people dying. I don't think that's good enough. So, yes, the hospital should provide training for what's appropriate for where people are working, but the people should be taking responsibility as well. It's their job, and it's their patients' lives. They should take that seriously enough to do something.

Our doctors are actually refusing to do it in ICU, like “I'm not doing it. I spent 25 years training; I'm not doing a tick and flick on a computer.” Everyone has to do it, nurses, doctors, everyone, this tick and flick thing that takes, like we just did it on night duty one night. In fact, I think one of my teammates did mine for me because I was busy, and I was like, “I don't have time to do this,” so I just logged in and she did it for me. I looked at a bit of it, and it's all just stupid, stupid, stupid.

Beyond Leila’s overt adjectives of “stupid, stupid, stupid,” she displayed her disdain for the self-directed packages, referring to them as “stuff” or “something.” Leila put

so little value in the activity that she had someone else complete hers. She added support for this in saying that the doctors were also refusing to comply.

I didn't feel valued

There were references from the research participants to instances where they did not cope with the demands that they were navigating, or where they witnessed depression, burnout and resignations owing to work stress in their colleagues. For example, Julian talked about feeling unvalued:

> **Julian:** I think there's that perception too, the perception that nurses think that the people leaving them don't care. I think that comes down to a lot; they don't feel valued. That's what came out to me: I didn't feel valued; I felt that I was disposable. I think that's how a lot of my colleagues felt as well.

Julian stated that he did not feel valued and he felt disposable; he added that he thought this was how "a lot of my colleagues felt as well." In cross referencing a criticism that the nurses leaving did not care, he demonstrated that he took note of what others thought.

SECTION II: CONTEXTUAL INFLUENCES

The nurses' work contexts influenced their ability to deliver the type of nursing care they desired. Their dialogues offered insights into system influences that impacted on their abilities to deal with competing discourses. This included influences of staffing, of resourcing and of specialisation.

Additionally, the nurses provided examples of feeling let down by their senior management in instances where they took a stance, but they did not feel supported or rewarded for their actions of advocacy. Several research participants expressed doubt about expectations for system-level changes.

System constraints on preserving the ability to enact ideal care

There's no one in the system

A continual concern for many of the nurses in terms of being able to enact appropriate care pertained to having enough (or not enough) staff. The research participants blamed inadequate staffing levels on the institutions, where they either did not supply enough nurses, or did not provide the right skill mix, including the level of nursing abilities (RN, EN or AIN) and the familiarity of workers with the particular ward or specialty unit. Toni noted:

> **Toni:** You had to fight to get any help, and it wasn't – as a nurse, you'd come on, and you were just tired before you got there mentally, because you knew what sort of shift you were going to have. I know all medical wards are pretty well full-on, but I think knowing that you weren't going to get any help because – as a team leader you would phone the afterhours manager and say, "Look, we're drowning here. We've got this patient wandering about with no clothes on. We've got this patient up here; can you send me someone?" "No." There's no one in the system." So patient safety is compromised because of finances. What do I pay my private health funding for?

Toni provided a picture of mental stress before the shift had even started, which she blamed on "knowing that you weren't going to get any help," and she described her pleas, using the words "we're drowning here." She linked the situation with the patient's safety, stating very directly that "patient safety is compromised because of finances." Her dialogue mimicked the answer that she would obtain from the afterhours manager with a simple one-word sentence: "No." She then moved the discourse to a comment on the private health system, and she personalised this as "What do I pay my private health funding for?"

There's a numbers game happening there somewhere

The research participants talked about casualisation of the workforce which was previously presented as beneficial to some nurses to allow control over the realities of shift work. Casualisation, though, may have other implications, including decreased continuity of care, decreased harmony within teams and decreased job security for

nurses. In fact, casualisation can range from working in nursing support with a permanent base to working any shift and in any ward as an employee of an independent agency. In some cases, the nurses felt that the organisations' use of casualisation trimmed the workforce to the bare minimum and exerted control over the nurses employed. Julian spoke of the effects for individual staff members who remained on temporary contracts:

Julian: In the public system, particularly where I was working – not so much in [city], but where I was working, everybody was on temporary contracts. I think that's a terrible thing for staff morale – not knowing whether your contract's going to be renewed. I know people that had contracts for four or five years – even longer.

So it actually brings about this real kind of culture of competition amongst the employees. Time and time again, I saw these very senior nurses that were actually beaten [for a job] by somebody that was new to the position, that had much less experience, because they interviewed better. So I think in terms of morale, it did very little for the unit that I was working in, and throughout the hospital, too.

Interviewer: Do you feel like it's intentional – that they intentionally keep people on part-time so that – sorry, on non-permanent, so that they don't rock the boat, don't get super-involved?

Julian: Possibly. I don't know. I just know it wasn't good for people's morale. Certainly going for a mortgage, you're employed under contract – you may have worked there for five years, but you still don't have a permanent position, knowing whether you're going to – and when I was doing rosters – this was with a completely different manager, I'd do the rosters, and I'd find that there weren't people on the rosters.

If I ever would ask the manager, "Well, this person's not on our roster" – "Oh, well, we're not renewing her contract" – but not letting the person know. The roster would come out and the people wouldn't be on it, or they'd be sent back to the ward where they got them from. So there were some practices there that I didn't really like. I think that's a really good question: do they do that to keep people, yeah, I guess, to make it – .

Interviewer: Marginalised.

Julian: Marginalised, or to keep people competitive – keep people up to their competencies and education, but it did make it really hard. Yeah, and I'm sure that we lost staff because of it. I'm sure that the retention of staff was – or our poor retention of staff was probably due to the fact that there was not permanent positions there.

Julian referred to the repeated negative consequences for people in terms of losing out on jobs with his wording, "Time and time again." He stated the repercussions, such as an inability to be eligible for a mortgage, but he voiced the biggest concern to be staff morale. Institutional practices impacted on morale, including staff members finding out by default that they were no longer on the staffing roster.

Debra also talked about contract positions – in particular, her contract position in the highly specialised field of theatre nursing:

Debra: I'm permanent with Nursing Support. When we did our grad, you got a permanent position with Nursing Support when you're finished. I think we were the last lot to get that. The rest might have got a grad position but no permanency. Then Nursing Support actually directs you where to go. Once you've got a contract, you can stay while they keep recontracting you in the one place. Until they advertise positions and you can't really have it.

Interviewer: But that's four years and you're not permanent.

Debra: You'd like to know that there are girls that have been there a lot longer than I have but don't have permanency in there.

Interviewer: How do people feel about that?

Debra: They're probably similar to me. Nursing Support and just contract. It grates a bit sometimes because you know all these staff are needed for theatre. Why can't you give them a permanent position in theatre? They're only talking about making theatre bigger, not smaller. They're not going to want to lose any of the staff. I just don't understand. It's probably a time thing again to organise positions, to advertise positions. To do all that it takes time.

Interviewer: Or does it mean that they can leverage you if they need to?

Debra: You just don't want everyone to be able to kick them out if you want to.

Interviewer: I'm not saying it is right. I just wonder about the motivation keeping that many people on contract.

Debra: Being working in government previously, I know that it's a numbers thing with govy, I think. That your casual positions aren't counted when they're doing how many permanent positions. It's an hour thing. I don't know how they do it. I'm sure there's a numbers game happening there somewhere.

Interviewer: Do they keep you from working full-time under what you're doing? Are you only allowed to do point eight or point seven?

Debra: It's my choice to do point seven. I started at point eight, and I reduced it to point seven.

When I expressed surprise about Debra being on a contract in a theatre situation where skilled labour is not abundant, she started her next sentence with "You'd like to know," which seemed to build on my surprise, and she cited an example to indicate that others were even worse off than she was. She was not pleased with the situation, and she said that "it grates a bit sometimes." In talking further about this situation, Debra switched to a managerial discourse: that it took time to organise positions, and that the real reason may have been to manipulate the number of staff members that hospitals were allowed. For this, she added as credibility that she had worked in government positions, "govy," and therefore: "I'm sure there's a numbers game happening there somewhere."

Janelle, who worked as a pool nurse on different wards, reinforced the lack of permanency:

Janelle: See, this is another thing. I'm permanent with the hospital, but a lot – I believe there's a lot of nurses that they don't seem to give out permanency. The permanent jobs don't come up very often, but, when I went into my job at [health organisation], at the end of my grad program, they gave me permanency, but it's more unusual now – it's just the structure. I think that they've got a few on nursing support. They've got nurses contracted to wards, but they're not in permanent positions, and a lot of deficits are filled with agency nurses.

In making her point, Janelle personified the bureaucracy as "they," but there was no identity attached to the "they": "they gave me permanency"; "they've got a few on nursing support" and "They've got nurses contracted."

Just a casual

Despite advantages to the individual and clearly to the institution, casual nurses' jobs were sometimes depicted as second-class positions. Those who were working as casuals were portrayed in a discourse of marginalisation, and those who were working *with* casuals conveyed a feeling of extra responsibility. Additionally, the nurses considered that the practice of casualisation negatively influenced continuity of care. Janelle's language in the next excerpt was telling:

> **Janelle:** [speaking of a colleague] She had a permanent job there, and basically what happened as a result of a particular incident was she lost her job. She did not have permanency, and I mean she really needs a job. But now she's just a casual.

The incident has not been recounted here, and it is inconsequential to the telling point of the text, which was Janelle's wording, the derogatory tone of "she's just a casual." In her language, the woman was not even a casual nurse; she was just a "casual."

Ingrid spoke of being casually employed as an agency nurse:

> **Ingrid:** I remember having to set some bloods up for a patient, and I just had to grab this nurse. I said, "Look, I just haven't done this before. I'm just not willing to do it at all. I'm just way out of my scope so, if you could help me, I'll do something else for you, but can you show me what to do?" They were really helpful that way.
>
> Other times it's been "You're the agency nurse, and you're getting paid more money than us; you should know what you're doing." Not so much in voicing that, but you get that sort of vibe of "I'll get back to you."

Ingrid contrasted the helpful text with a feeling that others resented the pay scale of the agency nurse and had high performance expectations for that position. Ingrid indicated that the treatment of being casual staff could not quite be put into words, but she described it as a "vibe."

Although earlier Jo made the point that staying casual enabled her to avoid the politics of the ward, she also demonstrated that she was not as involved as the full-time staff:

> **Jo:** Being a casual, you don't get involved in their treatments as much as what a permanent staff member would. But I feel like I'm contributing a little bit more now than what I was in the first 12 months.
>
> That's why I've felt, it's taken me, now, three years to really feel like I'm just now getting into what I'm doing because I'm only there casual.
>
> **Interviewer:** But is there an example of the time when you felt you did make a difference, or could make a difference with something more than just routine?
>
> **Jo:** There's probably been a few things, I guess. Being a casual, I suppose, it's – those opportunities don't come very often.

A lack of ownership of Jo's nursing role showed in the repetitive "Being a casual," "I'm only there casual" and "Being a casual."

No idea who or what you are working with

Those working with casual nurses spoke of the stresses involved in this. Even though Janelle herself rotated wards, she talked of working with agency nurses:

> **Janelle:** So sometimes you're working with – I think some of the shifts that I find very difficult is that – and this happens fairly regularly. You'll rock up to a shift – and this happened even when I was contracted to surg – you might be the only regular staff member, and you're working with a whole staff of agency nurses. You have got no idea who or what you are working with. That is scary, because it's kind of nice to know that you come on to a ward with at least a few nurses that you know that – you know what I mean? You feel comfortable with.
>
> This is what I think is – it's a concern because I don't know, with agency nurses, I guess there's good ones there but some of them, they don't have that level of responsibility. It's just like "I'm here for eight hours." Are they really – the responsibility – it's a bit like it's ended at 3:30 if it's a morning shift. But Joe Blow there was probably something that they could have handed over, but they missed it. But did they go home and worry that the important point wasn't handed over and did the next nurse pick it up? Because that could have been

the key thing to watch for that patient for deterioration. Do you know what I mean?

Janelle's attitude of the unknown capabilities and skills of agency nursing staff was expressed in her words that one has "no idea who or what you're working with," coupled with "scary." She conveyed an assumption that the agency staff were not wearing the responsibility of the regular staff, which was marked by her rhetorical question: "But did they go home and worry that the important point wasn't handed over and did the next nurse pick it up?"

Take ownership for my patients

Patient allocations were set differently in different venues. In some, the nurses completely "owned" their allocation and, for others, a team shared the responsibility for care. The staffing mix of ENs and RNs required the RN to concurrently deliver their own caseload care while supervising the ENs. Toni expressed conflicted feelings about team nursing:

Toni: Team nursing - I don't know whether that's – I've looked at other forms of nursing. I don't know if that's a better way to go. I think there's a lot of blame put on, like I told the EN to do that, or I told the RN to do that, or we both got confused, or I was down here and I didn't see that happen, and so I think there's a lot of – the ownership's not on that one nurse. So I don't really know.

Interviewer: Accountability?

Toni: Yeah. So the accountability is not there. Sometimes, when you're so busy, it's hard to be accountable for what happens if you can't attend to it. If you don't know about it, if you don't – so – and that makes that nurse feel guilty. Knowing that you should have been in that room at that time, because you knew that patient was probably going to climb out of bed, but you had to – you had the patient who was coughing and coughing and you had to do something with them, so you left that patient and they fell.

Toni's passage not only referred to the term *guilt* but also demonstrated guilt in self-ascribing ownership to a patient's fall: "you should have been in that room," and "you

left that patient and they fell." She highlighted that the registered nurse would be the one who would wear the accountability, which she also reinforced below as being exacerbated in the role of team leader:

> **Toni:** I've always intended to take ownership for my patients and it's hard for me, because, when I'm the team leader, I own every patient that's on my ward, and I need to know every patient that's on that ward, and I trust the nurses who are working with me to come and tell me what's wrong with that patient, if they've deteriorated or if they're upset or if they need extra help. Whatever. So I feel personally responsible for every single patient that's on that ward. So sometimes you have to delegate, and it's really hard for me to delegate.

Toni emphasised the responsibility of possession here: "take ownership for my patients," and "I own every patient that's on my ward." Although she said she trusted the nurses to come to her with changes in a patient's condition, she was conflicted between her sense of responsibility "for every single patient that's on the ward" and the necessity to delegate. She admitted that "it's really hard for me to delegate."

Makes a good nurse feel guilty

Throughout the data in this study, the nurses expressed a discourse of valuing holistic care. There was evidence in their narratives that opportunities for this care were not prioritised by the system; the contexts within which they were working made it difficult to address the psychosocial aspects of care for patients:

> **Toni:** They come in with – say it's a palliative patient and they've just been told that they've got metastatic CA and you need to spend time with that patient, but you can't. That really makes a good nurse feel guilty.
>
> **Interviewer:** So that's when you can't enact your vision for what nursing should be?
>
> **Toni:** Yeah. I mean, like, looking at the whole of the patient, not the hole in the patient, so to speak. You're time constrained, so much so that sometimes you can only focus on what you see, not what you know is there. Yeah. It's very – yeah, it impacts upon the nurse psychologically, emotionally and physically, because you're just so tired and – because you are running. Look, there wouldn't be a shift that goes by that some

nurses don't get to eat or don't get to go to the toilet until they're finished, like, you're desperate.

Lots of – even as their team leader or the clinical nurse, you're so busy trying to help all your fellow nurses that you – yeah. You're trying to do discharges. We have a computerised discharged system that's supposed to save us time. [Laughs.] Doesn't save you any time. Yeah. It's just the workload. Yeah, it's just overwhelming. To go home with that guilt and – yeah.

Toni choice of "That really makes a good nurse feel guilty" demonstrated the consequences that she feels as a nurse. She used the word "impact," and she emphasised the "running" with hyperbole, whereby not a shift went by that some nurses did not get to eat or to go to the toilet until they had finished the shift. She emphasised that the overall system did not help, in spite of computerised discharge processes that she scorned with laughter. She returned to the word "guilt" to round off the excerpt and again feeling guilt at home after the shift was over.

The positioning of nurses as the providers of 24-hour care also positioned them within the organisation and on any particular shift as the keeper of the care, the case manager:

Interviewer: Who ends up being the case manager? Who is it? The nurses, the doctors?

Sophie: The nurses [laughs] – the nurses definitely.

Interviewer: Do you have the same people – do you have a primary home where you might have the same person the next day so you can follow through on these?

Sophie: Yeah, we try to. We try and be – the team leader will try and delegate the same patients. It just depends on skill mix. I'd say probably 75 per cent of the time you would find that you'll continue with that patient. That's on the ward that I'm on.

Being a teaching hospital up there as well, it's very hard for patients to see the same – same doctor. We've got lots of residents and regis, and I find that's – that adds to a bit of – not conflict, but it makes the patient's stay a bit more difficult, I find – keeping that continuation and communication going.

Sophie led in with expressing the value of continuity of care, not only from nurses but also to have follow through with the same physician. She explained that the system makes it "hard for patients to see the same – same doctor," and she softened from saying that it caused conflict to "it makes the patient's stay a bit more difficult." She discussed how nurses tried to fill in the gaps through "keeping that continuation and communication going."

We don't get all this fancy equipment

Funding deficits were highlighted in Chapter 4, and Toni particularly showed how funding was linked to insurance in private hospitals. Nurses dealt with funding constraints for equipment for patient care by scavenging elsewhere for equipment:

> **Toni:** I mean, we beg, borrow and steal from other wards to get what we need, as anywhere from dressings to walking aids to chairs to mattresses to – you know? We will – I mean, it's nothing for us to – I mean, on night duty, you know, you go up to [ambs] and steal something [laughs] and bring back to our ward, because each ward's accountable for their stock. So if we need an air mattress and we don't have one, well, it's nothing. I've got nothing against going to taking one from somewhere else, and them finding it a couple of weeks later. But that happens pretty well much all through the hospital.

Contrary to her guilt expressed in other passages, Toni's repeated "you know?" her laugh and her word "steal" were expressed without shame, because she justified that it happened throughout the hospital. She confirmed this, and emphasised it by moving to the first person that "I've got nothing against going to taking one from somewhere else."

