SHAPING PRACTICE:

CLINICIANS’ EXPERIENCES IN A COMMUNITY OF PRACTICE

by

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Abstract

Large regional health authorities are challenged to find effective ways to increase interprofessional and intra-regional collaboration so that expertise and knowledge can be shared, enhanced, disseminated and more effectively translated into practice. Communities of practice (CoPs) have been introduced into healthcare over the last few years as a strategy to improve knowledge translation and organizational performance. The purpose of this qualitative study was to explore healthcare clinicians’ experiences of being a member of a clinically-focused CoP. Semi-structured interviews with 15 CoP members were conducted and transcribed. Thematic analysis revealed participants constructed CoP in four main ways: as a learning community, a means to cope with organizational life, a mechanism to get organizational work done and as an elite group. Important participant experiences in CoPs included: supporting one another, staying on top of things, and helping each other. Although participants talked very positively about their experiences in CoPs there were also challenges and frustrations. There were two main outcomes of membership in a CoP. First the CoPs were perceived to provide an opportunity to develop a sense of belonging. Secondly, CoPs enabled changes in practice. Practice changes ranged from individuals’ thinking about and enacting practice differently to organization-wide changes in practice standards. Information from the perspectives of the community members about their experiences in clinically-focused CoP can be used by administrators for future planning, resourcing and providing support to CoPs. These findings extend our understanding of the implications of this important and relatively new social structure in healthcare.
Preface

This thesis was approved by the University of British Columbia Behavioural Research Ethics Board (H10-02426) and the Interior Health Research Ethics Board (2010-045).
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Chapter 1 – Introduction

Introduction

We live in a time where access to information is unprecedented and knowledge is constantly evolving and changing (Wyer, 2007). Despite staggering investments in health research, 30-40% of patients do not receive care consistent with current scientific knowledge and 20-25% of care provided is unnecessary and even potentially dangerous (Grol & Grimshaw, 2003). The reasons for underutilization of research evidence are often complex, diverse and unclear (Grol & Grimshaw, 2003; White, Leske & Pearcy, 1995). Large regional health authorities are challenged to find effective ways to increase interprofessional and intra-regional collaboration so that expertise and knowledge can be shared, enhanced, disseminated and more effectively translated into practice. Scholars of late have acknowledged that reliable knowledge “can no longer be determined by narrowly defined scientific communities but by wider communities of knowledge producers, disseminators, traders and users” (Kitson & Bisby, 2008, p. 2). Leaders are called to engender high quality culturally healthy environments where research and the integration of new evidence is expected and considered the norm. Communities of practice (CoPs) have been introduced into healthcare over the last few years as a strategy to improve knowledge translation and organizational performance (Lesser & Storck, 2001; Li, Grimshaw, Nielsen, Judd, Coyle & Graham, 2009; Wenger, McDermott & Snyder, 2002).

Communities of practice are defined as “groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis” (Wenger et al., 2002, p. 4). This definition is widely
cited in the literature and commonly used by researchers to define the group(s) under study. The structure of CoPs varies widely from self-organizing informal networks to formal work-supported multidisciplinary, multi site project teams (Li et al., 2009). The popularity of CoPs has been fuelled in part by their bottom–up rather than top-down social structures that represent a promising solution for rapid translation of tacit and explicit knowledge into clinical practice (Bentley, Bowman & Poole, 2010). Over the last twenty years the success stories of CoPs in business (e.g., Chrysler, Hewlett Packard, Shell Oil, World Bank, Xerox) have created compelling interest from organizational development circles worldwide, including those in healthcare.

In Interior Health, the second largest geographic health authority in British Columbia, Canada, a number of clinical CoPs have formed and there is growing interest from the organization to understand how these groups impact practice. This development has been spearheaded and developed by passionate individual clinicians or small groups of clinical leaders, educators and clinicians who recognize a need or gap in care and begin searching for answers and resources. CoPs in Interior Health have provided a mechanism for clinical experts, clinicians and knowledge users to interact with each other and determine for themselves the best way to implement evidence informed and/or promising practices. The experience of participating in a non-hierarchical group structure that is organic or intentionally constructed presents a promising model for translating evidence based knowledge into practice is under reported and poorly understood.
Purpose

The purpose of this project was to explore healthcare clinicians’ experiences of being a member of a clinically-focused CoP. In this research, I focused specifically on understanding the impact a clinical CoP may have on individual members’ practice as an important and under researched area of inquiry. For the purposes of this study the term ‘healthcare clinicians’ was a deliberate inclusive term used to encompass the multiple health professionals (e.g., registered nurses, physiotherapists, social workers, nurse practitioners, pharmacists, to name a few) that form the community membership of many CoPs in Interior Health. The CoPs of interest in this research are those intentionally focused on clinical care as opposed to healthcare operations, research or education. The term ‘practice’ is an inclusive term that refers to front line clinical practice, health administration, health research and/or education. The specific CoPs that formed the focus of this research included: the Nurse Practitioner CoP; the Falls Prevention CoPs; and the Rural Nurse Educator CoP.

By turning our attention to understanding the value CoPs hold for their members we can begin to determine if organizationally more attention and support should be applied to forming CoPs over other group structures (e.g., project teams). It has been argued that the value people feel in social networks like CoPs is instrumental for their work and accrues in personal satisfaction as they interact with colleagues who understand their perspective and who are interested in a similar topic (Wenger et al., 2002). Wenger et al. point out that:

What makes managing knowledge a challenge is that it is not an object that can be stored, owned and moved around like a piece of equipment or a document. It resides
in the skills, understanding and relationship of its members as well as in the tools, documents and processes that embody aspects of this knowledge (p. 11).

The purpose of CoPs within Interior Health is to provide a forum for clinical staff, educators, managers and other related professionals to become engaged in their workplace while enhancing or improving quality care by contributing to the development and implementation of effective evidence informed practices (Interior Health, 2007). Interior Health CoPs have been observed by administrators to support clinicians in gaining voice, networking, making practice changes within their focus, and engaging with each other and with the organization as a whole (T. Fulton, personal communication, February 17, 2010). The perspectives of the community members on whether these outcomes have indeed occurred, however, has not been explored. Understanding the benefits and value (if any) CoPs bring to individual practitioners in complex healthcare organizations will allow Interior Health to not only manage knowledge as an asset but to intentionally develop a context of integrated communities where staff can learn, steward knowledge and prosper in an enhanced workplace culture (Wenger et al., 2002). It is suggested that CoPs are a necessary and powerful strategy for intentional knowledge exchange which results in optimizing the context and the relationships among diverse members (Wenger et al., 2002). Given the continued under utilization of research in practice it is reassuring to know that understanding, supporting and creating CoPs has been identified as a key research priority by the Canadian Health Services Research Foundation (CHSRF) (2005) as a strategy to cut across hierarchical and geographic boundaries and improve capacity in research, management and policy making. Like CHSRF, Interior Health is looking for a pragmatic mechanism to develop individual and organizational learning and knowledge creation while simultaneously
connecting clinicians across its vast geographic boundaries and inherent hierarchical structure.

Given the successes reported from the business and education sectors in applying the CoP model, it seemed reasonable to evaluate if the same successes can be realized in the health sector. The research studies done to date on CoPs in healthcare provide some initial insight into understanding how engagement in CoPs impacts members’ practice (Barwick, Peters & Boydell, 2009; Chandler & Fry, 2009; Fung-Kee-Fung et al., 2008; White, Suter, Parboosingh & Taylor, 2008; Gabbay et al., 2003). What is less well known is if and how participation in a CoP, that is not constructed and supported as part of research project, shapes practice. Understanding the experiences of CoP members from Interior Health adds to the knowledge that is developing around CoPs in healthcare and provides some useful information in terms of the benefits and challenges of initiating and sustaining a CoP model in complex hierarchical and often siloed healthcare organizations.

**Research Aims and Questions**

The primary aim of this project was to explore how healthcare clinicians’ experiences in a clinically-focused CoP shapes their practice. For the purpose of this study, Wenger et al.’s (2002) definition of a CoP was adopted. To assist in identifying CoPs the following three structural elements were required to be present in each group: a specific field, area, or discipline; a defined community of participants; and the goal of improving the practice and professional development (CHSRF, 2005).

The following research questions were addressed in this research:
• How do healthcare clinicians describe their experiences in a clinically-focused CoP and the way these experiences influence their practice?

