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Descriptive title: 'I'm not sure I'm a nurse': A hermeneutic phenomenological study of nursing home nurses' work identity.

Concise title: Nursing home nurses' work identity.

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TITLE: 'I'm not sure I'm a nurse': A hermeneutic phenomenological study of nursing home nurses' work identity.

ABSTRACT

Aims: To explore nursing home nurses' experiences and views of work identity.

Background: Nursing home nurses are in a unique position as they work at the interface of health and social care. Little is known about nursing home nurses' perceptions and experiences of working within this context. Evidence suggests that using the concept of work identity can support understanding of how workers make sense of their work.

Design: Hermeneutic phenomenological study.

Methods: The study was carried out in 7 nursing homes in North East England. Findings are based upon literary analysis of multiple episodic interviews with 13 nursing home nurses.

Results: Participants' responses suggested that nursing 'residents' is different to nursing 'patients', and nursing home nurses are required to modify their care activities to account for these differences. Participants also proposed that they are isolated and excluded from the rest of the healthcare workforce group. These issues led participants to feel uncertain about work identity. Many participants attempted to strengthen their work identity by aligning their role with what they perceived the 'nurse identity' to be.

Conclusion: Nurses' work activities and professional group identity influence their work identity. When work activities and professional group identity do not align with role expectations, as can be the case for nursing home nurses, work identity may be compromised. These nurses may attempt to change work practices to strengthen their work identity.

Relevance to clinical practice: Health and social care providers need to account for work identity factors in the organisation of care, and planning and implementation of integrated health and social care initiatives.

WHAT DOES THIS PAPER CONTRIBUTE TO THE WIDER GLOBAL CLINICAL COMMUNITY?

- Nursing home nurses can feel uncertain about their work identity as nurses.
- Nursing home nurses may change their work practices to strengthen their work identity.
- Health and social care providers need to account for work identity factors in the organisation of care, and planning and implementation of integrated health and social care initiatives.

KEY WORDS

nursing home nurse: care of older people: integrated health and social care: work identity: work role: profession: hermeneutic phenomenology

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INTRODUCTION

Societies across the globe are ageing, and one response to this phenomenon is the growth of nursing home (NH) provision and expansion of the NH workforce (Barnett et al., 2012; European Commission, 2015). Despite the increasing numbers of NH nurses, little is known about this professional group and the effect that working in this sector has on their work identity. This article explores the manifestation of, and perceptions about, work identity for registered nurses (RN) working in NHs for older people in England.

NH nurses are in a unique position as they work at the intersection of health and social care. They are healthcare professionals, but often work for social care, rather than healthcare providers (Colombo, Llena-Nozal, Mercier, & Tjadens, 2011). In England for example, most NH nurses do not work for the National Health Service (NHS) - the organisation that provides the vast majority of healthcare in the country offered free-at-the-point-of-delivery. Rather, as private companies provide 86% of NH places in England compared to 8% provided by the voluntary sector and 6% by NHS trusts, in the main English NH nurses are employed by private sector social care providers to deliver twenty-four hour nursing care for residents assessed as requiring primarily social care support (Jarrett, 2017). Unlike healthcare, in England social care is not provided free-at-the-point-of-delivery, and residents are means-tested to determine private and social services' contributions to social care needs costs (Great Britain. Department of Health, 2012).

NH nurses care for older people who have increasing levels of complex multi-morbidities, disabilities, dementia, and end-of-life care needs (Moore & Hanratty, 2013), but as the NH is the resident's home, NH nurses are required to address residents' social care and social well-being needs as well as their health needs. From a worker perspective this shifting context is very different to traditional contexts of 'acute care' and the provision of 'social care' in NHs.

Although some countries, notably Northern Ireland and Scotland have a long tradition of integrated care (Ham, Heenan, Longley, & Steel, 2013), Lloyd and Wait (2006) and the World Health Organisation (2017) suggest that for many other countries, this is a recent or current transformation. In the context of English NHs, new models of care, such as the Vanguard Enhanced Healthcare in NHs model are emerging, that recognise NHs are part of the economy of care, and that residents should be able to access mainstream healthcare (NHS England, 2016). By enhancing healthcare in NHs, health policy is also attempting to control the economic burden of this population on acute and emergency services (Smith, Sherlaw-Johnson, Ariti, & Bardsley, 2015). Implications of these changes include the need for healthcare services and NHs to effectively work in collaboration (Cook et al., 2016), something which has been difficult to achieve even in counties where integrated health and social care is well established. In their report on the existing integrated care systems in Northern Ireland, Scotland and Wales for the King's Fund, Ham et al. (2013) propose that often effective integration is compromised due to 'tensions surrounding joint working' (p.51).

NH nurses are both working at the interface of health and social care, and working within the changing context of NH services. In particular, with the increasing emphasis on enhanced healthcare in NHs, it is important to understand the work experience of this group of workers. This article uses the concept of work identity to provide a frame of reference within which NH nurse participants' work experiences can be interpreted. The article discusses how participants' viewed and experienced their role to be different to that of other nurses, and how these views and experiences impacted on their care activities and work identity. The article also discusses participants' strategies to manage work identity issues, and suggests implications for practice.

BACKGROUND

The dynamic relationship between work and identity has long been a topic of deliberation within the sociology of work literature. It has been suggested that work role can stimulate changes in perceptions of identity (Wille & De Fruyt, 2014), while identity can influence work,

in that differences between preferred work identities and actual work situations may lead individuals to attempt to change work situations (Kira & Balkin, 2014). In addition, there is evidence to suggest that work identity can influence levels of job satisfaction, feelings of accomplishment, and employment retention (Hackman & Oldham, 1980; Mael & Ashforth, 1995; Pearson, Hammond, Heffernan, & Turner, 2012).

Work identity is defined as a set of meanings attached to the individual by the self and others within the domain of employment (Gecas, 1982). Meanings are based upon identification by an individual with work environments and situations, including work-related tasks and activities performed within the role, and membership of work groups, organisations, or professions (Baruch & Winkelmann-Gleed, 2002; Miscenko & Day, 2016). Identity theory proposes that work identity is defined by expectations regarding roles and role activities. Stryker and Burke (2000) propose that in the work context, a pre-defined role is presented which, when assumed by an individual, assists that individual to develop an identity.