System support with building expertise

We can call at the drop of a hat

The nurses valued both a knowledge base and a skills/experience base for their practices. They were seeking this, for the most part because they valued obtaining knowledge for current practice, in spite of but not because of mandatory competencies from the nursing board or from their place of employment. Leila said that if nurses

"aren't kept up to date then we're failing [patients] and then they'll die" (Chapter 4). Several nurses spoke positively with regard to a support system where intensive care nurses mentored ward nurses in real-time episodes of care:

> **Sophie:** We've actually been fortunate enough they've started what's called an "ICU outreach service." We have an ICU nurse that we can call at the drop of a hat, and you can get referred in through that way now, which has been amazing. It's one of the positive things that are happening up there.
>
> **Leila:** It's actually really good. It had a three-month trial which has just finished, and so then they'll see what the data shows and hopefully get funding for it to continue. It was the ICU outreach program, which was great….So they would follow up our discharges onto the ward and for three days, four days or as long as it was needed to make sure that because the ward nurses are busy and sometimes they don't do that assessment, treat the assessment and provide cares related to the assessment.
>
> So that helps [to] keep track of the patients and it actually – I don't know the data of what it is, but just in the tea room we talk about it, and we're saying it really has decreased the readmissions back to ICU. Also it's decreased MET calls because of the ICU intervention…so they visit the patients discharged from them, but they also – they're just there for the team leaders on the ward to say, "Oh, look, I'm concerned about this patient. Can you come and have a look?" So that was really good. It stopped MET calls, then the ICU outreach nurse would be "Just do this and this, or I think you should call a doctor." Even those who called down to ICU doctors and just say, "Oh, can you come and have a look at this?," which was really good. They would also provide education to the nurses on the wards, which I think they really appreciated, and we're hoping that the wards will chuck a fit saying, "That really helped us, it helped patient care, blah, blah, blah," and so that we can put it back on.
>
> **Julian:** They do it in other hospitals, too. What they found is that nurses are often reluctant to ring doctors, particularly – it might be a ward nurse who may not be long out of uni, just doesn't have that confidence to speak to doctors, has a concern about their patient, may not reach emergency criteria yet, but there's just something not right.
>
> So, what they found is, they actually talk to other nurses. They're a lot more comfortable. So what the outreach service does is, they ring the outreach service, one of the nurses comes up and assesses the patient. If they believe that they need to be reviewed by the intensive care doctors or one of the doctors, they'll be in touch and they'll do that. Also they provide support for patients that may have a tracheostomy in the ward. So it's a great program.

The interdiscursivity that these three nurses enacted in describing the outreach program demonstrated their valuing of mentoring, and highlighted that ward nurses were looking for this level of help. The emphasis was on learning to assess more difficult patients on the ward, and to build this into their repertoires of nursing skills, but also into their level of "confidence" (Julian). The ward nurses "really appreciated it" (Leila). Leila urged a collective push from the ward nurses to maintain the funding for the program: "we're hoping that the wards will chuck a fit saying, 'That really helped us, it helped patient care…so that we can put it back on."

She can't be expected to educate the entire hospital and district

The exemplar above of the ICU outreach service, with an educator on call, was in contrast to the system constraint of difficulty in obtaining on-site education:

> **Leila:** We in the ICU have the educator, but she's the educator for…I don't even know, maybe for the whole hospital, which is ridiculous. She can't be expected to educate the entire hospital and district. We have our facilitators, which is great. They really help us. The wards don't have them, and we were all talking about this the other day in the staff room because I don't know – the managers are now putting in their things to get things for the next financial year, I guess. One of the wards has put in for a clinical facilitator, but they keep getting denied it. So they don't have – you know, even if the nurses wanted to get - like we can just go to our facilitator and say, "Can we go through this, not sure how to use it?" or "Can you go through this sepsis with me?" They don't have that. They've got no one that they can go to to say, "I want some help with this" or "Can you show me how to use this?"

Leila highlighted the double edge of this situation: (a) that it was helpful to the ICU nurses to have educators who "really help us"; but (b) that the wards did not have access to this service and "keep getting denied it."

Institutional responses to instances of the need to advocate

Two serious situations that necessitated advocacy left after-effects for the nurses involved. Julian and Toni talked about these experiences and the impacts on them and on their work.

If I wanted so badly to resign then I should resign

Julian's anecdote issue involved a level of reporting beyond normal reporting requirements, and it left him feeling unsupported by team leaders, management and peers:

> **Julian:** Then I found myself at odds with my management, which was the first time, but I wanted to know why nothing was followed up, what was being done to ensure that it wouldn't happen again. Anyway, I found that very, very difficult. I also – I think to a degree I was prompted a lot by the nurses around me as well, that felt much the same way. However, when it came to pursuing it, I felt very isolated. There really weren't people that were backing me up. So I decided to resign from my job. The manager encouraged me not to resign.
>
> During that time, I'd also written a letter to someone very senior in the organisation saying that "This is what's happened; I'd like you have a look at it; I think there should be an investigation into what has happened." I then got a letter asking me to resign – asking if I wanted so badly to resign then I should resign. Then I reduced my hours, because I wanted to resign on my own terms. I didn't want to be told that I had to resign. So I reduced my hours to point 5. In that time it made it really hard. I had difficulties getting holidays.
>
> So there [were] quite a few things that kind of happened, and some of it's probably life perspective, too, but I just knew that I wouldn't have the opportunities there any more. So I pursued work elsewhere.

Julian sequenced his account to demonstrate being prompted by the nurses around him, that they "felt much the same way." His "However," became a significant turn, to state that, when it came to taking things further, he "felt very isolated." From the management perspective, he received a letter, which he paraphrased with the wording "asking if I wanted so badly to resign." This conversation within his conversation was relayed as an individual having an argument, not a professional response. He confirmed that this became personal, that he "had difficulties getting holidays" and he "just knew" that he would not "have the opportunities there any more."

I actually reported this … and it didn't go down too well

Toni explained a situation that she deemed to be unsafe, and she found some obstacles in terms of trying to turn it around:

> **Toni:** Although a lot's changed since I started. A lot has changed. I guess for me – and it – I guess all nurses go through a process of being the newbies. There's very much a hierarchy in nursing, and I think that's an accepted practice. I shouldn't say it's a fair type of practice, but I think you have your top nurses. You're often – I won't – "bullying" is too harsh of a word. But I would say certainly rule it over the younger ones, and that was how – it was very much when I started.
>
> I didn't bear the brunt of that, but certainly saw a lot of that happening. I actually spoke up for a couple of nurses that were being bullied. It didn't go well for me. So I ended up going to admin, and it was a whole process. It was six months from the time I reported a level 2 and was told that I can't report a level 2, because I'm not at that level.
>
> This is very much to do with safety. There was actually a patient who couldn't walk, but the grad nurse was told that she had to get that patient up and walk that patient. It was physically impossible. It was impossible for the patient. So the risk to the nurse and the patient was just ridiculous. This nurse, this level 2, that had told this nurse to do this was a very senior level 2, and was very much the right-hand person to the NUM of our ward. So I actually reported this on our reporting system, and it didn't go down too well.
>
> I got called up to admin; I went through HR [human resources]. I had three months off on stress leave. I had to go and see a therapist, and I just –, I thought, this is ridiculous. These poor young nurses are coming along and are just being subjected to this type of hierarchy when it's not a learning environment. So I said, "Look, this isn't right. I'm not going to stand for it. It's not fair. This particular person has been reported by many other nurses, and you've refused to do anything about it. I'm not going to sit back and do nothing." So that nurse ended up leaving. That level 2 nurse ended up leaving and we re-changed the whole orientation system after that incident.

Besides her detailed description of the incident and the reporting of it, Toni's subtext was about the hierarchy in the culture, which was an "accepted practice." The nurse who exerted power over a junior nurse was "a very senior level 2" who was "very much the right-hand person to the NUM of our ward." The management took Toni to task for the process of reporting and whether she had a right to report, rather than focusing on the issue of potentially unsafe care/practice to both the patient and the nurse. Toni described the outcome of dealing with human resources and administration, and the consequences of stress leave and counselling. Even with the distance of time, she indicated her motives with a number of short phrases: "this isn't

right"; "I'm not going to stand for it"; "It's not fair." In that sequence, she quoted her considered argument to the administration: "you've refused to do anything about it," which demonstrated that this was a case worth fighting for, and she was "not going to sit back and do nothing."

Lack of expectations for system level changes

That's not going to change

Some of the participants discussed a lack of trust about whether systems will change, such as solutions to nurse shortages. Intertextually, this was informative because it transcended dialogue across settings, from mental health nursing in the community to a busy medical ward in a private hospital. When Jo discussed the transfer of patients in mental health settings to the community, she stated that it would be staffed by nurses. However, she qualified this with the statement that "It is staffed by registered nurses now, but the rumour is that – for how long? Maybe for 12 months. Then it will be personal carers, or untrained staff" (Jo).

During the time of this research, the Queensland state government was instigating mechanisms to provide improvements in nurse-patient ratios. Several nurses expressed doubt whether this would ease the burden at the front line. Both Sophie and Julian expressed that this may not be a counting of nurses on the floor compared with patients:

> **Sophie:** I think, yeah, I've got absolutely no issues with RNs doing hygiene needs, but just give us more – just give us more RNs to split the load. They talk about this one nurse to four ratio. That's not going to change. They count a team leader as a nurse on the floor, so it's all in theory. It would be lovely if we could have more nurses on the floor.
>
> **Julian:** Yeah, that had worked to some degree, having the ENs do those tasks so the nurses can focus on other things, but again there are still not enough nurses there. I think the nurse-patient ratios will help. I think it's going to take a long time to filter through, and I think we're going to have to be very clever on how we institute it.
>
> Some hospitals, what they'll do, they're already looking at their nurse-patient ratios, but, rather than actually count the nurse-patient ration on the ward, they'll actually count nurses throughout the whole

hospital, and the work – the ratio's based on that. So I think there's going to be some clever bookkeeping.

The nurses above voiced doubt over a rescue from the current strains under which they worked. Julian stated that down the track a change in ratio would help, but he also expressed doubt in terms of the number that would filter to ward level. Sophie highlighted that the real ratios would not be the same as those "in theory."

Myra felt that shortages would still exist:

Myra: Other thing is skill means and nurse-patient ratio. They were talking about nurse-patient ratio, but I don't think it's going to get tried as yet.

Interviewer: Why do you think that that wouldn't occur?

Myra: It's always unbalanced. People – more so nurses like to be working in a metropolitan area. They don't want to go out – there is – there are so much nurses, nursing positions to be filled, but they – there's – it's very hard up there to get the ratio right.

Myra felt that rural areas would still struggle as "nurses like to be working in a metropolitan area." There seemed to be an overall expectation that such improvements would not happen.

SECTION III: INTERPRETATION

The nurses' texts and their references to the contexts of competing discourses gave indications of whether or not they identified as professionals in their roles. The two previous sections of this chapter demonstrated that the research participants retained a knowledge base, worked to preserve autonomy and valued holistic care for their clients. They were, however, conflicted in their role in ward work, which often saw them acting as technical workers rather than as the planners or drivers of care.

Several of the nurses demonstrated difficulty in stepping out of a daily role to advocate their perception of truth in particular situations, which were often situations that arose

from conflict or sentinel events. Leadership from within the positions that the nurses occupied was not institutionally rewarded, but the nurses revealed personal growth from difficult experiences. From the transcripts in general, there was a lack of discourse pertaining to opportunities for them to exercise leadership.

Dealing with ward work

Everyone's going to be showered by x o'clock

The discussion in Chapter 4 showed that several of the research participants implied that filling in on the wards felt like they were being sent there, and it came with the connotation that ward nursing was so difficult that being sent there was like a punishment. One undertone was that working on the wards meant that a nurse was a "worker" and therefore on a lower rung of the professional hierarchy. One interpretation of this was the sheer volume of bodily care needed, and the reality that hygiene care and activities of daily living could be undertaken by non-licensed personnel and even family members. Toni described a picture of how heavy the care needs were – literally heavy – with eight patients in the given shift requiring a two-person assist:

> **Toni:** We're heavy most of the time. Like, at the moment, we've got eight doubles on our ward.

Some of the research participants explained that an additional workload burden occurred because many patients on the wards were quite unwell, had a number of co-morbidities, were often elderly and were understandably slow. This provided frustration for more than one nurse when multiple demands such as call-bells were commanding immediate attention (Harrison; Janelle). Harrison's words of "crumbly" and "sick," while politically incorrect, were quite descriptive (Harrison). This connotation of difficult patients also added to the cultural feeling that wards were the least glamourous places in hospitals to work.

A further conflicting discourse with regard to ward work was a desire for more contact time with the patients set against the culture of task nursing. Julian expressed this by saying:

> **Julian:** It was rushed. It was all about – it was very – working in a ward is very task-oriented. There's an expectation that you're going to do your pill round, your obs round, and everyone's going to be showered by X-o'clock, which is crazy and it's 2016, but everyone still believes that**.**

Julian's comment that "it's 2016" demonstrated that he assumed that working professionally meant working OR performing to an internal compass of standards rather than to a list of time-driven tasks, yet his observation that on the wards "everyone still believes that" highlighted that getting the tasks done by a certain time was the priority.

At times, the nurses' discourses revealed that their antidote to the dissatisfaction in ward work was to give more (Toni; Sophie): more passion and more time with patients; answering to one's ideals and to a ward culture that to be a 'good' nurse one needs to be providing exemplary care.

Autonomy to take it further

Toni spoke of an improved culture over time on her ward, and she stated that teamwork now was not just an assignment of patients, but it was an expectation of working together:

> **Toni:** So I've seen teamwork change for me. We were very much an independent type of person. They were your patients. You looked after them. Now it's – you have your set, allocated patients, but you work closely with all the nurses around you, and it is very much a team effort. So now you have that autonomy to take it further if you're not happy with what someone has said. Before it was very much what your team leader said you did. You didn't ask too many questions, and I don't think it allowed a lot of younger nurses to develop their sense of autonomy and questioning what was happening to their patients, but that's changed a lot now.

Toni highlighted an autonomy to take responsibility. She demonstrated a subtext of concern and a desire to mentor the newest nurses, with a perceived responsibility to help the graduate nurses to grow both professionally and with minimal scarring as they learn to navigate the demanding institutional and cultural expectations.

Lack of leadership opportunities

Here's my answer and then go away

Although most of the nurses in this study made reference to managing the staff members or students whom they were supervising, they showed very few ward-level avenues for providing their input into the workings of the ward. There was an absence of the ability to take criticism or ideas for improvement forward or upward.

In their interviews, the nurses relayed ideas about what they might do, but this was often without a corresponding mechanism for action related to their ideas. There was an absence of discussion regarding collaborative decision-making on the wards, in theatre or in any of the other specialities. A few instances of the nurses approaching managers were met with "Here's my answer and then go away" kind of thing. "I've just got KPIs and everything to meet" (Sophie). In Toni's case, she was told that she was not a high enough level to report a level 2 incident (Toni). Julian spoke of his clinical nurse (CN) responsibilities in terms of duties such as rostering, but not in terms of leadership opportunities. Janelle mentioned a ward team meeting once, but whether such a meeting was collaborative or purely dissemination of announcements was unclear.

Leadership within one's role can be considered part of being a professional (Lord et al., 2013), and this may have been more prominent if questions on my part had been asked in this direction. The participants did not focus their interview discussion on anecdotes that might allow reading between the lines in their narratives to generate references to professionalism in the leadership aspects of frontline nursing.

I felt isolated

Discourses of safety and 'keeping a patient safe' were part of the system-speak, and had been adopted by many of the research participants. Although the words of safety were employed throughout the nurses' discourses, they did not portray a climate or a culture where they felt safe to raise issues, or to capture 'near misses' at a preventative level. This was expressed in reference to the hierarchy, to managers and within ward cultures, including a concern with what others would think of them.

In the excerpts analysed earlier, both Julian and Toni indicated that they had time off as stress leave as the culmination of reporting their respective issues. Julian stated that he found himself at odds with his management, and Toni stated that, after reporting an incident, "it didn't go down well" (Toni). The culture for Julian extended beyond the dealings with management, in that he noted that the nurses who were originally backing his actions disappeared when things became public: "I was prompted a lot by the nurses around me as well, who felt much the same way. However, when it came to pursuing it, I felt very isolated" (Julian). In contrast, Janelle did not action a PRIME incident in an excerpt in Chapter 4, partly because she did not know how to word that her superior had made a mistake, but also because she knew that it would be raised in her absence at a ward level meeting (Janelle).

Transformative experiences

That's our forte

Sections I and II of this chapter demonstrated a number of strategies that nurses used to cope/manage/survive in today's fields of nursing. In reading across their discourses, I noted that a tenor of confidence was displayed through the dialogues as an asset to complement and support these abilities. Ingrid's transcript of working on the wards showed a contrast in confidence from when she referred to her community nursing job in Chapter 4. The community narrative was a direct and self-assured narrative, compared with her discussion of her newer job where she expressed tentative decisions

and an indeterminacy in her thought processes and actions as an agency nurse on the wards (Chapter 4; Chapter 5).

You need to stick to your guns

Several of the nurses recounted experiences of sentinel events that were transformational. Sophie and Leila's previously discussed incidents demonstrated acquired confidence to trust their sense of when a patient needed review.

Toni felt that the action of reporting a bully and her part in pushing for change helped to promote a positive work culture on her unit:

> **Toni:** I think my incident pre-empted a lot of the changes, because I think you just need someone to stand up and say, "Hey, this isn't right." You need to stick to your guns, because I've seen so many good nurses leave because of the culture, and it's not right. There are a lot of good nurses who have just left. Whether they – and I know with me, two of them left and are not nursing now from that culture alone, from that bullying culture alone.

The reflection and growth that these nurses recounted when evaluating transformational experiences can be considered hallmarks of professionals.

Julian felt that the negative experience of a sentinel event had helped him to position his career positively:

> Julian: I think it often takes some kind of sentinel event for people to change, because at the time I was constantly hearing people saying how hard it was now, how they wanted to leave, but very few people actually did. People have left since. I think when it first happened people didn't know what to think, but people have left since, but in different stages and for different reasons too. Yeah, I think as a workforce we get very comfortably stuck in the rut that we're in.

He augmented this position with statements that it was not that easy to leave either, and with the example that after a sentinel event it took time for those affected to exit from the workplace.

CHAPTER SUMMARY

The nurses in this study worked to build expertise, preserve autonomy and find rewards in their work. Individuals consciously re-storied themselves to find alternative jobs or conditions within their employment that provided these professional attributes. Sometimes they dealt with competing discourses by lowering their standards to cope with workload, and sometimes they felt that the organisation purposely isolated them. Casualisation of staff and other resource constraints left them with a lack of expectation that things would change from a government or a systems point of view. Professionalism was evident as they re-storied themselves in jobs with continuity of care, or when they grew from transformative experiences.

CHAPTER 6: DISCUSSION

In the previous two chapters (Chapters 4 and 5), I demonstrated a depth and breadth of the interviewed nurses' talk that were particularly evident when they spoke with passion about their practice or with discouragement when they were unable to enact this practice to their desired standard. The interpretation of text and context showed elements of the nurses' work that can be considered professional, but they also enacted many duties that were routine tasks or mandatory compliance of organisational directives.