• How do CoP members perceive the value of involvement in a CoP?

• From the perspective of participants in a CoP, what are the ways that the CoP supports changes in practice and ways the CoP hinder changes to practice?

• What advice do participants have for enhancing the effectiveness of CoPs?
Chapter 2 – Literature Review

An Overview of Communities of Practice

The concept of a CoP originally emerged in education (Lave & Wenger, 1991) and management (Brown & Duguid, 1991) as a useful and effective social structure to foster learning, develop competencies and manage knowledge. Lave and Wenger studied how midwives, meat cutters and tailors learned new knowledge during their apprenticeship process. Their findings illuminated the social character and situated processes of learning and problematized the assumptions that learning is solely an individualized act of acquiring facts and information (Lave & Wenger, 1991). They described how likeminded tradesmen informally gathered to exchange stories, experiences and practical information and in doing so, solved problems, learned from one another, improved their own practice and generated new knowledge (Lave & Wenger). Similarly, Brown and Duguid described the informal social networks that emerged as service workers in a large company gathered to exchange stories for the purpose of tacit learning that moved beyond the explicit information stored in company manuals. A common set of approaches to doing things in a specific way, shared understanding, active engagement in sense-making and improved practice underpin both Lave and Wenger’s and Brown and Duguid’s conceptualization of a community of practice. The central tenets that form the theoretical underpinnings of the CoP framework are situated learning, legitimate peripheral participation and reflective practice (Buyesse, Sparkman & Wesley, 2003; Fuller, Hodkinson, Hodkinson & Unwin, 2005; Lave & Wenger, 1991; Wenger, 1998; Wenger et al., 2002). The concept of situated learning is based on the principle that knowledge is situated in experience and cannot be separated from the complex environment in which it must be applied (Buyesse et al., 2003). In CoPs situated learning is
exemplified when “shared inquiry and learning centers around issues, dilemmas and ambiguity that emerge from actual situations in authentic practice settings” (Buyesse et al., p. 267). Legitimate peripheral participation, also a central theory of CoPs, is a term Lave and Wenger (1991) coined to describe the social process by which new entrants to an activity or workplace gain the skills, knowledge and habits necessary to become full participants by watching and learning from more seasoned workers (Fuller et al., 2010). Borrowing from ethnographic studies of apprenticeship, legitimate peripheral participation broadens the notion of traditional “master/student or mentor/mentee to one of changing participation and identity transformation in a CoP” (Wenger, 1998, p. 11). Reflective practice, a principle of CoPs, refers to understanding experiences through critical reflection with others who share those same experiences (Buyesse et al., 2003). In a CoP collaborative reflection can generate new knowledge that can be used to extend professionals’ “understanding and command of their work situation, but also to advance the knowledge base for the field as a whole” (Buyesse et al., p. 268).

Communities of practice are shaped by three structural elements: domain, practice and community (Wenger et al., 2002). Domain refers to the sphere of knowledge and expertise that all members share and around which they organize. This could be a specific field, area or discipline. Practice refers to the common set of approaches, frameworks and tools members share with the goal of improving the practice and professional development of the particular community. Community refers to a defined community of participants and alludes to the relationships, sense of belonging and connectedness among members. The presence of these elements creates a shared context in which perspectives on problems and issues can be shared, exchanged, validated, refined and accepted (Chua, 2006).
Reviewing the seminal works on CoPs and identifying the structural elements of a CoP provide some, albeit limited, help in identifying groups that are CoPs from those that are not. Not all communities are a community of practice and not all practice gives rise to a community of practice (Wenger et al., 2002). Li et al. (2009) reported that there is “no dominant trend in how the CoP concept is operationalized in the business and health sectors; hence, it is challenging to define the parameters of CoPs groups” (p.1). A helpful tool to distinguish CoPs from other familiar structures is offered in a comparison table provided by Wenger et al. (see Table 1). The CHSRF (2005) in their Network Notes I list the key characteristics of CoPs as capacity development, common vocabulary, passion, self-organized, non-hierarchical, flexible and informal.
Table 1 Distinction between Communities of Practice and Other Structures

<table>
<thead>
<tr>
<th>DISTINCTION BETWEEN COMMUNITIES OF PRACTICE AND OTHER STRUCTURES</th>
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<tr>
<td><strong>What’s the Purpose?</strong></td>
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<tr>
<td>Communities of Practice</td>
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<td>Formal Departments</td>
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<td>Operational Teams</td>
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<td>Project Teams</td>
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<td>Communities of Interest</td>
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<td>Informal Networks</td>
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Literature Review Process

Greenfield, Travaglia, Nugus and Braithwaite (2007) authored a detailed analysis of CoP articles, chapters and reviews from the healthcare literature. Their search included three health data bases using the time period of 1950 to September 2007 (Greenfield et al., 2007). Building on Greenfield et al.’s (2007) work, I searched the same data bases for the period October 2007 to April 2010 (see Table 2 for databases searched). I narrowed my search to those articles that focused specifically on CoPs and clinical practice (see Figure 1). This was intentionally done to identify research studies that were aimed at clinical practice as opposed to educational, administrative or research practice. The articles that focused on clinical practice were then hand sorted to identify those that focused on understanding the experiences of being in a CoP. Those studies that identified a primary or secondary aim of understanding the experiences of healthcare clinicians in a CoP were retained. Community of practice both in its singular and plural format was utilized as the key search term to ensure all relevant articles were found. The search was purposely not expanded to terms that are similar to or associated with CoPs so that a standard definition could be applied to the concept of a ‘communities of practice’. Narrowing the search in this way was pragmatic and allowed for enhanced comparative critique and analysis. I applied this same focused content analysis strategy to the literature search done by Greenfield et al. (see Figure 2) and found a combined total of five research articles that focused specifically on CoPs, clinical practice and the experiences of CoP members.
<table>
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<tr>
<th>DATABASES</th>
<th>SEARCHED FROM</th>
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<tbody>
<tr>
<td>CINAHL (Cumulative Index of Nursing and Allied Health Literature)</td>
<td>October 2007-April 2010</td>
</tr>
<tr>
<td>EMBASE (Medicine and health services)</td>
<td>October 2007-April 2010</td>
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<tr>
<td>Medline (Medicine)</td>
<td>October 2007-April 2010</td>
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Figure 1  CoP literature review process
Greenfield's et al.'s (2007) reviewed empirical research articles
N= 79

Research articles focused on clinical practice identified
N= 5

Research articles reporting on the experience of being in a CoP identified
N= 4

Figure 2 Distillation of Greenfield et al. (2007) reviewed empirical research articles

Review of the Literature

Healthcare literature on CoPs has predominantly focused on exploring the concepts of CoPs (Andrew, Tolson & Ferguson, 2008; Bartunek, Trullen, Bonet & Sauquet, 2003; Bentley, Browman & Poole, 2010; Braithwaite et al. 2009; Greenfield et al., 2007; Li et al., 2009); reporting the successes and/or challenges of building, maintaining and sustaining CoPs in practice settings (Cook-Craig & Sabah, 2009; Huckson & Davies, 2007; Lathlean & Le May, 2002; McDonald & Viehbeck, 2010; Parboosingh, 2002); or identifying CoPs as possible innovative strategies for collaborative learning and/or knowledge translation (Bate & Robert, 2002; Chin 2010; Demers & Poissant, 2009; Honeymoon, 2002; Gabbay & Le May, 2004; Gagliardi, Ashbury, George, Irish & Stern, 2004). Despite this recent surge of healthcare
research highlighting CoPs, there remains a dearth of research focused on understanding the impact members’ experience in a CoP has on their practice. After extensively searching the healthcare literature five research articles were identified that examined the experiences of CoP members and the impact of those experiences on their practice. In some studies understanding the CoP members’ experience of being in a CoP was a secondary study aim.

The most promising information about the impact of CoP membership on members’ practice can be found in five research studies originating from Canada and the United Kingdom. This could be coincidental or a reflection of the interest within these two countries to look at innovative solutions for collaborative and meaningful knowledge management. In Canada there has been considerable interest from the national research funders in knowledge translation activities (CIHR, 2004) and communities of practice (CHSRF, 2005). In England the National Health Service (NHS) has begun exploring ‘social movement’ theories as a new way of thinking and approaching service improvement and organizational change (Bate, Bevan & Robert, 2002).