According to Kirpal (2004), work identity is a means by which an individual presents the self to the outside world. Hackman and colleagues' seminal research investigating the effect of work activities or 'role characteristics' on employees' attitudes and behaviours at work led to the development of the role characteristic model (Hackman & Lawler, 1971; Hackman & Oldham, 1975; Hackman & Oldham 1980). This model proposes that job satisfaction results from individuals' abilities to perform the work characteristics that they perceive to be intrinsic to their role and work identity. The performance of expected characteristics associated with any role increases job satisfaction because there is a link between expectations regarding work identity and feelings of personal meaningfulness. When the actuality of the work undertaken does not equate with expectations, then job satisfaction is diminished and feelings of anxiety and disarray occur.

On the other hand, social identity theory emphasises that work is a means of social, as well as personal definition and identification (for example, Tajfel & Turner, 1986; Mael & Ashforth, 1995; Hogg & Terry, 2000; Van Knippenberg & Sleebos, 2006). Van Knippenberg and Sleebos

(2006) suggest that work role is not unique to the individual, but brings with it social identity, in that it generates membership of, and integration into, a work-based community. Thus, work role implies that the self is similar to other group members, and group characteristics can be assigned to the self. This process of self-identification with a group reflects what Van Knippenberg and Sleebos (2006) describe as 'psychological oneness' (p. 572) – a state of being that leads to a sense of belonging, and a strong sense of self-definition. Mael and Ashforth (1995) suggest that when identification with the group is strong, group values and interests become incorporated into those of the self so that the collective-definition strengthens self-definition. In these circumstances, individuals are likely to remain within the group. When identification with the group is weak or uncertain, individuals struggle to define themselves in relation to the group, and as a result, the risk of attrition increases. It is important to remember that work identity is complicated, and can become compromised and confused by the many layers of work groups that individuals are likely to be associated with (for example, work teams, professions, employing organisations). However, some studies suggest that where a particular work group demarcation is stronger and more stable than the others experienced by an individual, for example where a strong organisational brand exists, or where an individual has a profession, then the individual may form a work identity based more heavily upon that work group (Kirpal, 2004).

Other authors agree with this strong work group demarcation argument to some extent, but suggest that in the case of professions, a combination of this type of social identity theory and identity theory appears to be required to reflect the complexity of professional situations, in that professional work identity is based both on expectations regarding role practices, and membership of a professional group. For example, Beddoe's (2010) work considers professional work identity in relation to 'professional capital'. Beddoe (2010) defines professional capital as the combined worth of: acquiring professional qualifications and registration in order to provide the professional worker with a clear, credible knowledge-claim, well-defined practice activities and territory of practice, and congruence with the

professional group and its values. According to Beddoe (2010), the presence or absence of these characteristics impacts upon the development or maintenance of professional identity. Thus, in an exploration of the professional identity of health social workers, Beddoe (2013) suggests that these practitioners feel like 'guests' in their work settings because their social care knowledge is not valued in a setting where medical needs and medical knowledge dominate.

There has been little direct consideration of how registered nurses working in social care settings perceive their work identity, or how their work identity issues influence their work. However, a few studies have considered the work identity of nurses working in the acute healthcare sector. Kirpal's (2004) comparative qualitative study across four European countries explores the formation of work identity amongst nurses and other professionals in this sector. The study suggests that nurses generally do not develop a strong identification with their employer, whereas the broader professional community (i.e. being a nurse) is a key aspect of nurses' work identity. The study also emphasises the role of professional registration/qualifications to the formation of work identity, as well as placing the patient at the centre of care. Like Beddoe's (2010; 2013) work these findings suggest that having a sense of professional identity depends upon the individual sharing values with other members of the profession, practicing within one's own professional field, and utilising one's own evidence-based professional skills and knowledge within that field. However, Kirpal (2004) proposes that tensions between 'caring' (i.e. therapeutic relationship and personal care provisions) and 'technical competence' may undermine nurses' sense of having a defined professional field, consequently undermining their professional identity.

Although not directly concerned with work identity, literature that investigates the attitudes of acute care nurses and student nurses towards long-term care (LTC) nursing supports Kirpal's (2004) position. In Abbey et al.'s (2006) study, student nurse participants viewed LTC in social care settings as 'basic personal care' that is 'inferior' to acute care. This was because they viewed the utilisation of medical, scientific and technical knowledge associated

with acute care as 'the core of modern nursing' (p.16-17). Similarly, several student and nurse participants in Wade and Skinner's (2001) study reported that LTC is 'basic', and that NH nurses are 'missing out' on both the practice of medical and technical skills and the utilisation of nursing knowledge (p. 14). Neville, Dickie and Goetz' (2014) literature review regarding nurses' career preferences suggests that gerontological nursing in LTC is an unpopular career choice because nurses place higher value on the technological interventions linked to acute care. In addition, Reed and Stanley's (2003) study, which describes the development and evaluation of a patients' daily living plan designed to facilitate communication between hospitals and NHs, explores hospital nurses' ideas about the NH sector. The study reports that hospital nurses hold negative views about NH staff, portraying NH staff as less skilled and less professional than hospital nurses. In contrast to Kirpal's (2004) study which proposes tensions between caring and the practice of technical skills undermine nurses' professional identity, these studies suggest that nurses working in healthcare settings strongly identify the profession of nursing with medical and technical practices, while activities associated with LTC are not perceived as part of the 'professional nurse's' remit or role.

Other studies that describe and analyse the activities inherent within the NH nurse role suggest that the role is complex. For example, Hunter and Levitt (2010) suggest that due to the frailty, dependency, increasing acuity and high incidence of multi-morbidities within the resident population, NH nurses require complex and extensive skill sets. Bedin, Droz-Mendelzweig and Chappuis' (2013) study concludes that NH nurses are primarily organisers, responsible for co-ordinating and evaluating care, and supervising support staff. In common with support staff, they assist residents with personal care. However, nurses use personal care activities in conjunction with their knowledge of residents' multi-morbidities and care needs to exercise clinical judgement. Studies by Perry, Carpenter, Challis and Hope (2003) and Kane et al. (2006) report that there is much overlap between the care activities of nurses and support workers, particularly regarding personal care activities.

However, nurses' professional knowledge means their involvement in personal care is a nursing, rather than a carer skill, as they use these opportunities to assess and monitor residents' health and well-being. These studies suggest that while NH nurses implement personal care activities, they use these experiences to support clinical judgement and nursing care. Nevertheless, they acknowledge that involvement in personal care activities tends to be associated not with nursing work, but with support staff work, which is perceived as 'basic' and therefore viewed disparagingly by nurses in other settings.