In this chapter, I discuss the findings from this study within the theoretical framework depicted in Chapter 2, which was designed to gather an understanding of where nurses are situated as professionals in contemporary Australian nursing practice. The theoretical framework includes Stronach et al.'s (1995) understanding of *economies of performance* that provides a useful framework to examine where nurses in this study spoke of the overlay of organisational demands and an audit culture permeating their everyday practices. This overlay, which aligns with Fairclough's (1992) theory of the social world behind his text-interaction-context model (2003) that was applied in Chapters 4 and 5 to organise my discussion of the research data, is discussed in terms of other orders of discourse from contemporary nursing literature, particularly published studies that investigated or depicted Australian contexts.

Stronach et al.'s (2002) framework also considered *ecologies of practice*, which are the beliefs and praxes that arise from nurses' formative education, their continued education and from their experiences. Within their everyday practices, the nurses in this study also demonstrated significant discourses of their ecologies of practice. I discuss these discourses and relevant contemporary nursing literature, particularly from Australian contexts. Finally, I discuss the nuances between the economies of performance and ecologies of practice, which is where Stronach et al. (2002) argued

that one can find the status of professional nursing in the 21st century, and where Fairclough (2003, 2010) would interpret agency for the individual.

ECONOMIES OF PERFORMANCE

Economies of performance refer to the contextual influences for nurses in current practice, including both system-related expectations with overlaying processes to mandate these expectations and people-related influences that range between supports or constraints. These align with Fairclough's theory that an individual's ability to construct their environment is confined by sociocultural influences depicted visually as an "outer box" (see Figure 2, Chapter 3). The nurses in this study, and those depicted in relevant literature, exhibited the impact of contextual influences that affected their care provision as well as their well-being. Five economies, which presented through the data of Chapters 4 and 5, are considered further in this chapter: efficiency expectations; mandates for throughput; task-based performance; monitoring for recovery; and sociocultural dimensions that can become an economy of performance when they influence nurses' work.

Efficiency expectations

Chapter 1 in this thesis introduced macro level influences on Australian healthcare, including economic pressures and the effects of New Public Management. Authors of published literature drew links to these influences when describing the contexts within which nurses were working. For example, Shields (2014) linked "reductions and stringencies in healthcare funding" (p. 193) to macro financial strain beyond the healthcare industries themselves. Dudau and Brunetto (2020) described resource scarcity following the "adoption of neoliberal fiscal policies" (p. 11). Indeed, healthcare systems can constrain nursing practice owing to a lack of resources, an organisational culture that is not supportive of nurses advocating for improved patient care (Zuzelo, 2007) or one that is shaped by decisions made far from the bedside (Ross & Rogers, 2017).

Published studies attributed the healthcare organisations as the cause of resulting fiscal difficulties in enacting appropriate care. Verrall et al. (2015) blamed budgetary restrictions and shorter hospital stays for increasing demands on nurses' workload, which frequently led to consequences of missed care or rationed care. Horsfall and Higgs (2014) highlighted a conundrum in the nurse-patient relationship:

> There is something quite perverse and disquieting about telling people who enter the caring professions not to care too much, to keep their distance. There is something predominantly bureaucratic and dollar-driven about health and social care systems that emphasise efficiency, cost accountability and practice drivers such as empirical research grounded in principle of population consistency and exclusion of contextual considerations. (p. 86)

Forsyth and McKenzie's (2006) study also articulated this sentiment, with one nurse stating that, in the face of cost constraints, she and her colleagues continually needed to try to prove the worth of their role within an organisation because the health service did not have the same vision for their service. Other participants in the study considered that cost constraints were fundamentally changing the nature of nurses' work: "nursing is drifting away from its original role of caring for patients, to doing whatever one can with the budget" (p. 212). Similar comments appeared in other studies. For example, Harvey et al. (2018) contended that "cost constrained environments have a negative impact on nurses' capacity to complete care work" (p. 771). Nurses in Germov's (2005) study of health professionals in the Australian public sector tied fiscal need to their inabilities to enact best practice. One stated: "best practice doesn't come cheap … to really improve things costs money" (p. 749).

In the present study, nurses' discourses implied macro level policy constraints: "I'm sure there's a numbers game happening somewhere" (Debra, Chapter 5). With the exceptions of Toni (Chapter 5) and Julian's (Chapter 5) anecdotes, managers above ward level were portrayed by the nurses in the study as a vague entity, far removed from the point of direct patient care, but blamed for budget cuts that directly affected resourcing and thus nurses' work. A nurse in A. Dawson et al.'s (2014) study paralleled this sentiment:

> Upper hospital management… seem to enforce different work policies that impact greatly on RNs who work as hands-on practitioners. Their decisions are made without consultation with nurses and NUMs [Nurse Unit Managers]. Its these decisions that make delivering a high standard of nursing care consistently very difficult. (p. 5)

In other studies, nurses reported perceptions of healthcare managers and administrators in a negative context (Forsyth & McKenzie, 2006; Shacklock et al., 2014), or a distant one with middle and senior managers "focussed on budgets and targets" sequestered away in offices or "walking around with clipboards" (Hoyle, 2014b, p. 2532). A pervasive sentiment through the literature was a "them and us mentality" (Hoyle, 2014b, p. 2534).

Many nurses in this study experienced economic constraints first-hand when budgets diminished resourcing, including both fiscal equipment and human resources. Harrison and Sophie both told of difficulty obtaining supplies in public hospitals (Chapter 4), and Toni expressed embarrassment regarding the ethics of stealing equipment from other wards in a private hospital (Chapter 5). This was echoed in the literature. An Australian study demonstrated that nursing care is recurringly interrupted by an inadequate budget, resulting in a lack of "properly maintained equipment and a lack of resources needed to perform duties" (Verrall et al., 2015, p. 416). J. Henderson et al. (2016) highlighted the pressure for nursing staff during off shifts (e.g., night duty) when resources such as linen are scarce and it is difficult to obtain meals or changes in patients' meals because the inpatient meal supply is outsourced to non-health service companies. Resource stressors that constrain practice have a negative impact on the job satisfaction of nurses (Teo et al., 2012; Zuzelo, 2007), which impacts on their level of organisational commitment and on their psychological health (Hoyle, 2014a; Teo et al., 2012), including individual resilience (Cope et al., 2015). This supports Stronach et al.'s (2002) contention that constant bombardment from economies of performance was "demotivational" (p. 131) in its effects.

Staffing was a continual theme in the nursing literature, manifested in both inadequate numbers of staff and complaints about the breadth of staff for the tasks needed, a

concept commonly referred to as “skill mix” (A. Dawson et al., 2014; Roche et al., 2012). Staffing levels have not increased despite sicker patients and increasing complexity in care (Forsyth & McKenzie, 2006, p. 212). In a study investigating distressing work factors, Zuzelo (2007) concluded that the most morally distressing work factor for nurses was having to work with levels of staffing that they considered unsafe for the demands of patient care. The nurses who participated in this thesis confirmed this distress: Gemma said it was not a priority to have a nurse’s workload in a safe range (Chapter 4), and Helen spoke of burnout from her overtime to boost staffing numbers (Chapter 4). Indeed, many published authors attributed inadequate staffing to workload intensity (e.g., Forsyth & McKenzie, 2006; Huntington et al., 2011; Roche et al., 2012).

With different levels of staff providing patient care, the ratios of the type of staff (registered nurses, enrolled nurses, patient-care attendants or assistants in nursing) affect workload and work flow for all concerned. The skill mix of a given working situation has the potential to underpin inadequate coverage (Bogossian, Winters-Chang, & Tuckett, 2014; Goodman, 2014; Hall, McCutcheon, Deuter, & Matricciani, 2012; Harvey et al., 2015; E. Willis, Henderson, et al., 2015), and tests nurses’ tolerance (Schluter et al., 2011). The challenge of achieving an appropriate level of registered nurses in each shift extended to the perceived calibre of the staff on board. Overseas trained nurses, those from Non-English-Speaking Backgrounds (NESB), agency nurses and new graduates may all be blamed as part of the problem with skill mix (Curtis, 2013; A. Dawson et al., 2014). Janelle made this clear when she said, “You have got no idea who or what you are working with” (Chapter 4). Permanent staff state that working with unknown staff triggers more workload, as it involves orienting the casual worker to new routines and time expended in surveillance of them across a shift (Ross et al., 2019). Predictably, in a study that took the opposite approach to look at *positive* practice environments, the authors included adequate staffing as one of the gauges of a desirable workplace (Mills et al., 2017).

Mandates for throughput

New Public Management strategies in healthcare involve lean principles (Harvey et al., 2018), and procedures and audits to enforce mandated strategies. These strategies include institutional goals for both inpatient and outpatient occupancy to be as short as possible, and for beds to be occupied. Chapter 4 showed how Leila was conflicted by the National Emergency Access Targets (NEAT); she portrayed doubt about some of the follow-on effects, yet also a degree of acceptance that it had some benefit. In the literature, nurses felt pressure to drive the targets of this mandated four-hour maximum treatment allowance when they would have appreciated more room to focus on the patients' conditions (Crawford et al., 2014). Nurses acknowledged that non-acute patients were better served by this policy, but emergency department (ED) nurses also reported inadequate time to support the sickest patients (Hoyle & Grant, 2015, p. 2215). E. Willis, Henderson et al. (2015) noted that throughput can go only so fast, and that it is limited by the degree of time required by doctors and nurses to perform their respective responsibilities with a patient.

Studies have demonstrated that this throughput of patients remains an area of tension in other areas beyond emergency rooms, and causes conflict for nurses between their professional identity and the organisational identity (Hercelinskyj et al., 2014; J. Jones et al., 2016; Sharp et al., 2018). For example, conflicting demands arose for a nurse in her field of mental health nursing when a 20-year-old, with a new and terrifying diagnosis of schizophrenia, was sent home, to save the hospital money, before he or his parents were ready to deal with his behaviour or a treatment plan (Hercelinskyj et al., 2014, p. 27). In an operating theatre, maintaining throughput of clients created conflict for nurses in terms of being able to maintain concomitant compliance with standard operating room safety procedures (Espin et al., 2006, as cited in A. Jones et al., 2016). Medical/surgical nursing areas also experienced "increasing acuity of patients and fiscally driven demands for shorter hospital stays" (Huntington et al., 2011, p. 1416), and a focus on urgently moving as many people as possible through the organisation (Bogossian et al., 2014, p. 379). In some studies, nurses described an emotional burden in having to discharge patients earlier than desired (Gibson, 2013;

Harvey et al., 2018; Hoyle & Grant, 2015), with one using passive tactics of resistance when a manager was encouraging throughput. It appeared that this nurse did not take the time to arrange a woman's prescribed discharge by the end of his working day, and later stated that he felt she was not ready to return to her nursing home (Gibson, 2013).

A further economy that mandates the systems of work in healthcare settings is an omnipresent focus on quality and safety while thwarting risks for those working in or receiving healthcare. Risk governance is "manifested in the need to control, record and risk assess everything" (Goodman, 2014, p. 1266). This takes the form for nurses of: (1) patient safety, including elaborate systems of double-checking medication administration; (2) environmental safety, such as mitigating risk and meeting corporate governance and workplace safety legislation; and (3) professional risk management, including attending mandatory fire and safety competency training (Ross et al., 2019). Organisational safety to protect the hospital includes time-consuming activities such as documenting incidents or near incidents in an electronic database, such as PRIME (Ross et al., 2019). All these responsibilities include copious documentation that reflects the "governance policy and procedure mandates that may be designed to protect the organisation from litigation" (Ross et al., 2019, p. 5), and include multiple forms, such as falls risk assessments or skin integrity assessments (p. 5).

The discourse analysis of the present study showed that nurses had adopted the language of these economies of performance. For example, Toni recounted a staff member upset with another and threatening: "I'm going to Riskman you" (Chapter 5), and Janelle regretted that she did not "PRIME" an interpersonal incident (Chapter 4). This reinforces Stronach et al.'s (2002) premise that nurses adopted a "language of indicators" (p. 121) in their professional practice that reinforced a penetration of the audit culture into their practice to the degree that they were taking on a "new and arcane professional discourse" (p. 121).

The discourses of managerial mandates extend beyond safety to other references of quality and to measures of quantity. Analysing the discourse of an agency's documentation, Gibson (2013) demonstrated that managerial strategies promulgating

efficiency and productivity measures permeate through performance reviews, vision statements, recruitment strategies and job descriptions, to the extent that they become a measure of or are equated with nursing quality itself. Paperwork (either literal hardcopy or electronic records that have replaced paper copies but still require significant inputting) for procedures, policies, mandates and to measure compliance abound in daily practice for nurses. It is not only management that is walking around with clipboards but nurses in daily practice. I did not expect at the start of my research for the mundane, concrete action of documentation (paperwork) to become a discourse of its own that needed to be represented for the nurses in this study. Four pages in Chapter 4 were devoted to nurses lamenting the paperwork that took up so much of their work, and was seen as "duplication" (Harrison), "ridiculous" (Ingrid) and "immense" (Myra). The burden of paperwork evoked emotion: "I hate it" (Leila); "it's depressing" (Sophie). It was not a lone cry, and it was also widely represented in the literature (Braaf et al., 2015; M. Johnson et al., 2014). Just as every single nurse in the current study discussed paperwork as an over-riding work issue for them, every single article that examined the climate of nursing care in Australia mentioned the strain of organisational expectations for paperwork, documentation or electronic audits. From the articles that cited nurses' impressions of their current practice fields, paperwork was blamed for increased nursing workload (Bogossian et al., 2014; Forsyth & McKenzie, 2006; M. Johnson et al., 2014), as a reason why registered nurses could not appropriately support students in their clinical environment (Ó Lúanaigh, 2015) and as a source of frustration because the paperwork itself was often not done well, did not fit into the work shift and necessitated staying back to complete it (Verrall et al., 2015). In some studies, nurses cited documentation as a major impediment to the provision of quality care, with many of them overwhelmed by the sheer volume of it (Cope et al., 2016; Forsyth & McKenzie, 2006). Paperwork was attributed as the reason nurses could not use their repertoire of clinical skills: "you are taught many skills at university but you never get to use them in nursing practice. It is all paperwork and minimal patient care" (Birks et al., 2014, p. 29). In the study by Forsyth and McKenzie (2006), one nurse with 36 years' experience stated: "I was always taught that the patient comes first. It now seems budgets and paperwork are more important … patient care is going

out the window" (p. 210). In Germov's (2005) study, a nurse stated that any work that was not included in institutional measurement gets lost:

> The whole thing's turning upside-down so that what's important is getting the paperwork right so we get a "beautiful set of numbers." But what about the service part of it, the personal relationships with patients, the attention, the way we tailor things to individual needs? You can't measure that and so it gets lost. (p. 750)

The prioritising of paperwork was also noted by those observing nursing care:

> An old lady in an adjacent bed had vomited on the floor, some 15 feet from three nurses sitting behind a desk. Their paperwork was clearly more important than attending to the situation. (Hutchinson & Jackson, 2014, p. 83)

Paradoxically, the nurse scholars themselves occasionally provided solutions to the research questions they were studying, which included *more* paperwork. For example, Penney and colleagues (2016) proposed the use of an assessment tool when nurses were found lacking in appropriate assessment skills for elderly patients admitted to acute care wards. Several studies mentioned a process, which did not appear in the present study's interviews, that is utilised in some Australian hospitals: they discussed "rounding," which is a purposeful process of nurses checking on patients every hour and ticking a sheet to document that they had asked standardised, set questions (Verrall et al., 2015; Walker et al., 2015; E. Willis, Toffoli, et al., 2015). Not surprisingly, the literature showed that many nurses consider this as counterproductive to time management; the rounding procedure actually takes them away from care of the patient (Walker et al., 2015), and reduces "nursing to a time and task set of activities that impact negatively on the nurse-patient relationship" (E. Willis, Toffoli, et al., 2015, p. 1). In this example, the managerial mandate moved beyond controlling institutional processes, and extended to controlling and defining nurses' work.

Defining nurses' work in relation to a set a quantifiable numbers or qualitative audits is time consuming, seen as irrelevant and devalued by nurses when they do not see it leading to results. Audits, in the form of electronic staffing systems, are used to try to monitor, predict and respond to staffing needs, but authors in the literature arrived at

the same negative conclusions that Leila did in the current study when she said, "TrendCare is a time-wasting load of rubbish. It's for staffing, but it's so stupid" (Chapter 4). Verrall et al.'s (2015) study found that nurses believed the staffing systems did not measure important parts of their job such as clinical judgement or time for patient education, and the parameters were inadequate to account for nurses reworking their priorities in response to continual changes in patient acuity. These audits were in direct conflict with their ecologies of practice.

Task-based performance

Macro-economic forces and institutional economies of performance impact on 21st century nursing work as nurses struggle to find their professional role beyond that of a "compliant technician" (Stronach et al., 2002, p. 124). In Chapter 4, I highlighted the repetitive speech patterns that the interviewees used to underline their repetitive daily tasks, especially on medical/surgical wards. A number of Australian studies likewise depicted nurses (RNs) lamenting the task-based role of caring for people while simultaneously trying to care *about* them, monitor their progress, keep them safe and promote their optimal recovery or return to health. Bogossian and colleagues' (2014) publication, titled *The Pure Hard Slog that Nursing is…*, underlined the strain felt by nurses labouring under the consequences of excessive workload. The captured quotations about workload from their study included that "the biggest problem is overwork," workload was "excessive," "getting busier and busier," and this workload afforded "no let-up of pressure" (pp. 379–380). Huntington and colleagues (2011) chose similar quotations where nurses described their work situations as "overwhelming," with "increasing work hours and pressure," using words such as "turmoil," "unrealistic," "unpleasant," "destructive," and having "ridiculous workloads" (p. 1416). The awareness of language for the present study drew notice to the titles of these two articles; the first is included above, and the second one begins with the words "*Is anybody listening*?" (Huntington et al., 2011, p. 1413).

Nurse researchers have demonstrated that the nursing workload is increasing in Australia, with work intensification an accepted concept. Bogossian et al. (2014) stated

that one could argue that a nurse's workload has always been hard, but the overwhelming message from the 66 nurses in their survey corroborated that a nurse's workload is increasing in today's healthcare. This was echoed in studies by other researchers, including Holland et al. (2019), Kristiansen et al., (2015) and Verrall et al. (2015). The words *work intensification* were used by some authors to the degree that it became a recognised term through some of the literature (Germov, 2005; Rudge, 2013; Schluter et al., 2011; Teo et al., 2012), and an entity of its own to study (Harvey et al., 2018; E. Willis et al., 2017; E. Willis, Henderson et al., 2015; E. Willis, Toffoli et al., 2015). Several authors investigated nurses' intentions to quit nursing, which provided insights into nurses' perceptions of their working environments, including heavy workloads as a negative impact (A. Dawson et al., 2014), and as a driver of attrition (Bogossian et al., 2014; Burmeister et al., 2019; Cope et al., 2015). These authors found nurses expressing a nursing discourse of the grind of nursing tasks, even though the researchers were not necessarily investigating discourses.