In each of the identified studies, CoP structures were initiated as a mechanism to steward knowledge. The foci of the CoPs included quality improvement work in cancer care in Ontario (Fung-Kee-Fung, et al., 2008); creating opportunities to enhance interprofessional practice in seven diverse practice sites within Alberta (White, et al., 2008); addressing problem discharge planning practices in a large health region in the United Kingdom (UK) (Chandler & Fry, 2009); training for implementation of a new assessment tool in Ontario’s children’s mental health sector (Barwick et al., 2009); and improving health and social services for older adults within the boundaries of two primary care groups in the UK (Gabbay et al., 2003). In three of the studies the researchers used a CoP model for strategic
health planning (Chandler & Fry, 2009; Fung-Kee-Fung et al., 2008; Gabbay et al., 2003); in one study the researcher applied a CoP model to a mandated practice change (Barwick et al., 2009) and, in final study reviewed, the researchers developed CoPs around local participant-selected practice changes (White et al., 2008). The different CoP contexts and applications in the five studies make it difficult to compare experiences among the participants. On the other hand, the studies do showcase the broad range of activities and group membership that CoPs may be suited for.

The findings reported regarding CoPs were not consistent and sometimes conflicting. Researchers evaluating CoPs using case studies and action research methods reported a range of outcomes including significant (60%) planned practice change (Fung-Kee-Fung et al., 2008); enhanced communication, information transfer and interprofessional practice (White et al., 2008); greater use of and understanding of an assessment tool and increased satisfaction with implementation (Barwick et al. 2009); and increased value in personal professional development and in collaborating with other professionals to solve problems that affected teams/organizations (Chandler & Fry, 2009). These reported research findings suggest that involvement in CoPs may be useful to improve a variety of knowledge related issues including connecting professional, building relationships among people, linking and coordinating activities, building confidence in people’s ability to affect change and providing a forum for strategy development. In only one study researchers used a control group to evaluate the implementation of an evidence-based mental health assessment tool using CoPs (Barwick et al. 2009). In this study, no difference was found in readiness for change or reported practice when the clinical practice of CoP participants was compared with the clinical practice of practitioners not involved in the CoP (Barwick et al. 2009). However,
increased use of an evidence-based assessment tool, better content knowledge related to the tool and greater satisfaction with the implementation was reported by CoP practitioners as compared with the practice as usual group (Barwick et al. 2009). Questions remain about whether or not it is the application of the CoP model itself or the additional resources, tangible support, sponsored leadership, planned workshops and notable interest in the initiative that contributed to these outcomes.

The five research studies, discussed above, all involved the deliberate development of new CoPs that were supported directly or indirectly by the researchers. In Gabbay et al.’s (2003) multi-stakeholder and interagency ethnographic study two of the researchers facilitated the CoPs, while two more researchers observed the meetings as non-participants. While Gabbay et al.’s study is unique in healthcare research because of its ethnographic approach, it along with the other studies described above suggest a gap in research of organic and/or established or mature CoPs to learn if, and how, the experiences are different when the CoP is organic and the members have been involved for a greater length of time.

It is important to note that the healthcare literature on CoPs is not without constructive cautions about the practical and conceptual challenges of a CoP model. Bentley, Browman and Poole (2010) in their critical essay on the challenges of applying Wenger’s CoP model to a national Canadian cancer control initiative raise concerns about the ability of CoPs to address decision making any differently than usual practice groups. On the basis of their research findings Gabbay et al. (2003) reported how certain knowledge became privileged in CoPs; how new knowledge was individually and collectively transformed and internalized; how knowledge was haphazardly processed; and the effect changing agendas, roles and power-relations had on the collective sense making. These findings provide beginning
insights into the complex behavioral and social phenomena of CoPs. Wenger et al. (2002) themselves provide caution in setting the right expectations for CoPs in their comment that CoPs “are not a universal silver bullet” (p. 14).

There are a number of useful research articles describing CoPs in the business and education literature but few that report on the experiences of CoP members. Several groups of researchers have examined the framework of CoPs and its application in business or education using a case study approach (Evans & Powell, 2007; Fuller, Hodkinson, Hodkinson & Unwin, 2005; Hara & Schwen, 2006; Hemmasi & Csanda, 2009; Hodkinson & Hodkinson, 2004; Mittendorff, Geijsel, Hoeve, de Laat & Nieuwenhuis, 2006; Pemberton, Mavin & Stalker, 2007; Swan, Scarbrough & Robertson, 2002; Yandell & Turvey, 2007).

After sifting through over 1000 abstracts from the databases Business Source Complete and Education Resources Information Center collectively, looking for studies that focused on the experiences of CoP members in relationship to practice change only one relevant study was found. Both interestingly and importantly the study was catalogued in the education database and located within the Journal of Continuing Education in the Health Professions (Pereles, Lockyer & Fidler, 2002). In their study, Pereles et al. interviewed physicians known to be participants or facilitators of small groups that met regularly to learn more about the dynamics of their groups, their learning in conjunction with the group and the role of the group facilitator. The researchers reported that the physicians found the small-group learning environment was an important vehicle for initiating changes in their practice. Most of the changes in practice reported were regarded as refinements to existing practices rather than dramatic changes in practice. The authors of this study focused on small groups of 4-12 physicians that “appeared to function as a CoP” providing an opening for studies with CoPs
that report larger group membership and/or a more heterogeneous membership base (Pereles et al., p. 205).

Communities of Practice in Interior Health

The vision for CoPs as a workplace engagement strategy within Interior Health came from a newly appointed Chief of Professional Practice and Nursing (CoPPN) in 2004. Using a community development approach, the CoPPN articulated a vision for connecting front line staff across the health authority with similar interests and passions to develop and share knowledge aimed at improving quality of care, patient safety and professional development. To actualize this vision, the CoPPN spoke with other senior leaders about CoPs and then began single handedly removing barriers that had previously thwarted front line staff participation in local and regional knowledge based groups by sponsoring CoP activities, speaking at CoP meetings, eliciting participation, acknowledging the important contribution of the staff and nurturing the staff’s passion. Through the CoPPN a legitimate place for knowledge sharing groups within the organization was created.

By 2010 in Interior Health there were approximately eleven clinical groups plus a few emerging ones that identified themselves as CoPs. There were also a small number of voluntary workplace groups that function as a CoP but do not call themselves a CoP. The name of the group is considered to be less important than the fundamental characteristics it shares with officially recognized CoPs (Wenger et al., 2002). These fundamental characteristics include: voluntary participation, self governance and shared practice (composed of clinicians from the same discipline or multidisciplinary). For the purpose of this study, we focused on CoPs that were clinically-focused with a goal of enhancing or
improving quality care. The CoPs could be responsible for a host of knowledge-based activities such as recommending standardizing of practices in their area of shared practice; developing needed documents or tools; suggesting solutions to identified problems; fostering learning activities; and sharing tacit knowledge and clinical experience. At the time of this study, membership in the Interior Health CoPs ranged from 10 to 50 members. Participation takes many forms from consistent core members to occasional participation with overall attendance at CoP meetings and events fairly constant. The majority of the CoPs meet primarily by teleconference every 1-3 months for 1-2 hours and some try to meet in person at least yearly. Since CoPs are a new way of interacting for many, a sample terms of reference is available through the CoPPN’s office to assist with providing language around group purpose and member roles that supports and fosters a non-hierarchical social structure. Senior level sponsorship and support is provided by the CoPPN for all regional CoPs in Interior Health whether organic or intentionally created by administrators.
Chapter 3 – Methods

Qualitative Research

In this study qualitative research methods were used. Qualitative research is typically well suited to generate understanding about human phenomena and experience (Thorne, 2008). The inquiry is aimed at generating knowledge that helps us understand and discover as opposed to verify what we already suspect to be true (Thorne, 2008; Thorne, Kirkham & O’Flynn-Magee, 2004). The focus is on the complex human experience. Mayan (2009) writes that “qualitative researchers aim not to limit a phenomenon – make it neat, tidy, and comfortable – but to break it open, unfasten, or interrupt it so that a description of the phenomenon, in all its contradictions, messiness, and depth, is represented” (p. 11). As such, the use of qualitative methods in this study enabled an exploration of participants’ stories to develop an understanding of CoP members’ experiences and socially constructed learnings (their perceived changes in their practice) achieved through participation in a CoP.