While this literature provides some insight into perceptions and experiences of the nature of NH nurses' work, to-date little has been said about how work identity is influenced by NH nurses' own perceptions and experiences. Yet, for NH nurses, the concept of work identity may provide a useful tool to gain understanding of how NH nurses make sense of their work within the changing context of NH services where there is an increasing emphasis on enhanced healthcare.

METHODS

Design

The overarching aim of this study was to explore the experiences and views of nursing home registered nurses regarding their role, status and work identity. This article does not represent the study's findings in entirety, but presents one aspect: nursing home nurses' experiences and views about work identity. As the study was interested in understanding what it is like to have experienced a particular phenomenon, the aims of this study were consistent with those of phenomenology, because of the focus on exploring participants' individual views and experiences of undertaking the role of a NH nurse i.e. being a NH nurse. Gadamer's (1976) hermeneutic writings guided the approach as he argues that being or experiencing a particular phenomenon is actually synonymous with being-part-of-the-world: rather than disinterested observers, capacity to know is formed by, actively invests in, and takes meaning from, interaction with environments and contexts. In this case work role,

status and identity are very much influenced by, and influence, social contexts and environments related to work.

Sample

Sandelowski's (1995) phenomenal variation sampling approach informed the sampling strategy. This purposeful approach targets a population with experience of the phenomenon, but scopes for diversity within that population so that breadth of experience is maximised. Using this approach required a relatively unrestrictive inclusion criteria. Inclusion criteria for participants were that they were RNs employed by NHs that provided nursing care to older people. The study was located in North East England. Within the study location, 160 NHs provided nursing care for older people and all were invited to participate in the study. Only 12 NHs replied. This low response rate was deemed to reflect recognition of the substantial commitment required by participation. Characteristics of responding NHs were entered into a sampling matrix (Reed, Proctor, & Murray, 1996). Seven homes were chosen on the basis that they provided maximum sample diversity. Four of these were operated by large national companies, one by a regional company, and two by sole proprietors. The selected NHs provided a range of nursing care services including general nursing care, elderly mentally infirm (EMI), and respite care. Two NHs provided some NHS contracted beds for palliative care and rehabilitation. The NHs accommodated between 20 and 77 residents, and employed between 5 and 20 RNs. A total of 67 RNs worked in the sample NHs. All were informed about the study, and 13 consented to participate: NH A n=3; NH B n=3; NH C n=1; NH D n=1; NH E n=3; NH F n=1; NH G n=1. As each participant was interviewed a number of times, this sample size was considered appropriate. Cook, Thompson and Reed (2014) argue that small sample sizes in multiple-interview studies in NHs are balanced by in-depth and prolonged engagement with participants. In the wider care home literature, the majority of data collection strategies involve minimal contact with participants, but prolonged engagement with the provides new insights into their lives.

Participants were two NH managers, a deputy manager, a nurse manager, a palliative lead nurse and seven staff nurses. Participants' ages ranged between 25 and 59 years. Length of their NH employment ranged between 1 and 23 years. Participants were assigned pseudonyms to preserve anonymity. The study was approved by the Research Ethics Panel, Faculty of Health and Life Sciences, Northumbria University.

Data collection

Data collection involved utilisation of Flick's (2000) episodic interview technique, and a multiple interview technique. These techniques allowed the researchers to comprehensively address the study's aims and questions, in that these interview methods prompt the interviewees to discuss **what** their experiences and views are, and **why** these occur i.e. they prompt an interplay between narrative and context.

The basis of the episodic interview is the supposition that participants' experiences are related via narratives that involve utilising both episodic and semantic knowledge. In this technique, researchers ask participants to describe examples of their experiences of the phenomenon in detail (episodic knowledge – 'what'), and prompt general discussions based on participants' views and assumptions about the phenomenon under consideration (semantic knowledge – 'why'). This combination of semantic and episodic knowledge generates data that arises from concrete as well as experiential contexts. Data collection involved interviewing each participant up to five times. Although interviewing each participant a number of times can be time consuming and difficult to negotiate, the benefits to research are significant. For example, Cohen, Zhan and Steeves (2000) propose that inconsistencies in participant's responses can be corrected because the researcher has opportunities to revisit problematical issues with participants, and gain clarification. These authors also suggest that multiple interviewing allows participants to reflect on previous interviews leading to richer, more extensive data in subsequent interviews. Qu and Dumay (2011) explain that multiple interviewing permits the researcher's preliminary analysis of early interviews to generate topics for exploration in subsequent interviews. In addition, the trust established

during multiple interviews also encourages participants to speak freely about the personal episodes that are invaluable as illuminations of their social contexts and experiences.

In total, 60 interviews were undertaken over a period of five months. Eleven participants were interviewed five times, one three times, and one twice.

Interviews were informed by the study's aims, and analyses of preceding interviews. A broad outline of interview topics was used that supported achievement of the study's aims.

However, the interview schedule remained flexible to allow participants to lead discussions about their views and experiences of their work role, status and identity:

- What are your experiences, expectations, motivators, feelings and reservations about your role, status and identity as a NH nurse? Why do you feel this way?
- What are your experiences and feelings regarding relationships with other stakeholders, the general public, and the media? Are your role, status and identity affected by these relationships? If so, why?
- Do you think your experiences, motivators, feelings and reservations about your role, status and identity as a NH nurse influences the quality of care provided? If so, why?
- What are your future aspirations? Does your current role, status and identity affect your future aspirations? If so, why?

Final interviews were undertaken with the aim of facilitating opportunities for participants to corroborate or alter the researchers' interpretation of their responses, which supported trustworthiness of the interpretation.

Data analysis

Van Manen (1997) proposed that the creativity involved in literary analysis is more appropriate to the exploration of complex phenomena than more systematic research approaches. Therefore, this study employed a literary analysis approach, based upon the methods of Iser (1978) and Van Manen (1997). Individual interview transcript initially

underwent a holistic reading to determine its fundamental meaning. The second analysis stage involved highlighting prominent phrases within the text. This process confirmed, contested or modified the original inferences generated from the holistic reading. Next, the remaining non-highlighted text was then re-reviewed. This review allowed topics of potential prominence, as well as actual prominence to be identified. As data collection involved interviewing participants on a number of occasions, these potential topics could be revisited in subsequent interviews. The third stage of analysis entailed a line-by-line examination of the text. Strowick (2005) suggested that expressions used in speech may have hidden sub-texts. These expressions may not directly constitute meaning, but they might indirectly indicate underlying issues. Line-by-line analysis also emphasised relationships between separate phrases. Iser (1978) proposed it is important to perceive phrases both in isolation, and within context, so that the standpoint of individual phrases can be confirmed or modified by its relationship with others within the text.