Not only is patient care a hard slog, but also institutional expectations to complete task-based care in targeted time periods add to the pressure nurses feel and consequently their emotional (un)well-being. The voice of nurses from Harvey et al.'s (2015) study demonstrated tension and conflict between trying to enact caring activities and deficient time resources. One participant's quoted text expressed simply but powerfully: "1 nurse…6 bells…maths doesn't work" (p. 77). Nurses elsewhere stated that work demands exceeded the clinical time available, with one nurse describing driving home in tears after shifts where she could not provide proper care to patients (Bogossian et al., 2014, p. 379). These findings reinforced the emotional turbulence that Sophie, Toni and Harrison expressed in the data from this thesis (Sophie, Ingrid, Harrison, Chapter 4), and the findings from Teo et al.'s (2012) study that demonstrated negative effects on the psychological health of the nurses, including: "not having enough time to do the job as well as you would like"; and a "busy, fast paced workload" (p. 1449). Nurses were stressed by their "inability to be the nurses they want to be due to lack of time" (Zuzelo, 2007, p. 347), which can be a component leading to moral distress (Musto et al., 2015; Suhonen et al., 2018; Zuzelo, 2007).

A discourse of missed care percolated through the literature, with researchers studying what led to missed care as well as the nurses' feelings about this. Nurses ration their care in response to work intensification, which underpins many examples of missed care (E. Willis, Toffoli, et al., 2015). Harvey and colleagues' (2015) study of New Zealand nurses demonstrated that nurses miss aspects of care, when resources, such as the staffing skill-mix, are inadequate for the level of patient acuity in the nurses' workloads. This leads to stress and creates the potential for adverse events to occur (Harvey et al., 2015). E. Willis, Toffoli et al. (2015) related missed care back to efficiency measures of bed targets where the pace of throughput outstrips the speed with which doctors and nurses can care for patients.

Non-nursing tasks such as administrative work impinge on nurses' roles and workload (Teo et al., 2012). These may include additional or unexpected tasks such as telephone calls or visitor requests (Verrall et al., 2015). The degree of difficulty that this poses may be under-reported, as nurses have come to adopt extra duties without question. As Ross and Rogers (2017) reported:

> Nursing work is compounded by nurses undertaking much work that is not within [their] professional competency standards, lacks boundaries, but contributes to supporting direct patient care. As such, the workload attains an invisibility or "taken for granted" nature which insidiously grows as organisational demands increase. (p. 553)

Ross and Rogers (2017) cited a number of examples, including nurses physically retrieving linen when the ward was out of stock; having to schedule wards-people to assist with transport through a central computer program (even if the wards-person is on the ward just finishing another job); having to source drinking water for patients because the hospital has contracted a business for bottled water that is only delivered later in the day; and physically running medication back and forth to the pharmacy. Many administrative tasks were picked up by the nurses, including a requirement for two nurses to record and store patients' valuables (Ross et al., 2019). Some shifts increased the administration load to the extent that the impact of administrative/managerial duties was so demanding that some nurses found night duty

preferable as a welcome reprieve from "'chasing charts'" (West et al., 2012, p. 180). One nurse quantified: "'I'd say 45% of your time in the day shift is spent on chasing paperwork which you don't have on night duty'" (West et al., 2012, p. 180). They felt nightwork afforded them more ability to enact direct patient care (p. 180).

Monitoring, supporting, promoting recovery

The literature has demonstrated that institutional overlays of audit also influence the way nurses monitor patients. Monitoring, supporting and promoting a patient's recovery are a major part of a nurse's role, utilising critical thinking skills to assess and monitor patients appropriately and effectively (Milton-Wildey et al., 2014; Shields, 2014; Tuckett, 2015). This includes not only accurately measuring data but also interpreting the data appropriately (Considine & Currey, 2015, p. 301), and escalating review of or changes to the patient's treatment when the situation warrants it (Schluter et al., 2011, p. 1216). Leila and Sophie provided detailed descriptions of their thought processes and subsequent actions when they each described an incident where a patient's physiological status deteriorated and required escalated medical and nursing care (Leila, Chapter 4; Sophie, Chapter 4). This aspect of nursing has previously been an assumed scope of practice, often functioning by experience and intuition (Benner, 2015, p. 6; Hardy et al., 2002, p. 199; Schluter et al., 2011, p. 1216). The discourse of a monitoring role was not always overt, and had to be teased out of the literature, similarly to the transcripts of the present study where this aspect of care manifested subtly. This would not be a negative thing if assessment occurred automatically and appropriately, but again studies demonstrated that nurses struggle to find the time in their workload to keep on top of what is physically and psychologically occurring with their patients (Cardona-Morrell et al., 2016; Considine & Currey, 2015). *Surveillance*, *the deteriorating patient* and *failure to rescue* have all become established lexicon in nursing literature, frequently researched and often encouraged as continuing professional education to upskill nurses to mitigate error (Massey et al., 2017). Considine and Currey (2015) noted that the Australian Commission of Safety and Quality has promoted an increased focus on physiological surveillance (p. 301).

While this monitoring role comes from nursing knowledge and experience, and would thus be considered in Stronach et al.'s (2002) terms part of a nurse's ecology of practice, in current nursing practice it is also shaped by regulated monitoring and defined parameters for when to call for assistance, and thus it is also an economy of performance. Documentation sheets to accompany surveillance, which Leila and Sophie mentioned, are presently included as a part of standard practice in Australia, utilised to escalate or "trigger" a Medical Emergency Team (MET) response if a patient needs immediate review by an intensive care or medical team (Cardona-Morrell et al., 2016; Considine & Currey, 2015). A comprehensive review by Massey et al. (2017) showed inconclusive results as to whether the rapid response systems lowered patient events in the ward, but this may have been due to the systems being under-activated by the nurses. Norwegian authors, Stafseth et al., (2016), reiterated the importance of nursing intuition to accompany any system, and they suggested from a review by Kyriacos et al. (2011) that nurses base their referrals of patients on clinical judgement even if the vital signs are normal; therefore, nurses need the option and confidence to call for assistance for their patients even in the face of seemingly normal parameters on sheets. The sheets helped support nurses' ability to call ICU and not be intimidated by the ICU staff (Stafseth et al., 2016). Traynor, Boland and Buus (2010) pointed to nurses, just like Sophie (Chapter 4), who acknowledged value in utilising the formalised instruments prescribed for assisting with clinical decision-making. However, also like Sophie, they stressed a balanced view if modification in clinical practice needs to occur when the instruments are difficult to fully adhere to or when the situation requires such modification (p. 1589).

Monitoring of a patient's condition is one aspect of nursing that leads nurses to discuss fear; this was evident in the literature as well as threading through the nurses' talk for this study, and was collated as a discourse of fear in Chapter 4. Nurses from research studies mentioned fear that something negative would transpire in the monitoring of patients (Massey et al., 2017), fear that management will blame them (Hoyle, 2014a, p. 194) and a fear of litigation (Goodman, 2016; Ross et al., 2019; E. Willis, Toffoli, et al., 2015).

Sociocultural dimensions

While higher level management was often a broad and faceless entity, as shown above, managers at supervisory level remained visible to nurses enacting patient care. These supervisors or team leaders were depicted in this study's data and in published studies as influential to the nurses' ability to deliver comprehensive care. Leila and Janelle each spoke of both an exemplary manager and one whom they did not respect (Chapter 4). A number of studies found that supervisors were identified by registered nurses as effecting a positive or negative difference in terms of their levels of support for the frontline staff (Brunetto, Xerri, et al., 2016; Brunetto et al., 2013; Gountas & Gountas, 2016; Polis et al., 2015; Shacklock et al., 2014; Wilkes et al., 2016; Wilkes et al., 2017), including their style of leadership (Cheng et al., 2016; Karimi et al., 2015), and their allocation of manageable workloads (Cowin & Eagar, 2013; Rodwell & Fernando, 2016; Wilkes et al., 2016). Specific traits attributed to effective supervisors or Nurse Unit Managers (NUMs) included: an affective component that modelled or enabled compassionate care (J. Jones et al., 2016); a high degree of emotional intelligence and self-awareness (Cope et al., 2016; Cowin & Eagar, 2013); respect for staff; valuing staff (Cope et al., 2016); and being approachable so that staff nurses feel secure to ask for information or knowledge (Kristiansen et al., 2015; Zuzelo, 2007).

A nurse in Bogossian et al.'s (2014) study found the solution to the strains of shift work to be an exemplary manager who "enables us to balance our working lives with our family and social lives" (p. 380). Positive leadership skills became significant predictors for nursing teamwork in hospital settings (Cheng et al., 2016; Cowin & Eagar, 2013; Polis et al., 2015), while a good relationship with one's nursing supervisor influenced engagement with work and job satisfaction (Cowin & Eagar, 2013; Kuokkanen et al., 2016; Shacklock et al., 2014). In reverse, Rodwell et al., (2014) found abusive supervision in managers, and demonstrated the use of both personal and task-oriented attacks. From the research about nurses' intentions to quit their jobs, authors noted that supervisors could have more impact on this intention than team members (Brunetto, Rodwell, et al., 2016; Rodwell et al., 2017).

Nurses in the studies, as well as the researchers writing them, commented on the difficulties for NUMs or similar direct supervisors in navigating the tensions of staff roles that were at odds with institutional goals, efficiencies and targets. Taylor et al. (2015) presented an extensive literature review that demonstrated the complexity of clinical managers' work in having to manage both upwards through the organisation and downwards in their role of supervising. This necessitated thinking on their feet while navigating many competing demands. Further, managers worked within tensions of conflict in making clinical decisions that were best for the patients while balancing resources and costs (Hoyle, 2014b; Kristiansen et al., 2015). This may contribute to negative impressions of supervisors when they were seen to be too passive and not perceived as effective for staff needs if they were afraid to advocate in their direction (Zuzelo, 2007).

In addition to managers, other interpersonal relationships and social interactions are part of the context within which nurses work. These contribute not only to the favourability of their work, but also to their ability to enact ideal care (Kristiansen et al., 2015). Positive practice environments were linked to cohesive teams and collegial relationships (Mills et al., 2017), but more frequently the literature depicted and highlighted deficient collegiality among nursing teams. Deficient teamwork within nursing teams can be associated with tension, either from the skill mix mentioned earlier, where registered nurses find it difficult to delegate and fight a perception that delegating is equated with laziness (Schluter et al., 2011, p. 1218), or from a lack of cooperation to work together to get the jobs done either within shifts or between shifts (Daiski, 2004, p. 47). O'Keeffe et al. (2015) studied different nurses' variable attention to helping one another, and surmised that, although teamwork was necessary for working safely, it was not always given willingly or generously: "Many nurses were often reluctant to provide assistance since it disrupted their own work" (p. 117). This echoed Janelle's frustrations with her shift-mates (Chapter 4). Cheng et al. (2013, 2016) demonstrated that a strong team climate buffered the effects of work stress for some nurses. Polis and colleagues (2015) concluded that effective communication and leadership within individual nursing units were significant predictors of workplace

teamwork (p. 22). Although Brunetto et al. (2013) were unable to conclude in their measurement of an Australian sample of nurses that teamwork predicted workplace commitment or turnover, anecdotal evidence from nurses in two other studies demonstrated that collegiality was often what kept them turning up to their unit:

> In recent weeks I have come close to handing in my notice but the thing that keeps me there is the supportive staff (you don't get staff like that on all wards). (Huntington et al., 2011, p. 1417)
>
> The team I was working with was the only thing keeping me sane. (Cope et al., 2015)

A scarce discourse in my study, but one that continues to be pervasive in the literature, was that of nurses being difficult, even bullying, in their interactions with one another, or with students or new graduates. The aphorism "nurses eat their young" is established lexicon both in Australia and overseas (Bogossian et al., 2014; Daiski, 2004), but it was represented scarcely in the present study. In fact, nurses such as Debra and Ingrid emphasised their assistance of younger colleagues (Debra; Ingrid).

The nurses in the present study did relay instances of feeling intimidated, particularly by supervisors (Leila, Jodie), and in one instance by high level management (Julian), but this was not as pervasive as is found in contemporary Australian nursing literature (Blackstock et al., 2015; Cowin & Eagar, 2013; Cowin et al., 2019; Daiski, 2004; Foureur et al., 2013; Hanson, 2014; Hartin et al., 2019; Hawkins et al., 2019; Huntington et al., 2011; Hutchinson, 2014; Hutchinson & Jackson, 2015; Hutchinson et al., 2010) and relevant overseas literature (De Gagne et al., 2019; S. Johnson, 2015; S. Johnson et al., 2015). The pervasiveness of bullying, and of its cousin *incivility* (Mikaelian & Stanley, 2016), has been referred to in the literature as "rife" (Huntington et al., 2011, p. 1417), "endemic," "institutionalised," "graphic and entrenched but also sublime," and "normalised as part of nursing work" (Bogossian et al., 2014, p. 380). Cowin et al. (2019), in their research report on nurses' codes of conduct in Australia, noted that, of all the themes that arose from the nurses' talk about their work environments, bullying was the most common theme amongst all ranks of nurses (p.

324). The contexts within which nurses were working, and the resultant stress, were often blamed for the bullying behaviours (Happell et al., 2013; Hutchinson, 2014; Hutchinson & Jackson, 2015).

People beyond their own teams also comprise the contexts within which nurses work. Healthcare workers and visitors alike can add to the intensity of both workload and emotional drain when communication is misinterpreted or strained. Each focus group in a nursing study of collegial relations cited examples of loss of "respect, civility and courtesy" (Cowin & Eagar, 2013, p. 119) from patients, families, visitors and doctors alike. Relationships with doctors and communication regarding doctors' decisions could be a source of moral stress for nurses (Zuzelo, 2007); this emotional labour may be exacerbated by differing medical credentials and nurses' inability to communicate disagreement (Dudau & Brunetto, 2020). Myra spoke of difficulties when the doctors' English was hard to understand (Chapter 5), and Sophie shared that she was reprimanded by an attending physician when the resident would not respond to a telephone call for review of a deteriorating patient (Chapter 4). Ross and Rogers (2017) described a scenario where the pharmacy dictated how and when nurses would retrieve medications or deliver scripts, demonstrating another profession dictating nurses' work, and a difficulty with working relationships. Nurses in Bogossian et al.'s (2014) study felt victimised by other institutional team members; a respondent stated, "You get treated like dirt by all and sundry within the hospital system" (p. 381).

Relatives can be a source of connection for nurses, enhancing the ability of nurses to use or find compassion in their jobs (J. Jones et al., 2016). Toni, Julian, Leila and Harrison each described anecdotes that continued to resonate as meaningful memories. In contrast, working with clients' families may also precipitate degrees of emotional labour and dissonance. This often requires the covering of true feelings, which then adds to stress and even burnout for nurses (Delgado et al., 2017, pp. 71-72). Happel et al. (2013) provided examples of conflict, including families wanting to extend an inpatient's stay until completely well, and families reporting negative feedback about staff to uninvolved healthcare workers. Fear and helplessness on the part of family members may manifest as aggression to staff during times of heightened emotions

(Dudau & Brunetto, 2020). O'Keeffe et al. (2015) found that some nurses manipulated emotional boundaries to create either a connection with or a distance from patients and their families.

Patient behaviours can also affect work contexts. Harrison and Ingrid relayed incidents manifested as continual buzzer calls, frustrating them further in an environment that already made efficiency and response times difficult (Harrison, Chapter 4; Ingrid, Chapter 4). Dawson et al. (2014) demonstrated patient complaints with two anecdotes from nurses in their study:

> Patients are sicker and older and frequently ruder; relatives are more demanding and rude. (p. 7)
>
> Patients constantly complain about poor service. (p. 6)

Patient complaints may be a consequence of patients being encouraged in today's settings to have a voice, resulting as a direct response to a market-driven approach to healthcare, where, in line with New Public Management, the patient is thought of as a consumer (Forsyth & McKenzie, 2006). It may also be that care is substandard, and that patients and families target individuals whom they come across. This is speculative as caring in nursing is a well-researched subject, but "sparse attention has been paid to uncaring aspects of nurses' conduct" (Hutchinson & Jackson, 2014, p. 85).

The published journals discussed other contextual issues that affected nurses' work lives, and ultimately their job satisfaction and ability to work to maximum capacity. Some of these cited factors were external to nurses' workload, such as pay, shift work and limited career opportunities (A. Dawson et al., 2014; Perry, Lamont, Brunero, Gallagher, & Duffield, 2015; Teo et al., 2012). In one nurse's comment, these three factors were all represented when she stated that she turned down the career opportunities for supervisory roles because undertaking supervisory roles represents a decrease in pay when losing penalty rates: "Good nurses do NOT want to run a ward because they cannot 'afford to lose the income'" (Bogossian et al., 2014, p. 381). Jones and colleagues (2016) wrote that nurses struggled to find a balance between work and

personal demands, including family responsibilities or the distractions that come from outside demands. Nurses valued personal time because "personal time is not just about being alone but about recuperative space" (West et al., 2012, p. 184).

ECOLOGIES OF PRACTICE

This next section of the chapter analyses the nurses' "ways of being" that allowed them to enact professional practices in their daily work. Working under the supports or constraints of economies of performance, nurses utilised their ecologies of practice to work towards their ideals of nursing, and to maintain a degree of control over their practice. Stronach et al. (2002) discussed Dawson's (1994) view of professionalism as emanating from either outside-in or inside-out forces. Within ecologies of practice, nurses are working from inside-out scripts or drives, drives that are formed from their individual habitus, their learning, their experience and their professional identity. The nurses in this study, and in the literature reviewed below, demonstrated that they dealt with competing demands through finding intrinsic rewards in their job, or by positioning themselves in the most user-friendly situation either by manipulating conditions or by skilling themselves for specific career paths. The literature also highlighted nurses positioning themselves out of nursing entirely.

Knowledge for practice

Nursing knowledge has been notoriously hard to express. One reason is that a nurse's role overlaps with other professionals, including the follow through of medical directives that outline the medications, treatments and parameters for review during an episode of treatment or along their illness-wellness trajectory. Monitoring of patients is so much an ingrained part of nurses' roles that in this study they tended to take it for granted. They mentioned these actions as part of a narrative to make a point, rather than as a response for describing their work. When Leila provided a narrative in regards to her efforts to have a patient reviewed (Leila, Chapter 4), I nearly missed the importance of this nursing ecology of practice. As a nursing academic who studied, practised and taught through the years of a strong emphasis on *the nursing process*

(Blair & Smith, 2012; Grealish & Smale, 2011), I was searching for, and having a hard time finding, actions initiated by nurses that were tangential to medical care. Concurrently, my PhD supervisor was reading texts as a checkpoint to my learning of discourse analysis. Upon reading Leila's narrative, she said: "She really sounds like a nurse here" (personal communication, Robyn). This prompted an "aha" moment for me to acknowledge that the care aligned with medical directives *is* nursing – every bit as much as the independent nursing initiatives of rehabilitation, psychological support and comfort measures referred to under the umbrella of "holistic care." In resisting a medical discourse, scholars in nursing struggled for decades to articulate a language of nursing, but in doing so they may have underplayed the knowledge required in collaborative roles (Cusack et al., 2019; Roy, 2019). The nurses themselves did not underplay this: Ingrid, Sophie, Janelle and Leila voiced pride in their role of monitoring and enacting interventions related to medical care. Ingrid stated: "the doctors really rely on the nurses as their eyes and ears" (Chapter 4).