This study was located within an interpretivist tradition and a social constructivist perspective that contends that all subject meanings are constructed through historical and sociocultural norms that operate in individual’s lives (Creswell, 2007). Interpretivist epistemologies are aimed at understanding human action (Schwandt, 2000). Communities of practice by their very nature engage in the social construction of knowledge. Social constructivist epistemologies embrace the notion that humans actively engage in the process of constructing and making meaning; that there are multiple realities and multiple truths and that a research text presents just one possibility that is historically, culturally and socially constructed (Mayan, 2009; Schwandt, 2000). Constructivists reject positivists and empiricist
objective ideas “that meanings are fixed entities that can be discovered and that exist independent of the interpreter” (Schwandt, 2000, p. 198). During the research process the researcher and the participants co-create understandings (Creswell, 2007).

Along with the theoretical perspective of interpretivism and social constructivism, my assumptions were positioned within a disciplinary orientation of nursing. As a registered nurse employed as a regional practice leader, after a long clinical career, I am committed to connecting front line practitioners, clinical experts and administrators in non-hierarchical environments where passionate contribution rather than positional authority is revered. This commitment has led to my interest in understanding CoPs and in particular their application in health settings and impact on clinical practice. Posing questions about practice is an intentional effort to raise the voice of practice as experienced by the healthcare clinicians. It is also an attempt to contribute evidence to practice that is useful and meaningful to administrators and front line staff alike.

As a member of two CoPs in Interior Health I have firsthand experience of being a member of a CoP and hold a perspective of how those experiences have shaped my practice. The goal was not to enter my own experiences into the findings but rather to assume a reflexive approach. In using a reflexive approach I critically reflected on how my assumptions, beliefs and personal experiences in CoPs influence my construction of knowledge and how these influences were revealed in the planning, conduct and writing up of the research (Guillemin & Gillam, 2004). I recognized that my location as a registered nurse, a regional practice leader and a CoP member were all part of the personal, cultural and historical construction that I brought to this research. Merriam et al. (2001) state that all researchers bring certain assumptions about the phenomenon being investigated and the people being interviewed.
My assumption was that CoPs influence participants. My anecdotal experience seemed to indicate that CoP participation is a driver of individual practice change and I wanted to understand if and how that was the case.

The term ‘insider’ is often used to describe researchers who study groups or individuals in which they are also a member (Asselin, 2003). As a nurse, I was an insider to the team of health professionals that make up communities of practice; as an employee I was an insider to the organization; and as a member of two CoPs an insider to CoPs in general. Brayboy and Deyhle (2008) argue that while insider research does have its issues “these issues do not mean that [insiders] cannot conduct good rigorous research” (p. 166). While my insider knowledge afforded me easy access to potential participants and contextual data, it has been suggested, it can also influence who participates, the data that is collected and the analysis of the data (Thorne, 2008). A demonstrated awareness of some of the issues of performing research as an insider is evidenced in the methods section of this report, specifically the section about selection of participants. These steps were taken to emphasize an inductive reasoning process that generates findings that are well grounded within data and to minimize the impact that I may have had on the process of my research, while at the same time acknowledging that my involvement in conducting this study is reflected in the findings.

In this study, I positioned myself as a nurse, a research student with a social constructivist world view and as an insider. Revealing how one is situated when engaged in qualitative research is not unique to the theoretical perspective of social constructivism but it does need to be highlighted here because situatedness and its impact on meaning and reality is a central tenet of constructivist ontology.
Design

A qualitative research approach based on interpretive description was used in this study to explore how healthcare clinicians’ experiences in a CoP shapes their practice (Thorne, Reimer, Kirkham & MacDonald-Emmes, 1997; Thorne, 2008). Interpretive description was described by Thorne et al., as a noncategorical approach to developing nursing knowledge that draws from a variety of dominant methodological traditions (phenomenology, ethnography, grounded theory). This qualitative research approach was created in response to a need within nursing to have as an option of inquiry an approach that is less theoretically driven than traditional qualitative methods and more uniquely suited to applied clinical disciplines while still being practical, credible and defensible. Interpretive description was well suited for this study because it is practice based; privileges the perspectives of those most deeply affected by the phenomena and its findings hold the potential to directly influence system level change (Thorne, 2008). Grounded in a meaning-making orientation that acknowledges that reality is socially constructed through the people who experience it, interpretive description is methodologically congruent with the theoretical perspective of social constructivism and “offers the potential to deconstruct the angle of vision upon which prior knowledge has been erected and to generate new insights that shape new inquiries as well as applications of ‘evidence’ to practice” (Thorne, 2008, p. 35).

The interpretive descriptive approach presents an analytic framework as a platform to build a study rather than a traditional conceptual framework (Thorne et al., 1997). This analytic forestructure “orients the inquiry, provides a rationale for its anticipated boundaries, and makes explicit the theoretical assumptions, biases and preconceptions that will drive the design decision” (Thorne et al., p. 173). My study was constructed upon an analysis of what
is already known about healthcare clinician’s experiences of being in a CoP. This foundational literature review provided a beginning point to expand my research upon. The known knowledge formed a “foundational forestructure” for my new inquiry (Thorne et al., p. 173). While there was considerably more literature about CoPs from sectors outside of healthcare, particularly business and education, there were few studies that report on the experiences of CoP members. Rather, most commonly the CoP literature is filled with articles on the utilization of CoPs as a construct or structured intervention.

**Selection of Participants**

Members of all groups functioning as CoPs in Interior Health, with exception of two that I was directly involved in, were eligible for participation. In order to meet the criteria for eligibility, the participating CoPs needed to be clinically-focused and embody the three essential elements of a CoP (a specific field, area or discipline; a defined community of participants; and the goal of improving the practice and professional development of the particular group) regardless of whether they formally referred to themselves as a CoP or not. The CoPs were spontaneously or intentionally formed. Due to our interest in understanding the experience of being in a CoP over time we chose to target our study to CoPs that had been established for more than one year. This reduced the number of CoPs that met the criteria for study. In addition, CoPs in which I was a member were not considered for study, further reducing the number of possible CoPs. While it has been argued that you can or should be a participant in your own research, Morse (2009) strongly advises against it. As a beginning researcher I chose to take Morse’s (2009) advice and not overtly complicate my study.
At the time I began my research a total of six CoPs of the eleven in the health authority were eligible to participate in our research. Members of five different CoPs participated. The participants for the study were selected using purposive sampling. Purposive sampling allows the researcher to select participants who can intentionally “inform an understanding of the research problem and central phenomenon in the study” (Creswell, 2001, p. 125). The use of purposive sampling allows selection of participants related to the needs of the study and based on the desire to obtain maximum variation in the phenomenon being studied.

The sample size was guided by the principles of comprehensiveness and feasibility. Comprehensiveness relates to the adequacy of the data and richness of the data variation. This principle of comprehensiveness is chosen over saturation because saturation by definition seems illusive and quite frankly overwhelming. Thorne (2008) points out that “the claim of theoretical saturation (or, for that matter, its cousin ‘redundancy’) is one that expresses confidence that no new variation in the theory will emerge from additional data collection” (p. 98). Like Thorne (2008), I think claiming that no new variation in the data could emerge is problematic. As an alternative, comprehensiveness seemed attainable and feasible. The notion of feasibility was also expanded to include its intersection with pragmatism. As a student in a time structured program with limited resources, feasibility and pragmatism were considered when determining my sample size. To that end, a total of 15 participants representing 5 of the 6 eligible CoPs were interviewed. As a novice researcher this represented a reasonable number of participants to make the study manageable in light of the large amounts of verbal data that were accrued and analyzed.
Criteria for selection.

The criterion for selecting participants in the study was based upon:

- Membership in one of the clinically-focused CoPs in Interior Health. For example: Nurse Practitioner, Acute Falls Prevention, Community Falls Prevention, Residential Falls Prevention or Rural Nurse Educators

- Participation in the clinically-focused CoP within the last year.

Selection process.

Once approval from the Research and Ethics Board had been obtained, a letter (Appendix A) was sent to the facilitators or co-leads of the clinically-focused CoPs listed above to introduce the study and to ask them to distribute a recruitment flyer to the community members (Appendix B). Interested CoP members then contacted me directly.