After each interview had been subject to these three analysis stages, interview topic maps were generated which were then assimilated into individual participant topic maps (see figures 1-3). Next, all participant topic maps were compared, then topic categories were created. After re-reviewing the topic maps, it was possible to categorise associated topics under unifying headings. As the analysis advanced, categories were integrated and assimilated into themes. This paper reports on one aspect of the study: the theme element of 'uncertainty about role identity' that emerges from the unifying heading 'nursing 'residents' rather than 'patients'.

Figure 1: Interview topic map (Beth – interview 1)

Figure 2: Participant map process

Figure 3: Participant topic map (Beth)

RESULTS

Throughout the interviews, participants referred to their role as being different to the roles of other nurses. They suggested that this is because caring for 'residents' is different to caring for 'patients'. They explained why they perceived this to be the case. Analysis of their responses suggested that caring for 'residents' rather than 'patients' affected their views about their role, their care activities and their work identity. Analysis of their responses also suggested that they utilise strategies and behaviours to manage work identity issues.

Differences between caring for 'residents' and caring for 'patients'

Beth has a permanent position as a RN in a NH. She also works as a bank nurse (working on a casual basis) for the NHS. It became apparent that in Beth's early interviews, when she discussed the nature of the NH nurse's role, she referred to NH service-users as 'residents', and NHS service-users as 'patients'. In her third interview, she was asked why she referred to these two groups using different terms, and whether nursing residents was different to nursing patients:

Beth: They're a resident because they live here, and they're a patient because they're being treated for whatever illness they've got. Primarily it is a social environment for them because it is their home. They can decide if they want er, you know whatever they want to do. It shouldn't be structured around like how a hospital is. It should be sort of structured about how they want to live their life, so in that way, yeah, it's more of a social thing...In the hospital they're in and out, kind of thing. Whereas you're looking after someone, probably for the rest of their lives, and you know, end-of-life...Because I think, you know, when you work in a hospital, you know there's a much quicker turnover, and when I'm doing my bank nursing [as a community nurse], I go and see someone for 15 minutes and then, they're you know, left at home. Whereas here, it's day after day.

Beth's responses inferred that she perceives caring for 'residents' and caring for 'patients' as different activities. She acknowledged that non-nursing home nurses work in diverse environments, at different points in the patient's journey, but nevertheless regarded all as associated with 'patients'. She suggested that nursing 'patients' in hospital is primarily about treating physiological illnesses within an institutionalised healthcare environment that caters for a rapid patient turnover. She proposed that nursing 'patients' in the community involves treating 'patients' in their own home by holding pre-arranged visits or meetings, that last for short periods of time, after which 'patients' and nurses disengage until their next arranged meeting. However, caring for 'residents' in a NH is different in that the care location is both a permanent, LTC setting and the resident's home. She also proposed that because NHs are 'residents' homes, care is more about supporting social well-being, and being 'with' the resident as a 'person' and less about clinical care management of a condition.

The differences between caring for 'residents' and 'patients' that Beth suggested, were corroborated and expanded upon by the other participants. Andrea explained that she felt permanence, familiarity and continuity are essential aspects of providing a home for 'residents', so NH nurses need to account for these requirements in their nursing care:

Andrea: It's already their home, and we make it a homely environment for them.

The staff are like the family members already because they know them. They knew them already, they know their voices, they know their faces. They get used to the regular staff.

Participants acknowledged that 'residents' do at times require clinical interventions which involve the practice of clinical skills. They also acknowledged that when residents' health deteriorates, they might require referral to acute/community healthcare services, or admission to hospital. Nevertheless, many agreed that in the main, their own role is about supporting residents' social well-being, by stimulating conversation and social interaction. Alice and Diane indicated that 'residents' care priorities often focus on social pursuits or the 'little things' (Alice) that make up everyday life, rather than physiological and medical

concerns that are the focus of hospital admission. They suggested that this is possible because residents' health is relatively stable:

Alice (3): I mean medical needs, if they had stronger medical needs, they wouldn't be here. They're stabilised more or less - we're more of their advocates. I think we're more involved in what they want, their wishes.

Diane (3): In hospital usually they're so poorly that in some ways their guard's down. You know, because if you're feeling rough and you're in pain and everything, you don't want everybody to see you but, you go past caring, don't you? If you're so poorly and you're in discomfort. Well, here, they're usually quite comfortable...I think their priorities are different aren't they. So in some ways, it's more of a social thing, you know, we discuss what's on the TV, and we might all watch the proms together.

Impact on role, care activities and work identity

Nursing people in a LTC environment, in which residents were able to focus on social and biographical well-being rather than physiological concerns had a significant impact on the participants' role and day-to-day work activities, in that it led them to feel isolated from other healthcare workers, and resulted in the modification of their caring activities. These considerations in turn resulted in uncertainty about work identity.

Professional isolation and exclusion: Although some participants acknowledged that they work closely with social workers, many said they do not work much with other healthcare professionals, because the relative stability of residents' health means that intense levels of inter-professional input or team nursing is unnecessary. Physiological aspects of LTC centre upon preventative interventions and management of chronic illnesses, and participants proposed that, in the main, these needs can be accommodated by the care of a RN supported by a team of support workers. Beth proposed that because of this, she does not have the same role as other nurses:

Beth: You kind of don't have the same day-to-day role [in the NH], because often the people you're looking after are quite stable and not needing any acute treatment. I mean we're cut off in those terms, because you literally come in and you're a little bit isolated. You don't have other people to liaise with and you don't have other people to discuss the patient's care with.

Some participants proposed that other healthcare professional involvement does occur, but is generally only necessary if residents become acutely ill. These participants suggested that such occurrences do not constitute interprofessional or team working because they perceived other professionals' as 'intervening' rather than engaging in partnerships or collaboration. Anne and Barbara suggested that, in their view, this is tantamount to NH nurses being excluded from the rest of the healthcare team. They proposed the primary cause of this exclusion is other healthcare professionals' view that NH nurses are 'second rate' (Barbara) or 'a lower option' (Anne) because they are perceived to be less skilled in clinical practice, to the point that they are almost not deemed to be healthcare professionals at all. Barbara suggested that this led to disassociation between NH nurses and other nurses:

Barbara: I think part of this perception is of being second rate nurses, that we're not at the cutting edge. But one of the key issues for me is we should be working far more in partnership with the NHS, because actually, we're a service that is complementary to the NHS, but I do feel not associated with them. That's somewhat compounded by the fact that their attitude towards us is, 'That's them over there', type thing.