The previous section analysed measurements of monitoring: the ADDS charts, traffic lights and MET call parameters. Despite these audits, much of the process of monitoring a patient's condition is not measured or even articulated; it is an intuitive and experience-based observation that nurses learn and practise, combining their book knowledge and their knowledge of prior cases. Hardy et al. (2002) summarised a nurse recounting clinical expertise in practice, and applauded "an awareness of practice epistemology and professional artistry through a construction of clinical expertise including…rational and intuitive knowledge" (p. 201). This is not unlike the narratives of Leila, Sophie and Janelle recounting the process of monitoring their deteriorating patients.

The nurses' texts described a number of their actions beyond monitoring for recovery that were attributed to nursing knowledge and expertise. In an earlier chapter, Lisa and others described incidents of patient teaching (e.g., Lisa, Chapter 4; Ingrid, Chapter 4). Likewise, the nurses provided ample examples of their knowledge of assessment as well as their knowledge of interventions: wound care (Ingrid); discharge readiness (Ingrid); theatre preparation (Helen); medication administration (Julian); and

psychological care (Toni). The texts described a weaving of these actions in with other care, adding to the artistry of nursing, their ecology of practice and their desire for proximity to patients. Obtaining and utilising nursing knowledge are considered an essential part of a nurse's role (Benner, 2015; Penney et al., 2016; Shields, 2014), and are expected under the domains of professional practice in Australia (Grealish, 2015; Wilkes et al., 2014). Unfortunately, many of these more independent nursing actions are difficult to measure and are not articulated into work models, nor are they audited for staffing (Ross & Rogers, 2017; Sim, Crookes, Walsh, & Halcomb, 2018). This leaves nurses with limited time and less patient proximity for utilising knowledge and problem-solving skills (Hegney, Rees, et al., 2019).

The knowledge ecology of practice for nurses seems to intensify when it is represented by specialties. Nurses spoke with pride of their specialties (e.g., Debra, Chapter 5). They displayed a security in their knowledge base and an addition to their professional identity. They demonstrated expertise; for example, Ingrid showed both her knowledge of palliative care and her autonomous actions to enact this in community nursing (Ingrid, Chapter 5). Knowledge in specialities was corroborated in the literature that highlighted nurses building expertise, and consequently their individual confidence that served as a resource to allow them to act in challenging situations (J. Jones et al., 2016; Wilkes et al., 2016). Nurses, both in the study and in the literature, sometimes revealed their expertise when instructing newer nurses or students. Leila emphasised to students her skills in assessment (Chapter 4). Happell et al. (2013) concluded that clinical nurses in their study noted a sense of satisfaction and enjoyment in sharing expertise with newer nurses. Additionally, studies have shown that not only do some nurses eek a specialised field in nursing for the challenge of gaining expertise, but also specialised environments typically provide strong leadership and a greater range of resources than general wards (McLeod, 2013, as cited in Wilkes et al., 2016, p. 657).

Ward expertise was a conundrum to some of the nurses in this study – they venerated medical/surgical nursing skills, but for the most part they spoke negatively about actually working on medical/surgical wards. Several participants perceived a bias

against their skill set if not represented by medical/surgical nursing skills. Ingrid was wearily working to undertake agency shifts to prevent becoming out of practice for hospital work, even though it was clearly stressing her, and she was not enjoying it (Ingrid, Chapter 5). Sophie spoke of a desire to return to mental health nursing, but never wanted to be reduced to "new grad" status on a medical/surgical ward, and thus kept her hand in acute care (Sophie, Chapter 5). Jo felt the same about mental health nursing – that she enjoyed it, but that it may de-skill her for broader clinical roles (Chapter 4). Harrison expressed feeling out of his depth when he returned to the wards (Chapter 4), and Janelle's discussion continued with a theme of trying to prove to herself that she had to "nail it": she had to accomplish the challenges of ward work because she "is not a quitter" (Janelle, Chapter 5). An exception to these perceptions was Toni. The discourse analysis in Chapter 4 highlighted that she identified negative perceptions from others regarding medical wards and medical nurses. She worked hard to build a case that it has an identity in itself (Toni, Chapter 5).

Whether it is in a specialty or a generic disposition of nurses, there is evidence from the data that the expertise side of nursing is difficult to capture, and thus the forces within economies of performance may have an easier reach to dominate nursing work and workload. When nursing knowledge becomes subsumed under medical and managerial discourses, it can also be thwarted by these domineering voices. Hardy et al. (2002) interpreted that nurses can suppress innovation and hold back expertise if there is discomfort with challenging conventions and working outside the organisational structure (p. 200). McMillan (2016) put it like this: "knowledge becomes low ranking when dominant discourses deem it so" (p. 227). Birks studied nursing knowledge in terms of scope of practice, and concluded that scope of practice is a fluid boundary, influenced by internal and external factors with parameters that are themed under context boundaries and practice specialities (Birks et al., 2016; Birks et al., 2018). This makes it difficult for nurses to utilise the full extent of their wide boundaries for practice and designated expertise.

An ecology of practice that potentially supports nurses to act as professionals is their continued education for practice. In relation to this, the nurses' discourse ranged from

self-ownership (Leila, Chapter 5) to mandated Continued Professional Development (CPD) (Jo, Chapter 4; Debra, Chapter 4). Katsikitis et al.'s (2013) study targeted the knowledge and practice updates exhibited in continued CPD as an area where management demonstrated either support or lack of support for nurses' growth. Of note in this study, the nurses showed a narrow skills attitude to CPD when asked what areas they needed for CPD sessions. Some participants envisaged CPD sessions to be mainly based on technical knowledge or simply procedural updates (Jo, Chapter 4; Debra, Chapter 4). This was mirrored in Katsikitis et al.'s (2013) study.

Even though there has been strong support in recent decades for justifying nursing knowledge and nursing practice with evidence for practice (Berthelsen & Holge-Hazelton, 2017; Eskes, Chaboyer, Nieuwenhoven, & Vermeulen, 2020), the evidence-based discourse did not surface in this study. Similarly to the literature reviewed around nurses' work (e.g. Bogossian et al., 2014; Peet et al., 2019), the nurses in the current study did not mention working from evidence for practice or building nursing knowledge around documented best practice. It is possible that this absence in the literature may be because I sourced subject matter related to the contexts for the nursing discourses of this study. Broader reference to the use of evidence-based practice may have been more prevalent if my searches had included literature centring on research practices. It is telling, though, that, in a 2019 study of the updated code of conduct for nurses in Australia, the nurses surveyed scored "recognising the vital role of research" as the lowest of any listed items in terms of both "familiarity" and "importance" (Cowin et al., 2019, p. 323). Their results prompted the authors to question whether research is even relevant to the domain of the clinical nurse; nevertheless, they stated that "research and evidence underpin current and future nursing practice, and a lack of recognition can have a detrimental effect upon the image of a nurse or midwife as a health professional" (p. 325). Eskes et al. (2020) noted that under-attention to an evidence-based practice foundation not only affects nurses' self-image as professionals, but also affects appropriate care practices for the profession as a whole.

Patient proximity

Holistic care was addressed in the prior section in terms of the constraints from economies of performance that put strain on nurses when they were prevented from engaging in this ecology of practice to the degree they desired. Similarly to the disenchantment that Sophie described in Chapter 4 (Sophie), studies of nurses in Australian settings depicted their desire for more comprehensive holistic nursing care (Forsyth & McKenzie, 2006). Data from studies demonstrated that some nurses desire time to be with patients, to develop a rapport, a "deeper understanding of each person's needs" (Forsyth & McKenzie, 2006, p. 212), and the ability to be cognisant of the nuances of a patient's particular situation (Hardy et al., 2002; Hercelinskyj et al., 2014). Researchers have often labelled this as nurses' desire for proximity to patients and their families (Horsfall & Higgs, 2014; Schluter et al., 2011), even though the word *proximity* was in the researchers' lexicon but not in the published excerpts from the nurses themselves. A desire for being in contact with patients to deliver holistic care manifested as conflict for registered nurses when the close physical care was given over to assistants in nursing or similarly named patient-care attendants (Shields, 2014; E. Willis, Henderson, et al., 2015). Dissatisfaction with an inability to provide the desired level of care led to emotional and physical exhaustion (Harvey et al., 2015; Huntington et al., 2011), moral distress (Dudau & Brunetto, 2020; Kristiansen et al., 2015; Zuzelo, 2007) and in some cases, the intention to quit the profession (Brunetto et al., 2016; Holland et al., 2019).

When nurses in published studies (e.g., Bogossian et al., 2014; Halcomb & Ashley, 2017; Hall et al., 2012) spoke about positive aspects of nursing, they noted intrinsic rewards that affirmed their sense of purpose and their passion for the profession. Not only is it what they have been schooled to do, but providing holistic care also mobilises an intrinsic reward, a sense of satisfaction to many nurses. Hall et al. (2012) demonstrated that nurses gained more satisfaction in their work when their unit moved to strategies that provided more patient-centred care. This satisfaction is enhanced with mechanisms for continuity of care – for example, the ability of Ingrid to follow a patient through weeks of therapy until a chronic wound was completely healed (Ingrid,

Chapter 4). Some nurses cited active strategies to nurture intrinsic rewards such as taking pride in one's work (Cope et al., 2016; Craigie et al., 2016; Halcomb & Ashley, 2017).

The challenges that were so often a burden were also a reward, with nurses positively identifying that each day is different, and that nursing affords opportunities for learning and critical thinking on every shift (Tuckett, 2015, p. 261). After studying the variances in three generations of nurses of what keeps them in nursing, Shacklock and Brunetto (2012) found that, among Generation Y (GenY) nurses, their attachment to work itself was strong, as was their passion for the job at hand (2012). This correlated with the passion demonstrated in text excerpts from some of the GenY nurses in this study: Sophie, Leila, Julian and Myra. Stronach and colleagues (2002) interpreted satisfaction or pleasure in work beyond emotional wellbeing. They considered such passion as an ecology of practice: finding a stride of purpose in one's work puts it in the realm of a vocation, rather than simply an occupation.

The nurses' physical proximity to patients in their care settings also positions them as the case manager of a patient's particular care trajectory, liaising not only with doctors but also with allied health colleagues: physical therapists, speech pathologists, dieticians. Sophie laughed when I asked who was the case manager; she felt this was obvious: "the nurses [laughs] – the nurses definitely" (Sophie, Chapter 5). Although the nurse is in a unique position of being a lynchpin of knowledge to liaise with other practitioners, this role can also cause consternation when the nurse must also carry out directives from other health professionals or compete with them for patient time. Harrison expressed stress related to this liaison (Chapter 5). Conversely, some literature described other disciplines approaching nurses for information or for their assessment of the patient, which demonstrated respect for individual nurses' knowledge of the patient's status or their journey through the system (Daiski, 2004; Schluter et al., 2011).

Dealing with competing demands

An ecology of practice for some nurses includes their work ethic, manifested in a discourse of commitment, or conversely in a lack of drive that leads to cynicism in their attitude or decreasing their standards. Many nurses, including examples such as Janelle and Toni in this study, deal with competing workplace demands by working harder, working longer or adhering to their own sense of standards for patient care. Kristiansen and colleagues (2015) studied how nurses try to make sense of contradicting logic in their daily work, and concluded that working harder is one strategy. This came at a cost, with nurses saying they occasionally left their work shift feeling guilty about work left undone. The working longer included working unpaid hours to complete work (Harvey et al., 2015; Harvey et al., 2017), which was particularly unsatisfying if supervisors then insinuated that they should be working smarter and were deficit in ability because they could not get the work done in the normal shift hours (Harvey et al., 2017, p. 5).

By contrast, some nurses may cope by creating a distance. This can take the shape of deflecting personal accountability (Lyneham & Levett-Jones, 2016), building purposeful boundaries (Horsfall & Higgs, 2014) or suppressing emotions (Delgado et al., 2017). At times, the workplace culture, with demands of limited budgets, constrained resources and high turnover of patients, meant that nurses worked to this dominant discourse, which took them away from their own high patient-care standards (Hardy et al., 2002). At other times, just as Leila did in the current study (Chapter 4), nurses worked to their own priorities by refusing to comply with bureaucratic processes or finding ways to navigate around them. For example, E. Willis, Toffolli et al. (2015) wrote of nurses feeling insulted by requirements to document a process of rounding and therefore did not comply with it.

Jones, Johnstone and Duke (2016) described nurses' deliberate strategies to attempt to create room to accomplish everything. They used the nomenclature *cutting corners*, and demonstrated through their literature review that this term has been used in patient safety discourse, and particularly in relation to medication administration where

cutting corners can be a contributing factor to drug errors (p. 2127). It is considered a deliberate act, not an "unwitting deviation of action from intention" (p. 2127) like slips or lapses. As such, participants in their study had an awareness of these actions and justified their engagement in cutting corners with phrases like "it's okay," "saving time" and "on the run" (p. 2128). They also "train people by showing them our favourite corners" (p. 2129). The authors analysed that these actions were not malevolent:

> Even though there was a degree of intentionality to nurses cutting corners, it did not involve intentionally causing harm to patients or the healthcare system. The participants justified the practice of cutting corners because it did not necessarily cause adverse patient outcomes. (p. 2130)

While the act of cutting corners may not be malpractice, it has elements of decreasing one's standard of care.

As well as the nurses' discourses found in the published literature that depict their work, some authors also studied patient and family perspectives. From these perspectives, nurses did not always fare well. Disturbingly, some research showed that being time-poor can be used as blame for nursing care behaviours that are perceived by others as a lack of caring. In the wake of very public investigations into substandard nursing care in the United Kingdom (UK) (Shields, 2014), Australian researchers studied reports from a public blog detailing nursing care in UK National Health Service (NHS) hospitals and aged care centres. Counter to the "grand narratives of nursing," Hutchinson and Jackson (2014, p. 81) found stories in these blogs that they considered to "sit on the outer edges of contemporary professional discourse" (p. 81). They found that "carelessness or disregard was masked behind a mantra of 'too busy' to care" (p. 83), with blog participants writing anecdotes that demonstrated nursing care that bordered on neglect:

> In one experience recounted, a family member wrote of seeking pain relief for her distressed mother and being told; mum was not a priority; they had many people on the ward to care for. Suffering and pain were

> made invisible behind a mask of busyness – nurses barely even noticed my grandmother quietly dying in the corner. (p. 84)

Although a time-poor workload in nurses' perceptions is an established barrier to enacting care activities (Verrall, 2015), in these cases from family and patient perceptions it could be used as an excuse for indifferent care and caring. Hutchinson and Jackson (2014) pointed out that:

> Although statements were made by nurses as to their level of busyness – at the same time they were repeatedly witnessed to be gathered around the front desk and a couple of ante-rooms, chatting at the nursing station, watching TV or others were said to prioritise paperwork over the needs of patients. (p. 83)

This mirrored Janelle's perception about her colleagues who could not wait to get back to the nurses' station to talk (Janelle, Chapter 5).

Research suggests that another emotional strategy used by nurses to cope with competing demands was to develop further insulation from the contexts and managerialism affecting them by building a wall of cynicism, including doubt that anything in their situation would improve. When nurses experience changes in the workplace, especially if they do not have prior experience of change management being effective, they may develop a degree of cynicism that can lead to workplace dissatisfaction and even disengagement (Nguyen et al., 2018). Huntington et al. (2011) demonstrated a level of hopelessness when they wrote:

> I am basically happy with my life but resent the effect work has on it. I struggle regularly to cope with the demands of nursing. This didn't happen in the first 10 – 15 years … I was a keen, professional positive worker … now I feel like a survivor and constantly question my sanity…to cope with the workplace situation. I have had to compromise my standards of work. This has multiple flow-on effects – ultimately, I don't feel as good about myself and my nursing career as I once did. I am always on the lookout for alternative employment. (p. 1417)

Further, a degree of hopelessness coloured nurses' lack of desire to report unsafe workloads or to engage in quality assurance surveys, with the rationale that filling out audits on their work simply added to the work itself (Ross et al., 2019, p. 5).

Before turning my attention to the nuances between economies of performance and ecologies of practice, it is pertinent to address how nurses are preserving their ecologies of practice within the increasing bombardment of economies of performance. Stronach et al. (2002) stated that if professionalism is to be risked in the current climate, nurses will need to re-story themselves against the audit culture. This includes mechanisms for taking control of their lives, particularly when they cannot control their work lives. In Chapter 5, the nurses in this study gave indications of how they were dealing with competing discourses. Nurses studied in the literature employed similar strategies to those in this study to improve their job satisfaction and lifestyle, such as reducing work hours, changing jobs or engaging in study as a pathway out of present situations (Daiski, 2004; Huntington et al., 2011).

Some nurses manipulate work situations to preserve their abilities to cope with the demands of 21st century nursing. Although choosing to remain as a casual staff member may come with disadvantages, such as consistently needing to engage with new wards, and the feeling of displacement that Janelle expressed (Chapter 4), casual work also provided the advantage of distancing nurses from workplace politics (A. Dawson et al., 2014). Despite the notoriously bad reputation that shift work attracts, nurses in studies have also reported shift-work benefits, including fewer interpersonal challenges on the off-shifts such as night duty (Rodwell & Fernando, 2016), and a reduced gaze from management/supervisors (West et al., 2012). As with Gemma in this study (Chapter 5), to some nurses shift-work provided a level of flexibility that assisted family responsibilities, including assisting kin-care and avoiding paid childcare (West et al., 2012).