Members of the selected CoPs that had participated in their community within the last 12 months were invited to attend. Since the aim of the study was to critically explore how healthcare clinicians’ experiences in a clinically-focused CoP shapes their practice it was ideal to choose participants that could offer varied and rich stories. I interviewed all community members that responded to the invitation to participate, met eligibility requirements, and were available to be interviewed within the timeline I had developed.

The participants.

A total of 15 CoP members from five different CoPs agreed to participate in the study. The majority of the participants were female and ranged in age from 28 to 57. Seven registered
nurses were interviewed, four nurse practitioners, two physiotherapists, one occupational therapist and one quality consultant. Twenty-seven was the mean number of years in practice. Most participants were involved in one CoP while some were involved in two, three or four CoPs. Length of time as members in the CoP varied among the participants. Two of the participants had been involved in the CoP for approximately one year; five had been involved for 13-24 months; four for 25-36 months; and four had been involved for more than 36 months. When asked to self rate their involvement in the CoP, on a scale of 1-5 with 5 indicating high involvement, the average rating was 4. Half of the participants accepted additional roles within the CoP such as secretary, chair or facilitator. Research participants reported attending between 75 to 100% of all CoP meetings scheduled each year.

Data-gathering methods.

Data was collected using semi-structured individual interviews at a time and place that was convenient for the participant. Ten of the interviews were conducted by telephone and five face to face. With the permission of each participant the interviews were digitally recorded. Each interview lasted between 30 -60 minutes. An interview guide was developed and used to draw out the experiences of the participant while exploring the research questions. A pilot interview was conducted with a local research facilitator to establish appropriate guiding questions and optimal flow. A sample interview guide with prompts is provided in Appendix D.

To collect descriptive information about the participants, a brief questionnaire was used to obtain demographic information (Appendix E). Other data include recording field notes during each interview. The field notes were used to capture nonverbal information; to
backup to any failed recording; to help me record my ideas and insights including those that I might need to pursue or consider further; and to track my inductive process (Mack, Woodsong, MacQueen, Guest & Namey, 2005).

**Data Analysis**

The strategies I used when analyzing the data include inductive reasoning and constant comparative analysis. Inductive reasoning involves generating ideas from the data as opposed to using the data to confirm or negate an idea (Thorne, 2000). Constant comparative analysis involves taking one piece of data and “comparing it with all other that may be similar or different in order to develop conceptualizations of the possible relations between various pieces of data” (Thorne, p. 69). Mayan (2009) writes “the qualitative researcher collects data, analyzes them, collects more data to fill in gaps, analyzes them, collects more data, and so on” (p. 88).

The data analysis process involved a number of phases. After each interview I listened to the digital recording, read my field notes and took additional notes (memoing) before conducting another interview. Memoing involved writing preliminary analytic notes about the data in an attempt to make connections and ask questions about why something is the way it is (Mayan, 2009). A close read of the transcripts was done as soon as they were available to ensure they reflected the participant interview and to get a sense of the data from the interviews. Important ideas or statements were highlighted to identify common elements; to look for expressions of variation; to locate contradictions; and to uncover meaning of the participants’ experiences beyond the self evident and previously known. Posing questions about what might be going on in the data or what the data might be suggesting, as well as, writing initial
reactions to the data were part of the close read. More than one close read of the data was required particularly as new data was gathered so that comparisons could be made and similarities (if any) could be identified. The close reads were also intended to surface any ideas, perceptions or concepts that might have benefited from further exploration and therefore direct subsequent interviews.

After five interviews were completed, transcribed, memoed and read, I began fracturing the data into segments and open coding. Fracturing the data involves “taking it apart and examining those discrete parts for the similarities and differences they reveal” (Thorne, 2008, p. 145). The data was examined for persistent images, words, phrases or concepts so that patterns could be identified (Mayan, 2009). More specifically, an open code or label was applied to segments of the data as a description so that I could begin to compare and contrast the data. A preliminary framework was developed to house the coded data segments. Initially these labels (or open codes) were very close to the data and became more refined as the data was further distilled. The labels (or open codes) were compared and contrasted looking for groupings of similar descriptions so that focused conceptual labels could be applied to groups of open codes. Focused codes are more abstract, general, and inclusive than the initial labels (or open codes) that they subsume (Charmaz, 2002). Additional interviews were conducted, analyzed and coded. A number of changes and then refinements were made to the coding framework as interviews were compared and new meanings surfaced. More interviews were completed, transcribed, sorted and coded. The process of synthesizing and sorting the data, open coding and selective or focused coding was repeated until more precise analytic categories formed that represented distilled data from the multiple interviews (Charmaz, 2002). The categories assisted with bringing together data that was related (Thorne, 2008).
Broad categories or categories with large amounts of data were divided into subcategories. My thesis supervisor and committee members were asked to review my categories and provide input into my analysis. A summary of the categories provided insight into healthcare clinicians’ experience of being in a clinically-focused CoP and how those experiences shape their practice.

**Rigor**

The results of interpretive descriptive studies constitute a tentative truth claim about what is common in practice and in doing so provide insight about practice and a basis for informed decision making. As such, the goal of interpretive description is to provide credible, coherent, auditable, and potentially applicable knowledge to the discipline. This goal was supported using four approaches initially presented by Guba and Lincoln as cited by Sandelowski (1986). These four approaches were credibility, fittingness, auditability and confirmability.

A credible study is described by Sandelowski (1986) as presenting “such faithful descriptions or interpretations of a human experience that the people having that experience would immediately recognize it from those descriptions or interpretations as their own” (p. 30). Credibility can be threatened by the researcher ‘going native’ and becoming enmeshed with the participants and having difficulty separating their own experiences from that of the participants (Sandelowski, 1986). This must be balanced with the understanding that when using an interpretive description approach there is an “inseparable relationship between the knower and the known, such that the inquirer and the ‘object’ of that inquiry interact to influence one another” (Thorne, 2008, p. 74). Credible representation can be enhanced
through researcher reflexivity which required reflecting on and being mindful of the influences I had upon the data sources, knowledge construction and knowledge production (Guillemin & Gilliam, 2004). “Adopting a reflexive research process means a continuous process of critical scrutiny and interpretation, not just in relation to the research methods and the data but also to the researcher, participants, and the research context” (Guillemin & Gilliam, p. 275).

Fittingness of a study, according to Sandelowski (1986), is determined by how well “its findings can ‘fit’ into contexts outside of the study situation and when its audience views its findings as meaningful and application in terms of their own experiences” (p. 32). A threat to fittingness can be ‘holistic fallacy’ in which the researcher does not report all the data, but presents it as all encompassing or reports the data as “more patterned or regular or congruent than they are” (Sandelowski, 1986, p. 32).

Member checking was employed as a way to confirm, clarify and elaborate on the synthesis of my research finding (Thorne, 2008). Member checking was done during the interview process to verify statements and interpretations, as well as emerging themes. In addition towards the conclusion of the study preliminary findings were shared with three participants to see if any of what I was proposing rang true of their experience. The participants were chosen for member checking based on heterogeneity and experience with CoPs. This strategy was intended as a mechanism to confirm, clarify and elaborate on findings related to relationships, patterns and themes. In addition, member checking in this way challenged my thinking and produced questions to assist in refining the findings rather than affirm transcribed verbal text (Thorne, 2008). A final strategy to enhance fittingness of my findings involved close mentorship with and constructive feedback from my thesis supervisor and
committee to ensure I had synthesized the data and presented it as an interpretation as opposed to “reproducing the data in a shorter form for others to interpret” (Sandelowski & Barroso, 2004, p. 216).

The criterion of auditability, as an approach to establish rigor, is evidenced when another researcher can clearly follow the decision trail used by the investigator and “could arrive at the same or comparable but not contradictory conclusions given the [investigator’s] data, perspective, and situation” (Sandelowski, 1986, p.33). An audit trail is conveyed through the written representation of my research, how I link ideas together, explain decisions and choices, extract data and make-meaning from the data. As a novice researcher seeking direction from my thesis supervisor and committee to guide me through my audit trail was invaluable.

Confirmability is evidenced when auditability, truth value (or credibility) and applicability (or fittingness) are present (Sandelowski, 1986). Unlike quantitative research that views freedom from bias and objectivity as criteria of rigorous research, qualitative research “emphasizes the meaningfulness of findings achieved by reducing the distance between investigator and subject and by eliminating artificial lines between subjective and objective reality” (Sandelowski, p. 34). Sandelwoski remind us that “confirmability refers to the findings themselves, not to the subjective or objective stance of the researcher” (p. 34).