Barbara's comment is also interesting because of her reference to the NHS. She appeared to use the term 'NHS' to denote the provision of healthcare interventions. This may be because the NHS provides the vast majority of healthcare in England, and employs 99% of UK nurses (NHS Digital, 2017), so to Barbara, the term 'NHS' may have become synonymous with 'healthcare'. However, her use of the term 'NHS' also highlights that NH

nurses work outside of this organisation. Indeed, Cath proposed that NH nurses' exclusion arises from being employed by a different organisational group, rather than differences in care activities:

Cath: We've been excluded by the NHS because we're in the private sector.

For Cath and some other participants, it is not just being employed by a different organisation that is problematic, but that care in these organisations is funded differently. Unlike healthcare, social care is not provided free-at-the-point-of-delivery. Many participants suggested that working for private companies and caring for people who often self-fund their care influences how NH services are perceived. They become for-profit activities, rather than care activities:

Anne: [We are] some kind of private sector who's just after the money and not interested in the care.

Modification of care activities: All participants stated that they felt nursing care should be holistic, in that it should account for the physiological, social, psychological and spiritual concerns of patients. However, most suggested that in response to residents' particular care priorities, NH nurses modify their caring activities by dedicating a much greater proportion of their role to supporting social well-being:

Bella: I think, erm, for the residents, for our permanent residents here, I think it's more of like making their life, like there's still quality. That's what they need, it's like companionship, and like, keep themselves like busy. They still manage to see the beauty of life, you know. It's not just because you live in a NH that will stop you from going out, or like, good things which you have done, especially if you have been a very active person, like you have had an active life. So of course we look to that.

This proposed shift in caring activities towards the concerns of social well-being led some participants to question their professional identities as nurses. For example, Alice asserted

that nursing usually involves the inclusion of more clinical undertakings within the work remit, so because the emphasis of NH nursing is on social issues, she is 'not sure if I'm a nurse'.

Alice: It doesn't feel like...I'm not sure I'm a nurse. [Clinical tasks] erm. It's, well its part of what you think you are as a nurse, you know. What I was expecting to do as a nurse. It does seem important that you have more clinical tasks when you're still doing bedside nursing. Here, it's more social.

Alice's comment appeared to contradict the premise that nursing is about providing care that attends to the holistic needs of patients. Such statements could be indicative that while the participants did see their role as being about the provision of holistic care, they nevertheless viewed clinical tasks as being integral to that care - as Alice stated, she expected to practice these skills as part of her nursing role. Thus, when this aspect is removed or diminished – as the participants' responses suggested occurs in NH nursing – then uncertainty regarding role identity may result.

Strategies and behaviours to manage work identity issues

Most participants' discourses indicated discord between their expectations and aspirations regarding what they perceived the role of the nurse to be, and the actuality of delivering care that meets residents' requirements. Although this discord led to a degree of uncertainty about work identity, participants' responses suggested that they had developed strategies to manage this predicament.

A number of participants attempted to strengthen the clinical aspects of their role by developing, or trying to develop advanced clinical skills. For example, Faye wished to develop skills in maintaining a central venous catheter (CVC) so she could manage CVC care for a resident admitted with a Hickman line insertion to treat cancer. Faye acknowledged that CVC maintenance for cancer patients in community settings is usually the remit of community nurses specialising in cancer or palliative care. Faye argued that if she and her work colleagues were trained in CVC maintenance, then they would be able to

enhance healthcare provision in their NHs by providing continuity of care and a cost efficient service. However, her argument concluded with a statement suggesting that another reason for developing such advanced clinical skills is to align herself firmly with the nursing profession and demonstrate she is the same as other nurses. In effect, this would substantiate her work identity as a nurse:

Faye: There's a lady with a Hickman line in, and we didn't have that knowledge to nurse her. We were willing to learn but the powers to be from the NHS said, 'No, we're not prepared to train you'. And you just think, 'Well why?' From a financial point of view it was going to save them money, but they just weren't prepared to give us that training. And I think, 'Why? Why can't we be a partnership?' Because we're not daft. We've done our nurse training. We have qualified and we've studied like every other nurse.

This alignment with other nurses was also demonstrated by Anne. During her second interview, she expressed the opinion that NH nurses should be able to access the same advanced clinical skills training as nurses working in other settings so that continuity of care could be achieved for residents. However, similar to Faye, her argument concluded with an appeal to be, and be perceived as, the same as other nurses, suggesting that this is important to her understanding of her nurse identity:

Anne: And I think if we're all doing the same training - because we're working, we're doing the same thing. We should be you know, we all have the same goals and the same standards and things like that.

Some participants' responses suggested that another strategy to strengthen work identity was to leave the NH workplace in favour of more acute care environments which afford opportunities to engage in a wider range of clinical skills. Elaine proposed that attrition in NHs was partly due to nurses' preference for engaging in 'nurse things' – her term for clinical skill activities. Diane and Bella explained that they were actively looking for

alternative employment because the emphasis on providing social well-being care was eroding their skills and knowledge bases:

Bella: It's like everyday – skills and nursing...in the hospital, you know, like different ones, it's like a different condition, different situation, and so, I kind of want to get involved with that.

Emma also expressed a wish to leave the NH setting, but her motivation was because she wanted to work in the NHS. Working in, or with, the NHS was important to Beth too. She works in a NH that accommodates both a nursing care unit, and an NHS contracted unit providing intermediate care. She stated that this was important, as it enables her to feel part of the NHS, which strengthens her work identity:

Researcher: So the NHS unit here is important then?

Beth: Yeah. 100%. Definitely. I think if they didn't have the [NHS rehab unit], I wouldn't be working here.

Researcher: Why is that?

Beth: I'm still sort of..I've got connections with the hospital, so I still feel I'm part of working with the NHS.

In contrast to strategies that aimed to strengthen nurse work identities by aligning actual work activities with expected work activities, or by joining the dominant healthcare provider organisation, Cath attempted to create a new work identity. Her strategy involved the creation of a new job title for herself which both acknowledged her nursing roots and reflected the amplified social aspect of her role. In effect, she attempted to fashion a hybrid professional identity that encompassed both healthcare and social care.