Many nurses also deal with the demands of work by trying to improve their well-being and their non-work time. One nurse from a Canadian study reflected that utilising

techniques such as meditating may not be possible at work, but the process can help counteract the high-stress environment of nursing:

> I would like to be a better nurse! But it seems to me that I'll only a better nurse if I become a better person. Nursing has given me the opportunity to do this, and I'm free to go and meditate because of the money I earn while nursing. So, it's a win win kind of thing really. (A. Dawson et al., 2014, p. 6/10)

In Browne et al.'s (2018) study, the reputation of stressors in nurses' work preceded a cohort of beginning university students when they noted in a survey their desire for a work-life balance. Jones et al. (2019) studied barriers to compassion in nursing, and found from participants that stress was one of the key antecedents to a lack of compassionate care, with home stress and outside problems cited as impediments to compassionate care. One nurse in Huntington et al.'s (2011) study repositioned herself to deal with competing demands that subsequently changed her demeanour as well as her nursing role:

> I loved the actual work of nursing and midwifery, but didn't have the energy for the continual power, political, economic and environmental challenges. … I came to realise only I could affect any change, so I set myself the goal of getting out of clinical practice, studied for a master's degree while working night duty and caring for my family ... Now I am back to my old self, positive, happy, optimistic and enjoying life and work and feel I am making a difference to patients. (p. 1418)

CAUGHT BETWEEN

Ways of being in both economies and ecologies

Discourses from the nurses' interviews in this study illuminated contemporary economies of performance and revealed ecologies of practice with which the clinical practitioners identified. The data chapters detailed depictions of ecologies where the interpretation of text and context showed threads of narratives where nurses revealed a variety of professional behaviours. This mirrored Stronach et al.'s (2002) reading of their own data, where they commented that these fragments of narratives "did not

characterise an entity so much as they depict dynamic and ambivalent aspects of situated performance" (p. 117).

The data from this study also aligned well with utilising both Fairclough's (1989, 1992, 2003, 2010) theory and his approach to analysis, where examining the discourses of nurses allowed me to focus on how their talk supported not only particular systems of knowledge and beliefs but also how they manifested in ways of being in the institutional culture of 21st century Australian healthcare institutions. In terms of Fairclough's (2010) three box model (Figure 2), the contexts for the nurses (outer box) influenced verbal depictions of their work - and this talk (inner box) - influenced the context. For example, Ingrid recounted after the experience of spending an hour talking about what she does, that she could hear herself being stressed by acute care situations, and more self-assured when talking about community nursing. This is the interplay of discursive dynamics that Fairclough depicted in his model (Fairclough, 1992, p. 86). To repeat from Chapter 3, and drawing on Janks' (1997) observation, one part of the model is always in touch with the other (Chapter 3). Fairclough's mechanisms have served well for investigating nursing practice, as Crowe (2005) purports, to "identify sources of influence that determine particular discursive constructions and how these in turn influence clinical practice" (p. 61).

The data from the current study, supported by researchers' depictions in the literature of the status of Australian nursing, showed professional identities in flux. This encompasses plural identities from each of the nurses individually, as well as collective identities as members in the same professional field. They are not binary: technical vs professional; occupational vs vocational; or traditional vs progressive (Stronach et al., 2002, p. 110). The nurses are continually juggling their professional selves, working between their ideals for practice (holistic nursing, continuity of care, innovation in care, satisfaction in practice) and the threats to their preferred professional styles, including pressures of audit cultures or other external impositions. Stronach et al. (2002) proposed that it is in this juggling that nurses (and teachers in their study) show themselves as professionals, and that accommodation between the two registers

(economies of performance/ecologies of practice) is necessary for professionalism to survive.

Economies alone cannot drive practice

Part of Stronach et al.'s (2002) hope for a continued level of professionalism in nursing practice was that they considered audit discourses at the time of their writing to be "highly vulnerable" (p. 131). I have outlined from the literature that tensions from fiscal constraints, mandated practice and a documentation explosion have significantly increased in 21st century nursing (e.g., Braaf et al., 2015; M. Johnson et al., 2014; Le Lagadec et al., 2020). The data have shown how these economies of performance penetrate nursing practice to the point that they have become a part of it; nurses are not questioning this as part of their role. Myra said that the tick and flick sheets in her workplace were not an accurate depiction of the patient's condition, but she expressed dismay at the quality of documentation by junior nurses, rather than questioning the purpose (Chapter 4). Stenhouse et al. (2016) summarised that the individual nurses become so focused on getting things done that their work "becomes the completion of tasks, jobs and the meeting of targets" (2016, p. 14), and no longer has a purpose of facilitating health or alleviating suffering (p. 14).

The discourse of safety risk assessment and consequent audits demonstrated that nurses were often voicing concerns about the workload attached to quality and risk activities, but that they were participating as mandated to do so and accepting increased documentation as a given (Ross et al., 2019). Stronach et al. (2002) wrote that morale cannot continue to decline without consequences for retention, recruitment and commitment, which has been evident in a number of studies (e.g., Brunetto, Rodwell, et al., 2016; Collard et al., 2020; Shacklock et al., 2014), and in the discourses of non-commitment/cynicism outlined previously. Chapter 4 showed discouragement voiced by nurses like Sophie and Ingrid. Stronach et al. (2002) descriptively summarised their argument for mechanisms of professional behaviour beyond economies of performance:

> One conclusion is that the nature of the current "economy of performance" and its corrosive relation with ecologies of practice offer to professionals such an impoverished intellectual and practical diet that professional lives cannot be sustained. (p. 131)

Ecologies alone cannot drive practice

Likewise, a nursing role built entirely from ecologies of practice would not sustain the needs of modern healthcare, with institutions needing to look at bed turnover, the economics of reserving acute care settings for acute purposes and the expenses of staffing. The desire for holistic care, for example, may be a personal and collective craft ideology among nurses (an ecology of practice) that promotes an affective side to their nursing and that demonstrates commitment (Stronach et al., 2002, p. 132). However, if it remains an ideology and not a proven healthcare asset, it is not sustainable as sustainable capital. The completion of tasks was the expected work of which the nurses spoke when describing their daily practice (see Chapter 4). From the literature, nurses' discourses foregrounded the task aspects of care (something that is "done" or finished or ticked), which overshadowed their ability to deliver ideal and holistic care (Halcomb & Ashley, 2017; Scott et al., 2019; Sim et al., 2018; Suhonen et al., 2018).

O'Keeffe and colleagues (2015, p. 115) noted that, despite the many known impediments, the overall objective for nurses on any shift was to complete the patient-care tasks. One nurse in Bogossian et al.'s (2014) study stated: "Put another way, the 'must dos far outweigh the want to dos'" (p. 379). Another spoke of distressing compromises: "'Lack of time to show real care for patients … is heartbreaking and demoralising for those of us who really do care'" (p. 379). These words conjured a discourse of commitment and, similarly to Janelle in the study (Chapter 4), a perception, or perhaps a virtue script (Stronach, 2002), that it was only some nurses who care this deeply. This perception of a lone martyr was not supported in the data, as examples abounded that depicted many other nurses caring deeply, yet feeling dispirited by their unrealised vision for patient care amongst the realities of practice. Myra, Harrison and Ingrid gave telling examples (see Chapter 4).

Whether virtuous or mythicised, this discourse of commitment, and of patients' holistic care needs beyond physical recovery, is not enough to sustain nursing's future as a profession, at least one based in reality rather than in ideology. Put simply, the nurses may desire to sit with someone and listen to their fears (Ingrid, Chapter 4; Harrison, Chapter 4), but the employer is paying them for their tasks: patients are showered (Harrison, Chapter 4), pilled (Leila, Chapter 4) and put back to bed (Leila, Chapter 4). This ecology of practice, and others presented earlier in the chapter, must be worked *within* economies of performance, and conversely the economy of performance needs to be negotiated *within* ecologies of practice.

Stronach et al. (2002) pointed out that they did not consider one good and the other bad; they provided examples where economies are a positive impact on the work at hand, and where ecologies can be a negative influence on working as a professional. For example, in their writing about holistic care, they considered the possibility that holistic care had become a nostalgic myth or a utopian dream and thus, for nurses trying to reach this ideal, a figurative noose. In this sense, they painted holistic care (and evidence for practice as another example) not as positive ecologies, but as constrictive economies of performance (p. 114).

Data from the present study supported that economies of performance have some benefits. There were instances, for example, where the nurses felt that documentation charts were appropriate. Leila, who shared her experienced of anger when an incident of nursing negligence led to two patients dying of sepsis, stated: "It was there in the purple, in the orange and in the yellow, and they don't write a number there" (Leila, Chapter 4). She felt in this instance that a lack of a professional knowledge ecology was the issue, and that the documentation requirement (the economy of performance) could have been a positive influence if the nurses had paid attention to it. Stronach et al. (2002) stated that professional responses may be seen at the juncture between ecologies of practice and economies of performance. Although these professional responses potentially can be called forward, as this anecdote demonstrated, they are not a given.

Stronach et al.'s (2002) concepts of economies of performance and ecologies of practice served as registers for their theory of a "tension" (p. 125) for nurses. A status of professionalism is demonstrated when nurses are caught between these two metadiscourses. By using the term *metadiscourse* (which is my own term applied to their concepts, not Stronach et al.'s), I am highlighting that the concept of an economy of performance and an ecology of practice is discursively constructed. The former may represent an outside-in lens (Stronach et al. 2002), and the latter a conglomeration of inside-out qualities, but they are not a "thing" that can be inhabited or predicted for every situation or context.

Similarly to Fairclough's (1989, 1992, 2003, 2010) orientation to the construction of the social world that was explored in Chapter 2, a sense of realism exists, in that nurses work within constraints of documentation-heavy, bureaucratic institutions, but there is room for agency. With evidence of professional behaviour within practices, this augurs well for some hope in relation to the status of nurses as professionals. Room for movement theoretically exists within the symbolism of tension between Fairclough's boxes: the individual nurses and the profession of nursing working within contexts but also against them. Stronach et al. (2002) described this in the metaphor of a pulse – moving back and forth against itself, not simply a "push." In meeting at the juncture, the professional self "emerges as a contradictory effect rather than an agent within the audit culture" (p. 130).

In Stronach et al.'s (2002) reading of the professional, individual nurses were not "compliant technicians" (p. 112) mindlessly fulfilling audits and checklists; it was both the working within and the pushing against economies of performance that demonstrated professional nursing. As Stronach et al. argued, "It follows, of course, that how an 'economy of performance' is negotiated in relation to the ecologies of professional practice is vital to the well-being of the profession, and indeed to its future existence as a 'profession'" (p. 130). They suggested that an economy of performance calls forth an ecological response – even if that is tokenism or withholding of enthusiasm (p. 130). Negative responses may depict nurses constrained by the audit

culture, but in the many instances of give and take they are still searching for and working towards a professional ideal.

Ecologies at the juncture

These ecological responses, evident from the data from the nurses in this study, provided many examples of professional action in their daily work. Those that manifested highly stemmed from some of the traditional hallmarks considered as professional: autonomy, knowledge for practice and a moral compass (Stronach et al., 2002). It was no coincidence that these ecologies came with a level of risk (for the practitioner and sometimes the situation) when nurses brought them into their actions.

Where a nurse can exercise autonomy, professionalism can not only be seen but can also be cultivated. Data collated from the nurses' interviews demonstrated professional behaviour when the nurses were working from their knowledge or moral compass rather than following a script, a directive or a checklist. Not only did these actions demonstrate the behaviours of professional workers, but also, they provided satisfaction to the individual nurses involved, a sense of ownership over their work and pride with regard to what they could accomplish. Ingrid questioned the dose of a drug that nurses had been administering as it was prescribed but was not a correct dose for the situation (Chapter 4). Sophie pushed for a patient with respiratory stridor to be attended to by physicians; she had to work through and around the team to accomplish this, and she felt vindicated when the patient was eventually admitted to the ICU (Chapter 4). Not only did she honour her professional judgement, but also, she grew from the experience and indicated that it was transformational for herself personally: "Now I would be phoning that ICU reg until they come down" (Sophie). This, to me, signalled an example in line with Fairclough's (1992) concepts underpinning his model of where the text is influencing the context.

Sophie came to this realisation in the process of formulating her thoughts and conversation in this research. Further examples of autonomy extended beyond knowledge for making clinical decisions to the organisation of one's workflow. This

was seen particularly in specialties, such as Leila describing her ICU workday: “no one comes and fiddles with you,” “it’s your patient” and “it’s your little space” (Chapter 4).

The nurses in this study demonstrated varying degrees of accountability for their practice in their autonomous actions. Leila moved to first person in her dialogue of patient care to demonstrate a personal responsibility: “It’s up to me what happens with that patient.” She stated, “I organise it,” and “I have to make sure” (Leila, Chapter 5). Both Leila and Sophie assumed responsibility for obtaining medical reviews of their deteriorating patients, believing that the accountability was inherent in their role. In contrast, Harrison acted within the boundaries of prescribed practice in reporting a change within a patient’s condition to the attending doctor, but he terminated his responsibility with those actions, stating: “It’s like, once you've notified the other people as well, it’s like beyond your - it’s not - it's sort of not your responsibility any more. You’ve notified the people” (Harrison, Chapter 4). In this anecdote, his actions were unconvincing as professional behaviours. In these contrasting anecdotes, the nurses’ ecologies of practice were displayed as actions (or inaction) when facing organisational economies such as the systems in place for patient review.

The nurses described that they were willing to accept the accountability necessary for practice. They showed that this could be a measure of trust in their practices rather than an overlay of economies that measured their performance. Documentation was an example of this. In Chapter 4, I highlighted that Debra demonstrated her irritation with the scale of documentation required for recording nursing actions, and the lack of trust that it implied. She perceived this as an insult to her professionalism, and she lamented this surveillance of her work: “I know I jolly well did do it” (Chapter 4).

These nurses and those in the literature were cognisant of navigating the competing discourses of economies of performance juxtaposed against their own ecologies of practice. In fact, the bulk of the research outlined difficulties for current practice. They were also cognisant of sources of influence that could affect and impact on their clinical practice. Supportive teams and supervisors were two examples (Janelle,

Chapter 4; Leila, Chapter 4). A nurse in Wilkes et al.'s (2016) study equated the ability to give autonomous care with enjoyment in her job, and another stated that management can assist this: "Management needs to be more positive, needs to give us a sense of validation – not micro manage, give us more autonomy" (p. 660).

To make clinical judgements, and thus to employ autonomy in their work, nurses work with their underlying knowledge and experience. This was clear in the literature addressed previously, where Hardy et al. (2002) suggested that nurses suppressed innovation if it lay outside the organisational structure. Autonomy in a clinical job is not meant to imply being rogue or independent of the process of nursing; it is about using clinical judgement to interpret situations. Nurses in Hoyle et al.'s (2014a) study respected the ability to rely on their own knowledge, clinical judgement and acumen to guide their practice. One reflected that standardised advice could be useful as a guideline, but that nurses needed to interpret beyond standardisation utilising clinical decision-making skills (Hoyle, 2014a). In this study, Myra spoke with futility about whether falls risk audits could give an indication of a patient's risk of falling; she felt that nurses' judgements could be trusted further than an audit (Chapter 4). A Canadian nurse scholar (Slemon, 2018) investigated well-known examples of standardisation that affected nurses' work (e.g., pain scales, scales used in Canada for triaging patients through an emergency department and language for the categories that determine a cause of death), and she concluded from these exemplars that nursing knowledge and the healthcare trajectory of patients and communities are constrained by standardisation measures. She stated that the emergency room triage categories may not morph quickly enough for the evolving needs of those who present for care, and she used the example of the opioid crisis. She claimed that in order to adapt to changing contexts, nursing knowledge and nursing practice need to come from nurses themselves, not simply from standardised scripts. One suspects that, if she were writing today, she would also include the example of COVID-19.

The data of this research also demonstrated examples of the nurses taking a moral stance. Leila's passionate anecdote about nurses using the ADDs charts, but not adding their own assessment or knowledge parameters to the situation, demonstrated her own

sense of accountability and her adamant belief that professional nursing should stem from a knowledge base. She qualified that intuitive knowledge should be present:

> It shouldn't matter if they write a number; they should know that a blood pressure of, I don't know, 80 systolic with no urine output and a decreased level of consciousness isn't any good, but they don't pick up on it – well, they didn't pick up on it clearly. (Chapter 4)

She finished with disdain, comparing these nurses' actions with antiquated images of nursing:

> It's just not right. If you want to call yourself a nurse not in the 1920s when all we did was change bed pans. We're not there anymore. We do more than that. We're more important than that now. (Chapter 4)

This example demonstrated Stronach et al.'s (2002) point that the economies of performance are not all bad. In this case, the checklist could be a framework that provided efficiency for the basics to be covered, but there was an assumption that a professional nurse would work beyond the framework of this lowest common denominator. Leila was not saying that the ADD chart was at fault here – she commented that the nurses involved did not demonstrate professionalism in their monitoring of this patient. Her own professional stance demonstrated several ecologies of practice (e.g., nursing knowledge, nursing accountability, responsibility, advocacy and trust) that, if utilised in this situation, would have worked contrarily to simply auditing and charting the situation.

Other examples from the data demonstrated nurses taking a professional stance, and the behaviour it took to enact this stance. Julian went to lengths to advocate for a situation he judged as morally wrong. These actions came at a cost of feeling unsupported. He believed that his colleagues deserted him, and his employer asked him to find employment elsewhere (Chapter 5). Toni acted on a case of injustice that she worked through the hierarchy of management to report; the incident led to her taking stress-leave and engaging in psychological counselling (Chapter 5). Windows into professional behaviour were evident when the nurses provided examples of working from their moral compass rather than merely following a script.

At one stage in the research, I experienced disappointment when one of the nurses who had given examples of professionalism in her anecdotes of working from an "inside-out" ethos - questioning boundaries, working to her own practice, extending her knowledge level, being critical of things that were not right – also told of doing something I considered to be *un*professional. She recounted asking a colleague to fill out her competency worksheet that the hospital had mandated in response to nurses not understanding the deteriorating signs of sepsis (Leila, Chapter 5). I realise now, though, that this was because she *was* able to question the boundaries; she took a stand with regard to the decree. Again, this anecdote demonstrated a juncture between ecologies and economy of performance. Leila interpreted the mandate as a punishment; she expressed her desire for more trust from her organisation, both for her individually and collectively for the profession; she expected more professional treatment than the punishment of a worksheet.

With trust comes risk, and this was the point that nurses acting as professionals demonstrated in their push back of economies of performance. Measures and competencies to fill out are not only a poor indicator of actual ability, but are also demotivational in their effects (Stronach et al., 2002, p. 131). In Stronach et al.'s (2002) idea of the status of professionals:

> Professionalism, then … has to rely, in the end, on positive trust rather than be driven by performance ranking. If professionalism is to be "risked" once more, such a risk will involve re-negotiating an economy of performance from *within* professional ecologies of practice. (p. 131)

This gives permission for the "push and pull," the "pulse" (p. 131) required between these registers of practice for registered nurses in 21st century Australian nursing fields.

CHAPTER SUMMARY

Chapter 6 provides an analysis of published literature in light of the data from this study, and demonstrates that nurses are navigating their practices within complex and demanding sociocultural contexts. Within these contexts they are utilising nursing skills in a broad sense, and drawing on personal attributes for their practices. Considering the theory for this study, these behaviours can be called “professional” at times. This professionalism was often seen at the juncture of where a contextual economy of performance called for a response from within a nurse’s individual ecology of practice.