**Ethical Considerations**

Written approval to conduct the study was obtained from the Interior Health Authority Research Ethic Board, as well as, the University of British Columbia Behavioural Research Ethics Board. I worked under the supervision of Dr. Joan Bottorff, University of British
Columbia Okanagan and adhered to the Canadian Nurses’ Code of Ethics, as well as, the College of Registered Nurses of British Columbia Standards of Practice.

The rights of the participants were protected in several ways. Once approval to conduct the study had been obtained I sent a letter introducing the study to the CoP leaders/chairs and co-chairs (Appendix A). I asked that the CoP leaders/chairs and co-chairs distribute to their CoP membership the Recruitment Brochure (Appendix B). Interested participants then contacted me directly either by e-mail or telephone. Once contact had been made by the participants I provided them with a Consent Form (Appendix C). The consent form outlined the background, purpose, procedures, benefits and risks of the study. It also confirmed voluntary participation and confidentiality. If the potential participant agreed to proceed a date and time for the interview was established. Participants were assured that their decision to participate or not would not be shared with the CoP facilitators or co-leads. At the time of the interview the Consent Form was reviewed and collected. If the interview occurred over the telephone, the participant was asked to electronically scan or fax a copy of the signed consent form to myself, the research interviewer. Participants were also asked to complete the Demographic Form (Appendix E). The demographic data was used to describe the participants’ characteristics. Participants could withdraw from the study at any time with no negative repercussions. No requests for withdrawal were received. The participants were informed that quotes may be used to highlight findings. Careful attention was taken to ensure the quotes used cannot be attributed to an individual.

Digital recordings and written material from the study was kept in a locked filing cabinet in my home office while the study was underway and in a password protected file on the principal investigator’s University computer once the study was completed. Computer based
data (transcripts and analysis of transcripts) was kept in a password protected file on my Interior Health computer. To back up the computer data a USB flash drive also known as a data stick was used during the study and all data on it was deleted after the writing of the study was completed. After seven years, electronic files will be deleted and transcripts will be shred. Only my thesis supervisor, my Masters committee and I will have access to the data.

To maintain confidentiality the participants were given a coded number (e.g. P #4), general descriptors of the interview setting were used and any information that could identify the participant was altered. Participants were requested not to use names of persons during the interview and names were not entered into the written transcripts or data analysis. Within the study findings, specific information about the study participant’s occupation, position, site of work, or gender was not included to further protect confidentiality. A confidentiality agreement with the person performing the transcription was completed (Appendix F). Upon completion of the study the participants were provided with a written summary of the study findings and informed where they could access the completed thesis, should they be interested.

Participants may or may not have benefited from being in this study. At the very least it is expected that they will have thought about their experiences in a CoP and considered how those experiences impact their practice. There was no risk anticipated from participating in this study.
Chapter 4 – Findings

In this chapter I present an interpretive description of the experiences of healthcare clinicians in clinically-focused communities of practice from one large health authority. The description was constructed from the analysis of the study participants’ narratives. In the data analysis three primary dimensions of CoPs were evident: constructions of CoPs, participant’s experiences in CoPs and perceived outcomes of CoPs. These categories and subcategories provided a framework for presenting the study findings and will be described in this chapter.

Constructions of Communities of Practice

There were four main ways people talked about CoPs. Participants constructed CoPs as a learning community; as a means to cope with organizational life; and as a mechanism to get organizational work done. In addition, in some narratives CoPs were constructed as an elite group within the organization.

Communities of practice as a learning community.

The notion of CoPs being a community of learning was evident in some descriptors participants used to describe what a CoP is and what it meant to them. One participant talked about the CoP being a place she finally “fit” professionally; and another as key to her “professional satisfaction and professional growth.” One participant simply said it is “a learning place.” For these participants, CoPs provided a learning community where best practices were determined, negotiation of understanding occurred and clinical judgment was strengthened. Learning occurred both formally through planned education sessions that were led by guest speakers or CoP members, and informally through storytelling, conversations (both during and after CoP meetings) and electronic correspondence. The essence of learning
together and building a place where learning could occur in a safe and nurturing place were thought to be fundamental aspects of CoPs. Foundational elements to the way participants talked about this construction were professional development and the notion of developing as a profession.

Engaging with each other to develop expertise and understanding of subject matter important to the CoP and its members was evident in the way some participants reported that their CoPs structured their meetings to include (formal) educational sessions and (informal) round table sharing of case presentations. One participant explained that:

Everyone comes to the table with previous experience or expertise in a certain subject, whether it is pain or diabetes, and we learn from each other through examples. We take turns facilitating or providing continuing education and we review our required educational modules. So, it is key to learning from each other by talking about our current practice areas and bringing in our previous experience and learning we have had from conferences etc.

Participants also described incidental and informal exchanges of information such as musings and wonderings that allowed the group to begin to assign meaning to what they were hearing and develop a shared understanding. Their shared understanding, in some cases, informed best practices.

The space that CoPs provided for learning was emphasized in this construction of CoPs. Bringing together people in a CoP was described by one participant as a “pretty effective and relatively easy way” to create a safe place for learning together and building collective knowing. Providing a space for professionals with a common interest to learn and develop
their craft and their professional identity together was critical to the nurse practitioner CoP as pioneers “in a system that really didn’t know what to do with them.” One participant said “when we get together or even on a teleconference we strategize about how to deal with professional practice issues, how to deal with cases we haven’t seen before and how to deal with barriers to our role.” Still, other participants talked about building upon understanding and expanding others knowing by presenting their experiences in CoPs to other groups both inside and outside the health authority.

**Communities of practice as a means to cope with organizational life.**

CoPs were also constructed as a way of coping in the broader health system both within and outside the health authority. For those individuals who constructed the CoP in this way, the CoP provided a protected space for the members to “muddle through” or learn to “deal with” the complexities of the healthcare system and the large organizational structure that characterized this health authority.

Communities of practice were characterized as particularly important for individuals who felt isolated in their practice because they worked in rural areas or were the only professional in an area, urban or rural, with a similar set of skills. These participants constructed CoPs as a way to help them stay connected with the rest of the organization. One participant who worked in a rural community and felt isolated from colleagues in the organization shared how the CoP connected her with nurses from other rural areas and provided a place for her to learn about regional initiatives and implementation plans:

> Because I live in the rural area, the other educators [in the health authority] don’t have the same situation as me. Whereas in the community of practice those folks are
sort of in the same situation. I guess I do find it hard in this organization to know when things are in the works and when they are actually being pushed out of the door for official rollout.

A participant who had a solo practice in an urban setting said the CoP helped her connect with people that did similar practice, “feel a little less isolated” in her work and provide her with “a boost at times” knowing that other people were also battling similar things and “still sticking with it.”

The ability of CoPs to help individuals navigate across the large health authority was echoed by many. In particular, involvement in CoPs helped participants get to know others in the organization and to talk to them regardless of where they were in the organization. This was perceived as not only useful in understanding the organizational structure but also the resources available in different regions of the health authority. Some participants in rural practice spoke of the CoP providing them with a venue to share their resource challenges with others, while those in urban practice talked about the CoP providing them with a forum to learn more about rural practice and better understand rural challenges. This sense of ‘site awareness’ seemed to contribute to a connectedness across the region regardless of where they worked.

The importance of CoPs in helping orient new employees to the organization and/or new to their role was evident in a number of comments from study participants. One participant, a relatively new employee to the health authority stated that the CoP was “beneficial” for “learning the organization” and “learning what people are doing.” Another, familiar with her practice area but new in her role and its requirements to implement regional initiatives shared
that being in the CoP reassured her that she wasn’t the only one having difficulties. A number of study participants spoke about how the CoP they belonged to was instrumental in supporting their integration into a new role that was not only new to the practice area but also new to the health authority and the province. This was evident in the comments from one participant who said:

It was a connection for [us] to just connect because we’re scattered all over the [health authority] and it was a new thing that we were doing. I mean the position was new, the role was new, everything was new. I expected it to be a support group but not to the depth that I think that it actually is, because it is more than that. It is education; its support; it’s keeping in touch with everything that is going on.