Cath: You're doing your health side, but you have got to do a lot more on the social bit...it's more medical in the hospital. You're more social on this side. Erm, on the hospital side, you're a nurse, that's it. I tell them [residents] I'm a care

nurse. And they go, 'What's a care nurse?' and I say, 'I'm a nurse, but I work in a care home'. So I say, 'I'm a nurse, but I'm also a social carer as well'.

DISCUSSION

Participants suggested that nursing 'residents' is different to nursing 'patients'. This was because participants perceived 'patients' as individuals whose acute illnesses dominate their lives at that time. Analysis of participants' responses infers they perceive 'residents' to be individuals whose physiological diseases are well-managed, so 'residents' do not give the physical aspect of illness primacy, but continue to seek to fulfil their self-actualisation and social needs. Diane's (3) comment that 'their priorities are different' summarised this point and inferred that the acuity/stability and management of disease impacts upon the care requirements of individuals. This suggestion is borne out by research which investigates hospital patients' determinants of quality of life, and studies exploring NH residents' views of what enhances quality of life. 'Patients' with acute conditions primarily focus on biophysical quality of life indicators such as pain relief, treatment options, symptom recognition, disease prevention and self-care strategies (Rankinen et al., 2007; Rantanen et al., 2008). However, in agreement with the findings of this study, research by Cooney (2012) and Bradshaw, Playford and Riazi (2012) conclude that NH 'residents' and their families associate quality of life and well-being with social activities such as maintaining choice and self-identity, developing social relationships, and accessing opportunities for meaningful activity.

In response to residents' care priorities, participants suggested that NH nurses modify their caring activities by dedicating a significant proportion of their role to the maintenance and promotion of residents' social well-being. However, this shift in activities away from clinical and medical activities led some participants to question their professional identities as nurses to the point where Alice pondered whether she is a nurse at all. This may be because in NHs, acuity and medical health problems are not at the forefront of care in the same way as they are in acute settings. Unlike their acute care nurse counterparts, NH nurses do not spend the majority of their time nursing acutely ill patients, but rather care for residents who

require intensive medical interventions only occasionally. This may lead to their perception that their role is 'diluted' in terms of clinical skills. The emphasis on medical aspects apparent in participants' views about what constitutes nursing is echoed in studies cited in the literature review that investigate the views of acute care nurses and student nurses about LTC and what constitutes 'nursing' (Abbey et al., 2006; Wade & Skinner, 2001; Reed & Stanley, 2003; Neville et al., 2014). Analysis of participants' responses in this study, however, suggests that social wellbeing care (i.e. optimising biographical continuity, facilitating meaningful activity and social relationships) as well as personal care support compromises nurses' work identity. Secondly, NH nurses themselves, although they are immersed in the NH environment, nevertheless expect and aspire to provide care that is primarily clinically based. When this does not occur, or when they perceive their clinical practice to be diminished by a propensity for social care needs, they find themselves in a predicament regarding work identity. This is not so much as a result of tensions between 'caring' and 'technical competence' undermining work identity as suggested by Kirpal (2004), but because prioritising social care needs is not the norm in professional adult nursing. Data analysis also highlights that the frames of reference available to participants do not help them regard the healthcare they do provide as preventative and prophylactic, and as such a highly valuable and important means of managing complex multi-morbidities. The optimisation of stability in residents' conditions within the context of multi-morbidity that can be achieved in NHs, frees residents from focusing on their physiological conditions so that they are able to turn their attention to other concerns such as social pursuits. Literature that analyses and describes the NH nurse role (Bedin et al., 2013; Perry et al., 2003), and the management of multi-morbidities in NHs (Condelius, Edberg, Hallberg, & Jakobsson, 2010; Kwong, Pang, Aboo, & Law, 2009) indicates that the presence of RNs in nursing homes has a significant influence on residents' health and well-being. It seems then, that participants' negative and disparaging attitudes regarding their own skills practice suggests that they do not recognise the management of multi-morbidities as highly skilled practice.

This is not to say that acute clinical skills are not necessary in NHs. There is much evidence to suggest that the health demographics of the NH population is changing. Increasing acuity of residents in NHs means that the NH workforce and those working into NHs increasingly need skills to respond appropriately to health deterioration, deliver relevant clinical interventions, and work together effectively with other health professionals if avoidable hospital admissions and unnecessary referrals to community, acute and emergency services are to be further reduced (Spilsbury, Hanratty & McCaughan, 2015; Cook et al., 2016). Faye's and Anne's comments suggest that services offered in NHs are at a point of change, and that the NH workforce should reflect the increasingly complex health needs of residents. These participants stated that NH nurses should be able to access clinical skills training and be able to work hand-in-hand with, and be valued by, their NHS counterparts in order to promote efficient use of services and continuity of care and holistic care for residents. Nevertheless, analysis of these participants' responses suggests that their desire for clinical skills training is not just about enhancing clinical competence, but also about cementing their work identity as nurses.

Work identity can be explored further by considering the isolation to which participants reported being subject. Participants proposed they are isolated because they work with residents who are evaluated as having relatively stable health conditions so do not require much in the way of multidisciplinary team input. However, the findings also suggest that, in actuality, the participants do work with other professional groups – in particular, social workers. In addition, they come into contact with clinicians visiting the NHs to provide clinical therapies and interventions that the participants are not trained to undertake themselves. Such contradictory evidence might be explained by referring to previous literature regarding occupational role. By returning to the literature review, it can be seen that occupational role is not unique to the individual but brings with it social identity, in that it generates membership of an occupational group and/or an organisation (Tajfel & Turner, 1986; Hogg & Terry, 2000; Van Knippenberg & Sleebos, 2006). For participants in this study, it could be that

they feel isolated because, despite their engagement with social care professionals, and because they are observers rather than providers of advanced clinical practices and thus perceived as 'second rate', they no longer view themselves as members of the nursing occupational group.