CHAPTER 7: CONCLUSIONS

This study set out to investigate whether Australian registered nurses involved in direct patient care are thinking and acting as professionals in their roles. The research aim was to study data from experienced registered nurses in Australia to reveal the discourses that they utilised to articulate and explain their practices, their role performance and their cultures of practice. Through methods of Critical Discourse Analysis, I elicited rich data from 12 nurses in diverse practice fields, and examined these data to achieve a picture of what nurses working in direct patient care were negotiating in order to achieve both the demands of the job and a sense of satisfaction with their role. I analysed these data with reference to theories of professionalism to conclude that professional nursing does exist in contemporary Australia.

This final chapter briefly recaps the research process in the previous chapters to before outlining the findings from this research. Implications for nurses are considered, with suggestions for supporting nurses to continually pursue their ideals and the professional aspects of their practice. The significance of the findings and the implications for nursing are then explored before nominating contributions to knowledge. Limitations are addressed, as well as considerations for future research studies and my personal reflections regarding this learning journey.

RESEARCH PROCESS

The study was outlined and the research questions were articulated in Chapter 1:

> **Research Question 1**: How do discourses of registered nurses working in direct patient care reflect their ability to enact professional nursing practices in day-to-day work?
>
> **Research Question 2:** How do nurses say that they (and other nurses) deal with competing discourses in their practice fields?

Chapter 1 explained the impetus for this study and outlined the difficulties in ascribing the concept of a *profession* and its derivatives, such as *professional, professionalism and professional identity*, to nurses. It explored the political and economic contexts of the current Australian healthcare systems within which nurses work

Chapter 2 provided the theoretical framework underpinning this study. It consisted of a concept of professionalism distilled from the work of Stronach, Corbin, McNamara, Stark and Warne (2002), which aligned well with the use of Fairclough's (1989, 1992, 1995, 2005) theory of discourse as social meaning and his realistic stance in critical studies of the social world.

In Chapter 3, I explained the research design and the processes undertaken to gather, study and analyse data. The design employed methods derived from those that Fairclough (1989, 2001a, 2003, 2010) developed within the paradigm of critical discourse analysis for the purpose of understanding language and meaning in the contexts of social structures. His contributions to critical discourse analysis include theory development as well as tools for method. This study used both. Following his concept of three aspects of discourse analysis, I adapted his text-interaction-context model to this study and to the use of interview material for all three of these aspects. The research participation processes were outlined in this chapter.

With each covering a separate research question, Chapters 4 and 5 presented the collation of the linguistic, contextual and interpretive analysis of the interview data in a format that followed the methodological framework to present and analyse material from the interview transcripts. Verbatim excerpts from the participants' transcripts were included to show context and transparency for my interpretation of the nurses' talk and my analysis of the discourses that emerged. Chapter 4 examined Research Question 1, which focused on how discourses of registered nurses working in direct patient care reflected their ability to enact professional nursing practices in day-to-day work. The data analysis occurred from three angles. These aligned with Fairclough's (1995) theoretical boxes and examined the nurses' interview data, which were

considered as text, their clues to the contexts within which they worked and a level of interpretation regarding the actions that allowed them to act as professionals.

In Chapter 5, the analysis demonstrated a broader picture of the nurses' work lives, with an emphasis on how they were constructing careers and how they dealt with competing demands in their everyday practice. This was in answer to Research Question 2, which was about how nurses say that they (and other nurses) deal with competing discourses in their practice fields.

A final stage of analysis occurred through Chapter 6, which resulted from funnelling the responses to the two research questions and synthesising the interpretations from the earlier chapters with a breadth of research literature to explain the current professional position of nurses. Nursing literature was included as an order of discourse and supported the contexts of the social world discussed by Fairclough (1992, 2003, 2010, 2015; Fairclough et al., 2004). Indeed, my thinking about the research literature as a layer of context resulted in the presentation of the literature review after, rather than before, the presentation of data. Providing contemporary literature also updated Stronach et al.'s (2002) consideration of professional nursing.

SUMMARY OF THE DISCOURSES

Discourses of practising professionally

Collating, interpreting and analysing the nurses' responses from within a minimally bounded interview discussion resulted in clear indications of their abilities to act with professional behaviours, and of instances where their ideal actions were not possible. This began the analysis for Research Question 1 regarding how the nurses' discourses reflected their ability to enact professional nursing practices. The findings are summarised below.

Text

- Task-based care
- Holistic care
- Nursing by the numbers
- Discourses of fear

The nurses in this study shared a picture of working in tiers of direct patient care. This included task-based performance as well as care portrayed as higher order care, such as administering treatment regimes, monitoring patients' status, and attending to psychosocial and rehabilitative needs. Pervasive requirements for auditing and documenting that care permeated all tiers. Emotional involvement with their work was expressed both in their text and in the linguistic analysis of that text, and a discourse of fear emerged as they spoke of the implications of their practices.

Context

- Fiscal controls
- Institutional management
- Relationships/culture

The context affected the nurses' experiences of care-giving. Fiscal controls included unequal resourcing depending on the ward type and systems of specified patient throughput. The nurses portrayed the institutional management as subsisting remotely from the ward work, but as impacting significantly upon their daily work, particularly with mandated reporting and auditing requirements. Relationships could affect the nurses' work experiences, particularly whether team leaders, nurses in mentoring positions or nurse unit managers provided line level support.

Interpretation

- Nursing interventions
- Responsibility
- Knowledge for practice

The nurses showed that their more professional nursing interventions such as patient-teaching were hampered by the volume of task-based care and audit requirements, which left feelings of discouragement or strategies to stay focussed on the tasks required. At times, this included avoiding more holistic aspects of care, such as avoiding initiating nursing interventions or time-consuming dialogue with patients. The nurses' sense of responsibility for their decisions and their actions was variable across a continuum of professional behaviours. Knowledge for practice impacted on the nurses' decision-making skills, and was exhibited in degrees of professional behaviour.

Discourses of competing demands

Chapter 5 utilised the same interviews to examine Research Question 2, which asked how nurses spoke of dealing with competing discourses in their practice fields.

Text

- Building expertise
- Preserving autonomy
- Finding rewards
- Lowering standards

The nurses dealt with competing demands by finding defensive strategies to cope with work and by re-storying themselves within that work to make it palatable for themselves. This included building expertise in their practices, working towards the reward of a specialty or engaging in outside study for career development. Some preserved their boundaries by choosing their work situations, including working particular shift hours and avoiding management positions. The nurses found rewards in patient accolades or in an internal emotional feeling of a rewarding day, but they voiced discouragement in response to the rarity of this. Sometimes the nurses dealt with demands by lowering their standards and their level of engagement.

Context

- System constraints
- System supports
- Institutional responses
- Diminished expectations

The contextual constraints included resourcing deficits, with staffing numbers and staffing skill-mix featuring prominently. The nurses appreciated when management provided supports such as an intensive care clinical nurse mentoring nurses on the wards. There were examples of negative feelings towards management responses regarding issues that needed advocacy, and low expectations for workplace improvements.

Interpretation

- Dealing with ward work
- Lack of leadership
- Transformational experiences

Interpretation of the nurses' references to professional attitudes showed many tensions arising from their work in the wards, which constrained them from being able to move beyond task-based work to utilise more professional skills for practice. They voiced feelings of isolation when support from leaders was lacking. By contrast, for some of the participants, their reflection on critical events revealed positive transformational components of these experiences.

Orders of discourse/professionalism

In Chapter 6, I considered how the findings of Chapters 4 and 5 related to discourses of nurses and of nursing work in wider contexts presented through the nursing literature. Alignment with the literature was evident in the volume of task-based care and the volume of documentation. I noted some divergence as well; for instance, the literature captured nurses' discourses of workplace behaviours of bullying and incivility that were not prominent in this study. Additionally, several studies reported

on research regarding systems of rounding found in some Australian healthcare situations, but not noted by the participants in this study.

The study's findings showed that professionalism exists within and against the sociocultural constraints, and that it is within the movement back and forth between ecologies of practice and economies of performance that the nurses could be called professionals. They showed hallmarks of professionalism, including knowledge for practice, autonomy and responsibility.

Throughout this research, for the reasons outlined in Chapter 1, I have shied from naming the concepts of professionalism under study as one's professional identity. I still believe that focusing on one aspect of professionalism, such as identity, is too narrow for identifying whether nurses can practise as professionals. This research has supported that premise. *Professional* as an adjective, being a *professional* and *professionalism* may be broad in language terms, but the study has shown specificity in attributes and actions. These emerged through ecologies of practice, most specifically when they intersected with the situated economies of performance. The visible ecologies of practice embraced not only how nurses identified with being a professional, but also how they enacted that role, how they demonstrated it to others and how they fought for it amongst ever encroaching economies of performance.

These professional behaviours exhibited as a continuum, with the nurses across the study showing varying degrees of professional actions and attributes. The study did not aim to quantify those behaviours, but the acknowledgement of a continuum notes that the nurses were not uniform in either their approach to care or their attitudes towards their role.

The final section of Chapter 6 summarised that the professional attributes and behaviours exhibited by the nurses in this study occurred in response to contextual influences affecting their work. Professionalism in nursing occurred at this juncture when nurses' ecologies of practice were utilised as necessary responses to economies of performance.

STUDY'S FINDINGS

Collective findings from this study were evident after considering the discourses of the nurses in the study, the theory underpinning the processes of analysis and the conclusions about professional nursing.

A synthesis of the overall research findings follows:

1. The nurses portrayed many daily practices, expected in their jobs, which did not initially seem to be professional nursing. They shared their frustrations regarding the repetitive tasks that expended their time and focus; frustrations that were amplified by consuming paperwork or electronic documentation mandated either to record these tasks or to fulfil a discourse of safety. In meeting these tasks, though, professionalism could be seen in specific actions that went beyond the task. This encompassed nursing interventions requiring knowledge, agency in execution and accountability in following through.

2. A discourse of holistic care permeated through the nurses' talk. When it was achievable, such as a story of palliative care with a patient and her family, the nurse stated that she felt rewarded. Although she cried in the re-telling, she remembered the care episode positively. In contrast, these same discourses, grouped under the umbrella of holistic care, often encumbered the nurses with feelings of discouragement and a hopelessness for not achieving their ideals. As one research participant said, having a good day was "becoming very, very hard to achieve these days" (Sophie, Chapter 4). Yearnings for holistic care included desirable nursing actions, such as patient teaching and psychosocial care, which have traditionally been assumed to be part of a registered nurse's scope of practice. The holistic care references also included desirable behaviours emanating from more personal attributes: the ability to show kindness, empathy, the understanding of the patient as a person and respect for their dignity.

3. The nurses' work roles revealed an expansive scope of practice that was often poorly defined. Nurses were performing administrative tasks and routines for patients' activities of daily living that could be delegated to others. Although the nurses voiced a desire for proximity and continuity of care to give them close access to patients for assessment and subsequent problem-solving, this research also showed that these high ideals may be serving the institution more than the nursing role. Proximity and single ownership of care can leave the registered nurse in a position of doing everything; something that they also rejected as unpalatable. As one nurse repeatedly expressed, "[Everything] falls back to the nurses."

4. Knowledge for practice included knowledge for nursing actions directly related to medical treatments and monitoring of patients. Nursing roles were significantly aligned with actions that were directed by the medical staff, and occasionally by the allied healthcare staff. These actions became more than tasks when professional behaviours could be seen in the responsibility and accountability that nurses applied. They showed expertise and professionalism when their knowledge helped them to advance the patient's medical care, and when clinical foresight improved the trajectory of recovery.

5. Knowledge was aligned with confidence and was displayed especially in autonomous responses to system culture, conventions or mandates. Knowledge provided confidence for nurses when they needed to advocate for action, such as insisting that a patient be medically reviewed. Knowledge also aligned with expertise, and the nurses found reward in this expertise. Some of the nurses sought formal qualifications in a speciality, but qualifications were not the only determinant of knowledge. The nurses also showed their expertise of how to function in clinical practice, such as the knowledge of a pathway for palliative care or the understanding of a wound care trajectory. Transformational experiences and the recounting of critical incidents provided insight into the nurses' professional growth and continual formation.

6. The nurses highlighted systems, procedures and enculturated practices that impacted on their daily work, but they also demonstrated autonomous actions that belied routine and superficiality. Autonomy showed in actions where they read the clinical situation and used multiple ways of thinking within their ecologies of practice to now seek solutions. These ecologies were different for each nurse, and they contained a continuum of behaviours that could be considered professional. Behaviours ranged from seemingly offhand comments that questioned why the wards had a collective obsessive culture of expecting patients to be showered by a deadline, to overcoming intense intimidation when navigating a frightening personality whose expertise was paramount to remedying an unfolding critical situation. Professional behaviours across this continuum were thus seen at junctures within enculturated practices when nurses could question or act agentically.

7. The study showed that the nurses valued leadership as a professional behaviour, but that they rarely identified themselves as leaders. They did identify positive supervisors; a couple were credited as pivotal to individual nurses' sense of security. They valued mentors such as the registered nurses sent from intensive care to assist with MET calls. They demonstrated instances of personal leadership skills without identifying them as such. Confronting and providing an alternative to the new graduates who were falsifying their care plans was one example. The nurses did not refer to organisational mechanisms that encouraged their ideas or acumen within the organisation. This included two nurses whose higher duties were notably administrative tasks such as roster scheduling and policy documentation.

8. The nurses understood the safety dialogue inherent in much of the lamented documentation expected in practice, but they were willing to be accountable for many aspects of care with a professional acceptance of responsibility and a less visible measurement of accountability. They questioned the reliability of

audit tools, such as falls risk assessments, assuring that they felt their assessment was done intuitively in the care situation. While some resented competencies being prescribed, all the research participants resented the overlay of documentation. Among the anecdotes that they described were 10-page booklets, electronic theatre input that could hold up the next case and notes that were separate from those of the physicians and the allied health personnel. They did not accept that standardisation brought efficiency to their work and, in some cases, they felt that it was dangerous – for example, when nurses filled in forms but did not evaluate the observations in those results.

9. Many of the aspects of the nurses' care and their caring were driven from the inside-out professionalism that Stronach et al. (2002) highlighted. For instance, a strong moral compass could be seen when the nurses took a stand against others' unsafe behaviours. Additionally, instances of injustice were reported, which in two cases resulted in the high price of stress leave for the whistle-blowers and lingering resentment resulting from a lack of managerial support. Some of this professional conduct appeared more subtly – for example, speaking of dignity for patients under anaesthesia, or questioning the ethics of unsafe overtime.

10. The nurses provided examples of how they were re-storying themselves in their present-day practice by choosing jobs for the rewards that the job afforded, such as an environment with a palatable patient ratio, the autonomy of managing one's own work flow in ICU or continuity of care in community nursing or general practice (GP practices). As well as seeking autonomy in the care of patients, they sought autonomy in the care of themselves, by choosing to remain casual, choosing shifts that worked with family life or choosing to avoid supervisory/management positions.

IMPLICATIONS

There are clear implications for nursing from these findings. Given that professionalism manifests at the juncture of where ecologies of practice meet economies of performance, implications from this study can be applied to both sides of the juncture in anticipation of keeping the pulse that Stronach et al. (2002) referred to as a strong pulse.

An ecology of practice perspective

At the end of Chapter 6, I quoted Stronach et al. (2002) when they suggested that, for professionalism to survive, economies of performance need to be negotiated from *within* ecologies of practice. I interpret this, and the findings of this study, as a call for nurses to embrace registered nursing as a professional field, to wear this badge not figuratively but practically, by engaging with mechanisms for empowerment to fulfil professional ideals.

This study indicates that nurturing and fostering nurses' ecologies of practice will impact on their professional orientation and abilities. The research showed that clinical decisions, whether collaborative interventions related to medical care, or holistic care that strengthened the patient's recovery resources, were comprised of knowledge, confidence and the ability to communicate outcomes of assessments. This has implications for both pre-registration nursing education and continued education in the field. As Benner (2015) asserted, a professional orientation is not derived simply from infused technical knowledge; therefore, pedagogies are needed to cultivate it as well as mechanisms for developing attributes and skilled know-how in the field.

The nurses in the study, through the discourses that they favoured, provided evidence of what they felt was beneficial in building their knowledge ecologies. One example was the desire for specialising in a field, thus arming themselves with knowledge, expertise and confidence. In some fields, this also provided autonomy. Even the medical wards, provided evidence of expertise, despite being maligned generally

throughout the study as underserviced wards with “crumbly” patients, provided evidence of expertise. One nurse identified the tedium and hard work depicted by others, but found expertise and pride in ownership of this as a specialty.

There are implications for professional bodies, as well as for institutions driving healthcare, to foster nurses’ growth in knowledge and ownership of specialties, thus encouraging and rewarding continued professional development within fields. Likewise, managements within healthcare services could find mechanisms to reduce economies of performance contrary to this objective, possibly through staffing models and gradual changes to organisational culture. It is possible that these may even be economical when recognising nurses as a valuable commodity in a particular field, rather than a generic nurse who can easily be pulled to another floor to fill routine tasks.

The nurses showed that they accessed those in positions directly above them who could teach or mentor, including effective nurse unit managers, team leaders and outreach educators such as from ICU. The study indicated, however, that such opportunities were not always a given, perhaps owing to flattened management structures and hence the disappearance of positions because of economic rationalisation. The use of appropriate mentoring resources is valuable, not only for clinical nurses’ knowledge gaps, but also for situated coaching in times of decision-making or emotional challenges, such as in relation to the discourse of fear that peppered many interviews.

Beyond staff supervision, the registered nurses did not identify avenues for their own positions as leaders. They did not depict pathways for bringing their ideas forward or for participating in improvements for practice. In fact, one nurse said that she hoped staff members would “chuck a fit” to maintain the outreach position that they found helpful. This comment showed enculturation in registered nurses positioned as workers; they did not see other channels for expressing their feedback. The nurses said that they were avoiding management positions for the purposes of preserving work and stress boundaries. They did not address that leadership attributes could also be fostered in the positions they presently held as registered nurses. These implications

pointed to a need to expand nurses' attitudes towards the possibilities of professional leadership, and to foster transformational leadership to encourage and utilise the potentially rich ecologies of practice that were evident.

The nurses demonstrated mechanisms for building their own resilience to the economies of performance that pressurised their work lives. These ranged from boosting stress antidotes, such as meditating and avoiding work social events, to drawing boundaries around work hours, work effort or their own expectations for change. Many studies that examined nurses' work have recommended solutions such as increasing resilience strategies (e.g., Cope et al., 2016; Delgado et al., 2017; van der Riet et al., 2018). These utopian fixes may over-emphasise fixing the nurse rather than the system.