Communities of practice were thought to provide an important supportive structure or network to help the members to situate themselves in their new roles wherever they were in the organization. Accordingly, as suggested by one participant, the CoP directly contributed to the success of her new practice role both individually and collectively.

**Communities of practice as a mechanism to get organizational work done.**

Some participants constructed CoPs as an organizational strategy to get required policies or practices enacted. This construct was reflected in two ways. First, it was suggested in participant’s descriptions of CoPs as groups intentionally formed by administrators to bring people together around core practice requirements. Second, it was apparent in the way study participants talked about the tension between ideal notions of CoPs as voluntary and autonomous groups that determine their own goals; and the “reality” of CoPs being required to meet organizational objectives within a voluntary structure.
The perception that CoPs were intentionally cultivated to meet the needs of the organization was suggested by one participant who described the CoP as “something the [health authority] organized in order to connect people together…and to share ideas and develop strategies and education and things like that.” Reflected in these comments was the belief that CoPs were an ideal conduit to frontline healthcare workers where organizational information could be channeled and regional initiatives could be developed and refined for implementation. One participant stated:

The overall purpose is to inform and implement regional strategies in whatever setting it’s focused on. So we’re about advancing practice. So we don’t just develop and that’s it. Our people are frontline people and their role is also to implement those strategies in whatever sphere they work.

In constructing CoP in this way, there was a sense that it was critically important to belong to a CoP to fulfill job responsibilities, so as not to be “left behind,” and to have a say in organizational change. One participant explained:

There is a sense of sort of wanting to make sure your area is being heard…[because there is] a lot of decision making and determining what is going to roll out on a regional kind of standard and I think people don’t want to be left behind in that.

Another participant stated that if she didn’t participate there would be no one to represent the voice of her practice area and she worried that decisions might get made without all perspectives being considered.

Some participants in one CoP believed that their CoP had been given a “mandate” by the organization to improve patient safety and they needed to “deal” with the changes and “be a
part of [the changes]”. While admittedly not opposed to a “mandate” of safety, some participants felt overwhelmed with the CoP’s obligatory decision-making responsibilities given they functioned as a “voluntary” group with fluctuating participation and little authority. This struggle was reflected in the following comments about CoP: “They give lots of direction in it and um, like you guys have to decide this and you guys have to decide that. Well if we have to make all these decisions then why is it voluntary?” The perceived need of the CoP to be productive and get required organizational practices implemented created frustration for some when others didn’t come to meetings “prepared” prompting the suggestion that meetings should be mandatory. One participant proposed that a manager from each site should be required to attend the meetings so that they were aware of and could be accountable for the practice changes occurring. This tension between wanting to improve practice and the reality of trying to implement improvement strategies within the voluntary structure of a CoP proved to be troublesome for some. One participant’s comments illustrated this frustration:

So to me it’s kind of an oxymoron. The CoP is supposed to be something that you’re suppose to participate in voluntarily but at the same time it’s like management wants all hands on deck with implications right? Like, so to me it’s kind of odd that way.

In CoPs that appeared to function as mechanisms to enact organization goals concern that the organizational needs were taking away from the intent of the group was expressed by one participant who said:

I think it should be more about subtle exchanges of information rather than committee work where you are documenting or bringing out a document or making decisions. I
feel like it is an opportunity that we don’t get very often to just share stories and to
dialogue together. And everyone who is interested in that for whatever reason is
together and influencing each other because of these story telling opportunities more
that the decisions we make.

Communities of practice as an elite group.

Some perceived CoPs as being somewhat special and having a certain degree of status in the
organization. This status was embedded in particular meanings participants and the wider
system afforded the group. This notion of elitism applied not just to one group but there
were instances of it across all groups. It was reflected in discussions about efforts to join
CoPs, who attended meetings, and the way that CoPs were valued in the organization.

While some CoPs are well known in the organization and actively recruited new members,
others CoPs were less well known and membership was perceived to be restricted. The
exclusivity of the CoP was reflected in the comments by one participant as she talked about
the effort she went to in becoming a member of the CoP:

    I think I got invited as a side person and then I actually had to work at getting my
    name on the list and access to things and all that kind of stuff, but I just found such
    benefit from that group, that I worked to get myself in and on it.

Membership was perceived to hold value in these CoPs because the social connections
provided access to information, skills, and enhanced power within the organization that was
not available in other ways.
Implied in some descriptions was the notion that CoPs were mechanisms for producing or reproducing inequities in the health care authority by virtue of the focus of the group and who attends CoP meetings. Special status appeared to be attributed to CoPs that differentiated themselves from front line staff because of a focus on advanced practice or because they required members to have advanced educational preparation. The status of the CoP was also influenced by the timing of meetings which inherently restricted membership.

In a healthcare system where the majority of staff has patient care assignments and work shift, the notion of being able to attend a daytime meeting was typically afforded only to those with authority or status. The notable absence of front line staff in most CoPs appeared to reinforce the status of these groups in the organization. One participant pointed out, for example, that it was challenging to get feedback from the “grassroots” since “the majority of the people who are free to participate in these communities of practice are a little bit up the food chain” as professional practice leaders, managers or supervisors.

In the member checks one participant suggested that CoPs might be considered “privileged” groups rather than elite groups. She rationalized that as an interest group passionate about a certain area of practice CoPs collected knowledge and exchanged information across the health authority, and in some cases across the province allowing for “privileged access to information” and enhanced knowing. This enhanced knowing enabled the group to represent the “voice of practice” and with that came a certain amount of opportunity, benefit and “privilege.”

Although CoPs had the potential to benefit some staff more than others, the perception that CoPs were valued by the organization because of their ability to recruit new staff to the organization and retain current staff was also evident in the data. An example of this
perception was evident when a participant shared that the “wonderful…reputation” of a CoP was key to her decision to join the organization. Another participant talked about a CoP that was formed to support the successful integration of a new nursing role in the health authority and how that CoP has contributed to “100% retention” of the first nurses hired because of how much the nurses “have felt supported by their community of practice.” A third participant, a member of the same CoP as the two participants above commented that the “good retention rate” of advanced practice nurses in the health authority “versus other locations” was because of the “relationships of colleague support and collaboration” that had been built in the CoP.

**Experiences in a Community of Practice**

The experiences within a CoP were all grounded in the relationships that developed in the group. Communities of practice were described by participants as a place for them to develop relationships with others in the organization. At a very basic level a CoP provided individuals with the opportunity to link with others and get to know others in the organization. One participant who joined a CoP that meets by teleconference stated:

[It’s] an odd experience because you have connections to a person that you know the name of, you don’t actually have a face to put to the name, but you know what they’re doing because of what they’ve shared in the session and you’ll use them as a resource in the future.

Over time some participants developed long standing or deeper relationships that tied them to each other and the group; and cultivated friendships which made their work experiences more meaningful. Through these relationships the CoP members described their experiences
in the following ways: as peer support; practical help; and a way to stay on top of things. These experiences will be expanded on in the paragraphs that follow. While the majority of the participants reported their experiences in the CoP were positive, challenges and issues surfaced which will also be presented in this section.

**Peer support.**

For some participants the support they experienced from the CoP was the single most important aspect of the CoP that kept them engaged in and returning to the CoP. One participant shared that the “relationships that are built aren’t necessarily mandated as part of your job but they happen because people are interested and engaged in what they are doing.” The kind of support the members valued in the CoP were being listened to, getting positive reinforcement from their peers, being acknowledged for the work they were doing and having a group they could go to for reassurance and friendship.

Supporting one another, for some, required a deeper level of engagement than linking and was expressed as meeting an emotional need. The essence of this was present in the comments from one participant who described how the CoP she is involved in connects with its members “who are struggling to make them feel valued [so that they know] there are solutions and that they have colleagues they can contact who may be able to help them with their problems and share the good stuff.” The relationships developed in a CoP were perceived to contribute to the communities being a safe place to ask for help. One individual spoke of reaching out to CoP members for guidance and reassurance about a practice situation and feeling comfortable in doing so because of the supportive relationships that had been developed in the CoP. Similar comfort, the participant shared, had not be attained with
other groups she had been involved with. A sense of the value participants placed on the support they received through the CoP was conveyed in their continued involvement with the group. This was evident when talking with one participant who shared:

I just do the community of practice because it matters to me…I like the relationships and I make it happen…I just do it because I want to and because I know I get such gain from it and I know it directly relates to my job.