This proposal can be explored further by examining the NH nurse role in the context of 'professional capital'. Beddoe (2010; 2013) proposed that having a sense of professional identity depends upon the individual sharing values with other members of the profession, practicing within one's own professional field, and utilising one's own evidence-based professional skills and knowledge within that field. In this study, participants expressed their accordance with healthcare values (for example, person-centred practice, advocacy) but suggested that their expectations regarding clinical practice and utilisation of their nursing expertise do not meet the reality of their actual practice. Alice for example, expected nursing to be about acting as a health clinician, using health-based knowledge and qualifications within a healthcare environment. However, she finds herself primarily addressing the social concerns of residents, within a very undefined territory of practice in that it lies at the intersection of health and social care. Furthermore, she perceives herself to be utilising her acute clinical skills (which she feels define nursing) to a limited degree. In other words, the participants are working outside of (or at least, at the edge of) the healthcare arena – an arena which they feel should be their natural practice environment. This interpretation may explain why some asserted that they should be involved in acute care interventions (for example, CVC line maintenance) – healthcare interventions that they acknowledged are usually the remit of specialist practitioners. By wishing to train in, and practice, these skills, they are attempting to change their work situation to match their preferred work identity (Kira & Balkin, 2014). This also may explain why some wished to leave the NH setting in favour of acute settings. They desired to align themselves with other nurses in order to generate work identity via group membership (Van Knippenberg & Sleebo, 2006). Rather than taking measures to align her skills and behaviours with other nurses, Cath's approach to managing

issues of work identity was to create a new job title for herself – a ‘care nurse’. However, when defining the role, she described it as a twofold or dual role – ‘a nurse and a social care worker’, thus not being altogether successful in her attempt to amalgamate the roles to create a new work identity. Her approach also, paradoxically, reinforced the division between health and social concerns, suggesting that she, like the other participants, viewed clinical care, not the provision of support for social-wellbeing, as nurses’ work remit.

In many ways, participants’ views and behaviours appeared to reinforce Kirpal’s (2004) conclusions that nurses’ work identity is based primarily on identification with the professional community rather than with their employer. Nevertheless, employing organisations did seem to be influential in some participants’ views about their work identity. Analysis of Barbara’s and Cath’s responses inferred that employing organisation affiliation is an important aspect of their work identity, but this may be because of the particular way in which health and social care services are currently set up in England, and as a consequence, the NHS and healthcare provision are so strongly linked that the terms ‘NHS’ and ‘healthcare’ have become interchangeable. Therefore, for nurses working outside of the NHS, there may be a perception that their role is disassociated from healthcare provision, which in turn, may impact on their work identity. Cath’s and Anne’s comments, that NH nurses are excluded because they work in the private sector add a further level of complexity to the issue of work identity, in that they suggest NHs’ association with the private sector and privately funded care is at odds with the values of NHS care provision. According to Bourdieu (1977; 1990), where a dominant socioculture exists (in this case, the NHS), then that socioculture influences the value systems of society so its view becomes the world view. Values that do not originate from its beliefs and tenets are therefore not endorsed. It may be that working in the private sector exacerbates participants’ sense of feeling different or excluded because values regarding care funding in this setting are at variance with those accepted as the norm for healthcare in England.

CONCLUSION

Participants prioritise holistic, person-centred care, but expect nurses to deliver this care primarily via the practice of clinical and medical skills and interventions to the extent that they base their work identity on this expectation. While they are willing to modify their activities to address the mainly social well-being needs of NH residents, thus demonstrating commitment to person-centred care, this is nevertheless seen as an alternative identity to that of other professional adult nurses. Analysis of participants' responses also suggest that the significance and value of their ability to manage complex multi-morbidities is largely unrecognised, suggesting that the focus of nursing is responding clinically to illness and disease rather than maintaining health and well-being.

Findings suggest social identity via membership of a group has a significant bearing on work identity, and that in the case of the nursing profession, clinical work activities, clinical knowledge claims and congruent values strengthen professional capital and group membership. The study proposes that when a healthcare organisation dominates or monopolises the provision of healthcare, as is the case with the NHS, professional capital becomes incorporated into the brand so that professional group and organisational group identity become synonymous, and the organisation's values, activities and knowledge claims influence the characteristics of the profession. Nurses working outside of this organisation are therefore at risk of feeling disassociated from not just the dominant organisation, but from their own profession.

RELEVANCE TO CLINICAL PRACTICE

A number of practice implications arise from this study. For example, participants' perceptions of their work identity suggest a disparity between the role aspirations of the 'nursing profession' as a body, and the nursing profession as a work group. It is possible that 'holistic, person-centred care' is a theoretical ideal to which the nursing profession body

aspires, but it is clinical skills practice which is the actual work practice to which the work group aspires.

Participants' responses inferred they are skilled at providing social well-being care, managing complex multi-morbidities, and maintaining residents' health stability. If their call to be trained in more clinical skills is heeded, they would have a skill set that would facilitate care continuity, and quality cost-effective care for NH residents who increasingly present with complex needs; but also their work identity would be strengthened, potentially reducing attrition and increasing job satisfaction.

In addition, how the move towards an integrated health and social care system, and models of enhanced healthcare in NHs are organised and implemented may need to account for work identity factors. These approaches recognise that NHs are part of the economy of healthcare and afford opportunities to improve access to quality healthcare for residents. If embedded organisational practices and values of the dominant healthcare provider influence perceptions and characteristics of professional identity, as this study proposes, then the move towards integrated and collaborative working may increasingly generate work identity problems for professionals at the health and social care interface who work for other organisations. This suggests that either health and social care organisations should merge, or steps should be taken to value and support all organisations within the health and social care team, acknowledging them as equal partners and significant and important contributors to care provision. This may reduce the risk of NH nurses' professional identity being compromised by their organisational work identity, which again could reduce attrition and improve job satisfaction.

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Figure 1: Interview topic map (Beth – interview 1)