An economy of performance perspective

While it may possibly seem even more utopian to try to fix the system, constraints depicted in this research showed that it is worth trying. Expecting nurses to work harder, smarter or longer, or reducing their hours to part-time contracts that reduce capacity for mortgage repayments, may bring nurses to a breaking point beyond the tensions for professionalism seen in this study. Certainly, the stresses were evident in the nurses' discourses, tenor of conversation and choice of topics. In the wider context, the review of the literature showed nurses' intentions to quit nursing (Brunetto et al., 2016; Holland et al., 2019; Rodwell et al., 2014), and evidence of moral distress or burnout (Dudau & Brunetto, 2020; Zuzelo, 2007).

Changes to economies of performance may seem costly to implement, but it is possible that they could be more economical in the long term if registered nurses are being used for *nursing*. The example of one of the nurses going from ward to ward to procure linen begs the question of whether the nursing time is factored into a budget that rations supplies to the point of shortage.

Institutions need to explore mechanisms to free nurses to do nursing care in the widest scope of what this entails (not simply activities of daily living care or comfort care). Nurses and nurses' leadership could better articulate and defend the boundaries of practice, and this requires understanding these boundaries first. This requires both an economy and an ecology adjustment. Nursing at the clinical front may need some "letting go" of traditions and enculturated practice, acknowledging what is realistic for an episode of care. In some settings, such as contexts with rapid throughput of patients, this might entail the ability to fix "the hole in the person," but possibly not the "whole" person. Institutional management could acknowledge and promote different staffing needs for different ward types, and nurses could avoid their ecology of trying to do all, which ultimately results in creating yet another economy of performance for themselves.

A discourse of documentation (paper-based and electronic) emerged in this study, and the quantity of safety audits needs attention. Investigating the duplication and additive effects from an institutional point of view may underpin changes and economic rationalism if staffing costs, in terms of the productivity lost to paperwork, could be accounted for. Here those in nursing management could look at whether some of this paperwork has been designed for a discourse of holistic care that may never articulate into practical direction for daily care planning. The 10-page nursing admission history is an example. Additionally, one nurse recounted that, in his institution, the doctors' and allied health workers' notes are separate from the nurses'.

The discourse of fear that ran across the study needs attention for nurses' well-being, and to understand the mechanisms underlying these fears. As the research has shown, registered nurses are willing to wear accountability, but they need to be supported to do so. Their anecdotes showed that many of their concerns were about not being able to keep up with the required workload of their role, and about the potential that this had for causing harm or neglect. A simple example was a nurse's fear that the patient fell because she left the fragile woman when she needed to attend to someone else. Political will, government policy and institutional missions need to investigate and support adequate nurse/patient staffing ratios. Additionally, registered nurses deserve

transparent and supportive processes to exercise their professional ecologies in defending safe practices, advocating for clients or staff members and reporting instances of malpractice or potential harm. They should not face fear in the decision to do so, or a lack of support in the process or its aftermath.

CONTRIBUTIONS TO KNOWLEDGE

This study adds to what is known about the clinical work of nurses and how they work as professionals. The findings have revealed multiple contextual constraints for the nurses who participated in this study. The effects that they portrayed of working within 21st century demands of economic rationalism confirmed similar results from prior research studies and nursing literature. I was able to show, using an original theoretical framework designed for this study, that, despite pervasive audit cultures, efficiency mandates and increasing workloads invading the nurses' work, they provided examples of utilising many hallmark attributes of professionals. These included comprehensive nursing knowledge and skilled delivery for both autonomous and collaborative nursing interventions. Additionally, their discourses portrayed professional behaviours, attitudes and actions.

The use of this particular theoretical framework, which drew on the work of Stronach et al. (2002) and Fairclough (1989, 1992, 1995, 2003, 2010, 2015), has also contributed to knowledge. Stronach et al.'s theory of a tension as the pivot point where nurses battle for but succeed in acting as professionals was found useful nearly two decades since it was first proposed. Fairclough's writings of the possibilities of agency for individuals and the realism of contexts have influenced an account of these sometimes-opposing forces that are the same necessary tensions that Stronach et al. proposed. The present study showed how the two frameworks spoke to the same points, and using them together is an important contribution to theoretical knowledge.

Considering a range of terms related to professionalism assisted the conceptual process of research and elicited a breadth of answers that a specific definition may not have

afforded. The nurses showed multiple angles of this concept – for instance, *professional identity* (that 21st century nursing is more than following checklists), *professionalism* (in skilled knowledge and actions) and *being a professional* (advocating, working autonomously and working ethically).

Finally, this study contributes to methodological knowledge in research. Using Fairclough's (1992, 1995) framework was both consistent with what others have done, but also innovative in approach. Capitalising on generating the data from interviews, I was able to use the nurses' texts, and the discourses that emanated from them, throughout all three of the angles of analysis that Fairclough proposed. The texts themselves became a means for studying both context and interpretation of that context that supported the research aim of evaluating professionalism. I also used a review of the literature as part of the study, grounding the nurses' discourses within existing discourses found in published works. Fairclough (2001b) highlighted flexibility within his methods, and this study provides one more example of how that might be done.

CONSIDERATIONS FOR FUTURE RESEARCH

Although the number of participants did not allow generalising to larger populations, the study did consider the data relative to findings in contemporary nursing literature, and found that insights about the contexts and professional roles that registered nurses were negotiating were aligned with other Australian research. It would be useful, however, to conduct this research in other settings. Investigating the discourses of similarly experienced nurses in other regions in Queensland, or in other Australian states/territories, would provide meaningful insights into the professional role abilities of registered nurses nationally.

Owing to the breadth of research, the study could not explore in depth the singular attributes of professionalism that emerged from the nurses' discourses. Future research could continue this exploration by dialoguing further with practising registered nurses

to examine aspects of their professional nursing roles, such as leadership, ethical decision-making or communication strategies.

Further research examining the influences behind the professional orientation of nurses would help to build on the study's findings related to nurses' ecologies of practice. While this study was able to show professional behaviours in a group of nurses, it was beyond the research scope to explore how they acquired these behaviours, or why some displayed more than others on a continuum. The lenses of other nursing or sociological theories, such as Bourdieu's (1990, 1991) notions of *habitus,* could be used to continue to understand contemporary Australian registered nurses as professionals.

Longitudinal studies, built on this research framework, could explore nurses' professional affiliation as they move from pre-registration nursing students, to novice practitioners, and then to the stage of more experienced nurses such as those who participated in this study. This could inform what is known about identity affiliation and growth (or stymied growth) in professional roles. Such contributions to knowledge could have pragmatic implications and potentially be transferred to strategies for nurses' professional development, such as pedagogies in education or mentorships in practice apprenticeships.

Likewise, some of this study's findings of established conventions that served as constraints on nurses' practice as professionals (economies of performance) warrant additional studies. For example, the findings underlined a breadth of documentation, audit mandates and risk assessments in the settings within which the nurses work. Some of the nurses expressed doubt regarding the usefulness of these assessment tools. There is scope to take these findings further with research that examines the relationship between existing risk assessments and the effects on patient outcomes related to their use.

In this study, the role boundaries for the scope of practice of registered nurses evoked a tension through a number of the research findings. These warrant examining the

discourses that may prevail from other stakeholders in the nurses' practice environments – for example, those in positions of management who drive many of the economies of performance, those in line supervision above the nurses, interdisciplinary co-workers, and the patients and families who are the recipients of care.

During the timeframe of this study, the national registered nurse standards for practice were revised (Nursing and Midwifery Board, 2016). It would be timely and useful to map the findings of the current study against the designated standards, to provide insight into how experienced registered nurses are working within those standards in current healthcare contexts, as well as insight into their abilities to work to the maximum professional potential expected of the role of registered nurse.

LIMITATIONS OF THE STUDY

I acknowledge that this study cannot make claims about all registered nurses within Australia or internationally because of the limited number of research participants from one region in one state within Australia. Although the results are not generalisable, the study provides rich data about, and deep insights into, the talk of a small number of nurses in a specific location.

Although the process of interviewing and the process of analysis provided a number of findings, the selection of topics of focus, by the participants and by myself, may have limited a complete picture of each of them enacting their professional role in the situations that they recounted. For instance, as the nurses focused on telling about task-based care, their story may have omitted details of the compassionate aspects of care or of their unconscious intuitive assessment as a patient was "pilled" or an audit "ticked." In my looking for broad indicators of professional nurses, the breadth of this research prevented singular attributes being investigated in depth. In addition, the data were all collected through interviews, and there was no way of verifying the stories told by the nurses.

PERSONAL REFLECTION

I was uplifted to conclude from this research that professional nursing for registered nurses in Australia is alive and evident in patient-care roles of registered nurses. It is guarded optimism, though, as the audit culture against which the nurses are struggling shows no signs of abating. In fact, as the final editing of this study was being completed, the climate of healthcare within the currently surging pandemic of COVID-19 suggests that political forces, governmental control and institutional mandates will continue to be a necessary response to coordinate care across many public and private health and welfare sectors.

I have learned, through the process of this research, an appreciation for language use, and I find myself noticing the ways in which its use can overtly or subtly influence discourse, particularly in the current times of heightened awareness of inequalities, enculturated views of the world, oppression and ingrained prejudices. My journey through this research process leaves me with a constant thinking of "What is the context here?" as I consider meanings beyond words and other possible reasons for prominent discourses.

I started this research from a colleague's observation that "We need to get them ready for practice," which butted against my orientation of preparing nurses for the profession. From doing this research, I now believe that there is a necessity for both approaches. As educators, we have a role in exposing pre-registration nurses to considerations of ethics, moral questions and responsibility, and to guide them in leadership studies. Nurses in practice would benefit from exposure to growth opportunities and a culture of nursing that models professionalism. Above all, they need confidence so that they can exercise their ecologies of professional practice when coming up against conflict, moral uncertainty or situations that require advocacy.

This confidence is found in experience, but also in knowledge, technical skills and people skills. In this sense, there is room for the "technician" as well. If we are not "getting them" ready for practice, we are sending them unprepared for the work

environment that this research has shown is frequently regarded as “scary.” The clinical environment is emotionally challenging, fast-paced and sometimes delivers fear. Expectations need to align with reality, with an acknowledgement that comprehensive care is desirable in many situations, but that it may not be the primary objective in others.

FINAL THOUGHTS

For evidence of professional nursing to be dependent on a theory of tension summarises the past, present and immediate future of nurses as professionals. In years past, as a profession, nursing hoped that movement into higher education for nurses’ development would promote benefits to the recipients of healthcare in the expertise that nurses could offer. The present research showed that professionalism is evident despite the process of struggling within constraints of ever-increasing work intensity. My future hope is that nurses can balance the role of the registered nurse as employee, accountable for working for an institution, against the role of the nurse as a professional, accountable for their profession’s scope of practice and their own internal compass.

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APPENDICES

APPENDIX A: NURSE PARTICIPANTS

Synopsis of work status at the time of interview for this research

Debra: Debra was an enrolled nurse for 15 years before completing her Bachelor of Nursing five years ago. She is in her fifties. She works in theatre, which has been her primary place of employment both as an EN and as an RN.

Gemma: Gemma graduated with her Bachelor of Nursing degree two years ago. She works part-time night duty for an agency, and she receives shifts at nursing homes and hospitals. She states that the night duty is purposeful because she has a toddler. She has also worked for a general medical practice (GP) office.

Harrison: Harrison has been a nurse for six years; he is 34. He stated that he feels he is still finding his feet. As a new graduate, he travelled to several towns on contract work – mostly in theatre positions. He has also nursed on general wards, but he is currently in a part-time contracted theatre position. He stated this is presently the extent of employment he has been offered, although he desires full-time work.

Helen: is a theatre nurse at a private hospital; she graduated 16 years ago. Recently she has also been taking shifts at a GP clinic. She is studying for a master's degree in public health and tropical medicine.

Ingrid: Ingrid is 48 years old but came to nursing only eight years ago. Her graduate job was in community nursing, where she worked for a few years before going part-time due to family needs. In the last two years she has been working casually, as a fill-in staff member for a variety of wards at a public hospital. She stated she is doing this for the primary intention of maintaining her medical/surgical skills.

APPENDIX A: CONTINUED

Janelle: Janelle is 39 and has been a registered nurse for seven years. Presently, she works on contracts in a nursing support unit at a public hospital. She has also worked in permanent, full-time positions for fixed-term contracts on specific wards.

Jo: Jo has been a nurse for five years; she is 42. She works in a casual pool for shifts in mental health, but she also engages in some relief shifts on medical/surgical wards.

Julian: In his 12 years as a nurse, Julian has worked in a variety of acute care roles. He is currently working part-time in ICU and part-time in a cardiac catheterisation lab. He is studying his Master of Nursing degree, potentially towards nursing education.

Leila: Leila graduated eight years ago as a 20-year-old; nursing is her first career. She worked in a country hospital. At the time of this research, she was working in an ICU at a public hospital and was studying for her Master of Nursing degree in critical care.

Myra: Myra is 32 years old. She obtained her original registered nurse qualification in India, and fulfilled her Bachelor of Nursing requirements in Australia four years ago. She remained in Australia after graduation and worked at a country hospital for a year before obtaining her Australian Citizenship. At the time of this research, she was nursing in medical/surgical wards in a regional town. English is her second language.

Sophie: Sophie works part-time on an orthopaedic ward. She graduated from nursing at 20, and she is now 25. She has worked in mental health nursing, which she states that she enjoys and to which she wishes to return, but she remains in the job on orthopaedics because it affords her family flexibility.

Toni: Toni is a 55-year-old nurse, practising for 16 years as an RN. She worked in healthcare prior to this in administration roles and as a nursing assistant. She works in a medical ward at a private hospital and sometimes team leads in a role that still involves a patient-care load on her shifts.

APPENDIX B: PARTICIPANT INFORMATION

University of Southern Queensland

Participant Information for USQ Research Project Interview

Project Details

Title of Project: Registered Nurses in the Field: Negotiating Professional Identities in 21st Century Australia
This study has been approved by the Human Research Ethics Approval Committee of the University of Southern Queensland. Approval Number: H14REA188

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Telephone: (07) 4631 2692

Invitation to Participate

You are invited to Participate in a research project which is being conducted in partial fulfilment for the qualification of PhD for Marie Cleary.

This study is looking at the perceptions of Australian nurses regarding their current practice in terms of their ability to carry out the professional aspects of their role. The study will benefit nurses, educators and nursing organizations in terms of looking both at present day practice and future directions for Registered Nursing.

The nurses sought for this study are those who participate directly in patient care in a variety of healthcare settings.

Voluntary Participation

A maximum of 20 participants are being invited to an individual interview with the researcher to answer questions and discuss their current role in nursing and their perceptions about current nursing practice.

Your participation would involve one individual interview which will last approximately one hour. The place for this conversation will be a mutually convenient location.

Questions will include:

1. How do you feel your day to day nursing fits with your vision for nursing practice?
2. Explain some of the competing demands that occur when you are caring for patients.

The interview will be audio-recorded for the purpose of collecting the information. This will be transcribed by a confidential transcription service. You will have the opportunity to read and edit the written transcript of your interview.

APPENDIX B: CONTINUED

Your participation in this project is entirely voluntary. If you do not wish to take part you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project and remove any data collected from you until such time as the study is close to being submitted. At this stage the data can no longer be withdrawn. If you do wish to withdraw from this project please contact the Research Team (contact details at the top of this form).

Your decision whether you take part, do not take part, or to take part and then withdraw, will in no way impact your current or future relationship with the University of Southern Queensland.

Expected Benefits

It is expected that this project will not directly benefit you beyond the opportunity to share your experiences. However, it may benefit understanding and knowledge of practice drivers and of appropriate education for the field of contemporary nursing.

Risks

There are minimal risks associated with your participation in this project.

The project will take your time to participate in an interview and then to read and check the transcript of the interview once it has been transcribed to a word document.

Sometimes thinking about the sorts of issues raised in the interview can create some uncomfortable or distressing feelings. If you need to talk to someone about this immediately please contact Lifeline on 13 11 14. You may also wish to consider consulting your General Practitioner (GP) or an Employee Assistance Program for additional support.

If you feel any discomfort in working with Marie Cleary on this project you are welcome to decline or withdraw at any stage.

Privacy and Confidentiality

All comments and responses will be treated confidentially unless required by law.

The audio recording of the interview and the written transcription will be treated confidentially.

- Only the researchers listed above and the professional transcription service would have access to the interview and transcript.
- You will have the opportunity to read and edit the written transcript of your interview.
- The write-up of the interviews and analysis of this data will be written in a way that the interviewee cannot be identified

Any data collected as a part of this project will be stored securely as per the University of Southern Queensland's Research Data Management policy.

The research will be monitored through a process of research supervision and in accordance to the approval granted by the USQ Human Ethics committee**.**

Consent to Participate

We would like to ask you to sign a written consent form (enclosed) to confirm your agreement to participate in this project. Please return your signed consent form to a member of the Research Team prior to participating in your interview.

APPENDIX B: CONTINUED

Questions or Further Information about the Project

Please refer to the Research Team Contact Details at the top of the form to have any questions answered or to request further information about this project.

Concerns or Complaints Regarding the Conduct of the Project

If you have any concerns or complaints about the ethical conduct of the project you may contact the University of Southern Queensland Ethics Coordinator on (07) 4631 2690 or email ethics@usq.edu.au. The Ethics Coordinator is not connected with the research project and can facilitate a resolution to your concern in an unbiased manner.

Thank you for taking the time to help with this research project. Please keep this sheet for your information.

APPENDIX C: CONSENT FORM

University of Southern Queensland

Consent Form for USQ Research Project Interview

Project Details

Title of Project: Registered Nurses in the Field: Negotiating Professional Identities in 21st Century Australia

Human Research Ethics Approval Number: H14REA188

Research Team Contact Details

Principal Investigator Details

Marie Cleary
Email: cleary@usq.edu.au
Telephone: (07) 4631 2364
Mobile: 04686 90020

Other Supervisor Details

Associate Professor Robyn Henderson
Email: Robyn.Henderson@usq.edu.au
Telephone: (07) 4631 2692

Statement of Consent

By signing below, you are indicating that you:

- Have read and understood the information document regarding this project.
- Have had any questions answered to your satisfaction.
- Understand that if you have any additional questions you can contact the research team.
- Understand that the interview will be audio recorded.
- Understand that you will be provided with a copy of the transcript of the interview for your perusal and endorsement prior to inclusion of this data in the project.
- Understand that you are free to withdraw at any time, without comment or penalty until the stage when your data has been de-identified and incorporated into the final copy of the written study.
- Understand that you can contact the University of Southern Queensland Ethics Coordinator on (07) 4631 2690 or email ethics@usq.edu.au if you do have any concern or complaint about the ethical conduct of this project.
- Are over 18 years of age.
- Agree to participate in the project.

Participant Name	
Participant Signature	
Date	

Please return this sheet to a Research Team member prior to undertaking the interview.

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