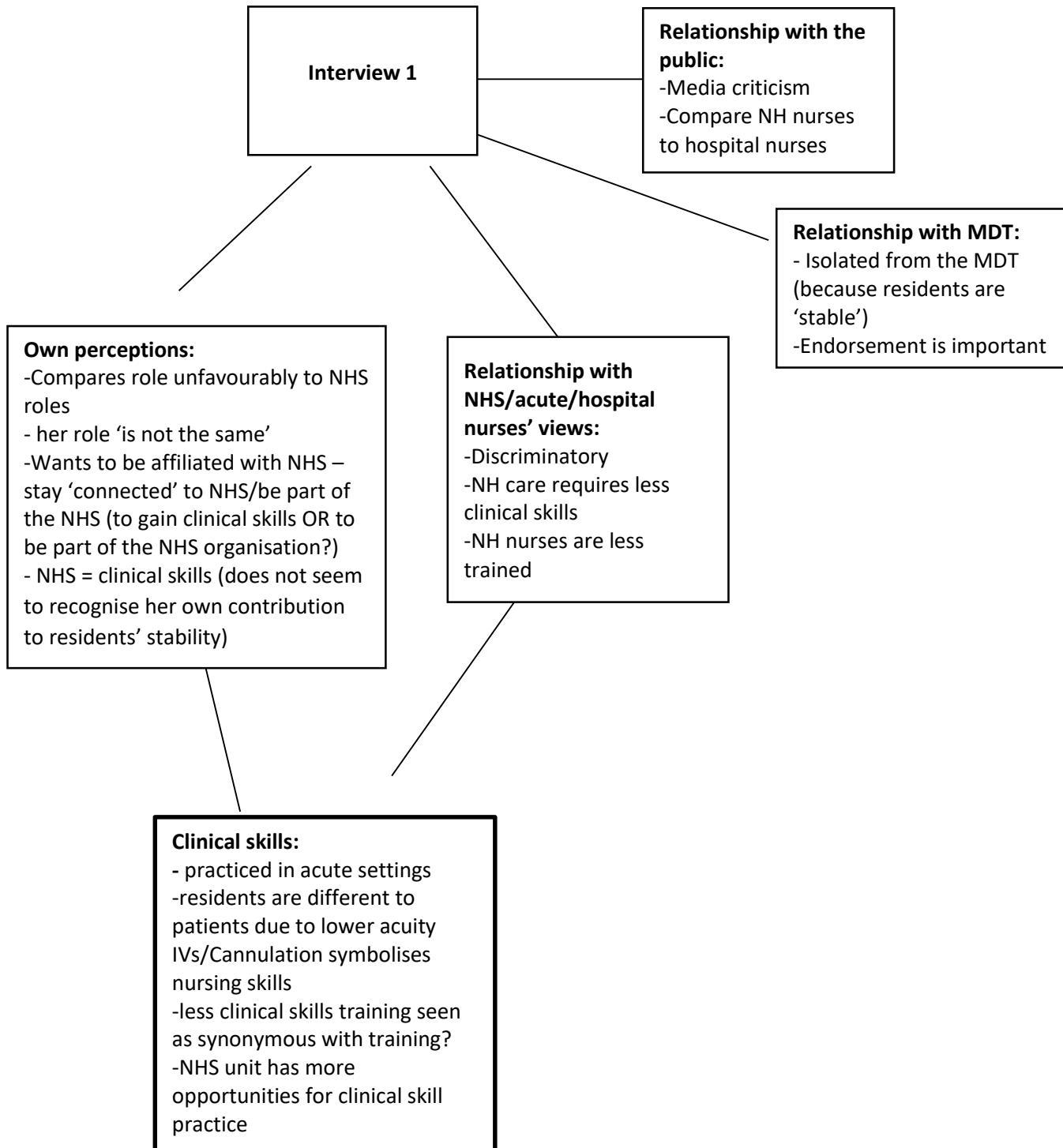


Figure 2: Participant map process

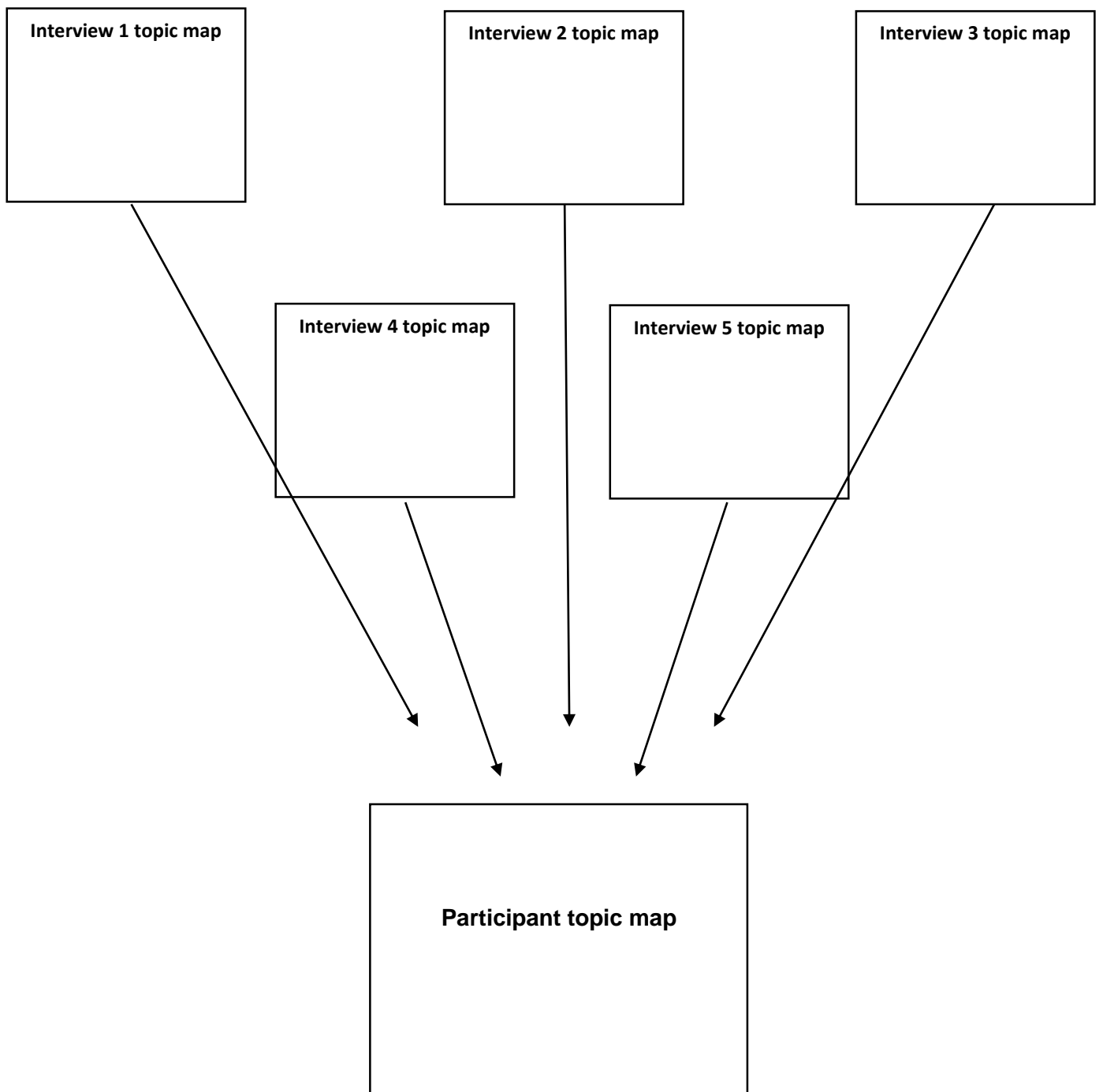


Figure 3: Participant topic map (Beth)