**Practical help.**

Participants talked about experiences of helping each other in very practical ways in CoP meetings. Helping each other was deemed as particularly beneficial for those who worked in rural areas or had solo practices because they had few colleagues in their immediate practice area to pose questions to or to assist with troubleshooting care strategies. Study participants described working together on projects, mentoring, problem solving, challenging each other’s thinking and bouncing ideas off one another as ways they helped one another.

For some, the CoP was a forum to quickly access the expertise and opinion of others to help solve everyday problems and share ideas. One participant constructed her experience in the CoP as providing some “really practical help…exactly the information [she] needed” to improve the safety of patients in the environment she worked. The ability of the CoP to act as a network where individuals contributed to solving problems and offering solutions permitted participants to share practice problems by “firing an email out or giving somebody a call and say ‘you know, this isn’t working right for me what do you think?’” This notion of a network of people being available across the organization to help each other was also acknowledged by another participant who said:
People can actually bring real time, real life challenges to the community of practice and we’ll problem solve them on the fly. Or somebody else will say ‘I got a really good resource around that, I’ll email them to you. Or let’s take this offline and go have a conversation about it’.

For others, the CoP provided a forum for debate and discussion which helped them become clearer about the implications of the changes they were experiencing in the organization and the introduction of new roles. One participant shared that in the CoP that she belonged to, they helped each other become clearer about their new role and its function as they debated their ideas and “challenged each other’s thinking.” Challenging each other’s thinking allowed them to “come away with much more clarity about the role” which in turn helped them in communicating and enacting their new roles.

Some participants talked about projects that members of the CoP worked on together. A rural acute care nurse described the process the group went through to improve the identification of patients at risk for falls by “building the questions about falls” into the nursing assessment on admission to hospital. Another participant shared a list of projects the CoP had worked on including improving injury prevention pamphlets; developing reminder posters for staff of best practices; and influencing new equipment purchases. For some the helpfulness of the CoP was embedded in the story telling and sharing of practices that occurred while they worked on projects. The sharing of stories and practices was found to enrich the project collaboration and improve participants’ project experiences. This was evidenced when a participant talked about a falls prevention project her CoP was working on and how she was able to share her experience with a certain type of non-skid sock and that this information was taken up and used by the group as they developed the project.
Gaining practical help in their practice area through mentorship from others in the CoP was identified by some participants as a key function of their group and by others as a bonus of being in the group. A member of an advanced practice CoP shared that they mentor all new members to their group and found this strategy important to “really help each other and the [new] role succeed.” Another participant, stated that mentoring is “hugely important” because in a new practice role the “mentor piece can’t be replaced by your manager at the office or a physician.” A nurse in rural practice shared her delight in finding mentors, within the CoP she belonged to, making her experience in the CoP “more than [she] expected.”

**Staying on top of things.**

Some participants constructed their experience in a CoP as an important means for them to “stay on top” of what was going on in the organization. This was seen as important to participants because of the rapid pace of the changes occurring in the organization, in the provincial healthcare system and in clinical practice. The CoP provided a forum for knowledge to be shared, vetted, validated and disseminated.

Participants talked about learning from each other, sharing information and presenting knowledge as important CoP activities. One participant in a new practice role described how the CoP “in and of itself is an avenue to share new changes, scope of practice, ideas, concerns, funding and that type of thing.” This was affirmed by another participant who said “we learn from each other” and “take turns facilitating or providing” education including updates from conferences. Coming together from “different areas in the health authority with different interests and discussions” was identified by one participant as helpful in “gaining
experience” and “getting a wide berth of information” from a variety of sources. A rural nurse educator stated:

By being part of the community of practice I am finding out about things that I can implement at my site that for me, the upfront work has already been done, so at my sites it’s more of a roll out, more information sharing, more getting the information out there about things that have been previously developed that I had no awareness of, and didn’t have a formal way of finding out about prior to.

Participants perceived that members of the CoP held important expertise gained through experience in the organization, years of clinical practice and education and were willing to share this first-hand knowledge with their peers. Learning from the “experts on the phone or at the live meetings” about “how [they] tried things or “how [they] do this” was identified as significant by many participants. For some participants learning from others was a way for them to stay on top of clinical practice and “connected to the front lines” particularly if in their current position they no longer provided direct patient care. This was evident in comments from one rural site manager who talked about how she learned from CoP members about a new and effective strategy to reduce patient’s risk of falling that she would have never thought of herself: “I mean I did not know non-skid socks existed before being in the community of practice. I mean how would I know that? I mean the light bulb doesn’t go and say ‘go look up non-skid socks’.”

**Challenges and issues.**

Although participants focused on the perceived benefits of CoP, there were indications in the data that membership in CoPs came with some challenges. Busyness, securing time to meet,
travelling to meetings and getting release time to attend meetings were identified as some of the ongoing challenges that influenced participation in CoPs. For some these practical constraints made it extremely difficult to not only attend meetings but to come prepared for meetings. For others, not being able to attend made them feel disconnected from the group and in some cases “lonely.”

The growing size of the CoPs presented new challenges for some. These challenges ranged from issues such as slowed productivity and difficulty gaining consensus to a growing lack of trust. As these issues emerged some participants described a rising sense of impatience with the group. This was captured in the comments from one participant who stated:

As the community has grown, we’ve had a little bit of fragmentation because it is very hard to keep everybody on the same page. We were trying to set up documentation, some patient hand out things, some things we would use for teaching, and when there were only eight of us it was pretty easy to gain consensus. Now that we’re more like 20 or 30, and sometimes we go around and around while everybody has an opinion.

Another study participant described how she felt the “trust” in the CoP she belonged to had lessened as the CoP had grown and “moved away from the safety that a smaller group provides.” The growing group made it difficult to connect with people and develop trust. A lack of trust, the participant shared, could in the future contribute to her leaving the group.

As CoPs evolved and changed over time the changes were embraced by some and accepted tentatively by others. During times of change, some study participants described a “nurturing” of their CoP that occurred to ensure the members’ needs were met, participation
remained high and the community stayed true to its intent and philosophical ideologies. As the community strayed from its primary intent CoP leaders were called upon to re-engage the group and strategically work with the organization to improve its understanding of the purpose and characteristics of a CoP. One CoP leader described the biggest challenge she thought the groups faced as:

Helping the formal organization and leaders within the formal organizations understand the value of a structure like this. People need to be comfortable with the fact that these are knowledge brokering kinds of communities. The value and benefit is in the outcome, in what happens in these communities. It’s not you know, seeing a whole bunch of stuff on paper necessarily. It’s the shared learning that goes on, peer support that goes on. But it is a different way of thinking about things.

Challenges arose for some CoP members when their need for productivity and conformity from the CoP members went unmet. Others felt stifled by the need to produce outcomes that were required by the organization. These opposing viewpoints created dissension in some groups that was palpable by some and seemingly undetected by others. This tension did not exist in all CoPs but when present was frustrating and had the potential to limit the success of the CoP.

**Perceived Outcomes of Communities of Practice**

As participants described the outcomes of a CoP, there were two main themes: a sense of belonging and practice changes.
A sense of belonging.

A sense of belonging created by the CoPs was suggested by some participants to be a key outcome of membership. It was experienced as a connection not only to others in the group, but to the organization as a whole and was reflected in descriptions of camaraderie that developed within the group. Participants described a sense of feeling they were not alone as they went about their jobs. One participant summarized this when she said:

The strength of the community of practice is absolutely that we’re not standing alone. I can take advantage of all the knowledge out there and all the tools that currently exist and just use the resources that are there and that to me is the biggest thing.

The security of being in a group and having a collective voice were identified as positive outcomes of community membership. Suggested by one participant was the notion that CoPs allowed participants to contribute a larger voice within the organization and the province to issues or concerns “because it’s not one person [speaking] it is a group [speaking].” A sense of belonging was attributed by another participant to have added to her personal and professional satisfaction and growth. This same participant pointed out that the sense of belonging CoPs create contributes to employee retention.

Changes in practice.

Stewarding changes in practice was identified in the data as a significant outcome of participation in the CoP and was reinforced by their desire “to make a difference” in the lives of others. For some, participation in the group resulted in changes in practice not only for themselves but for the organization as a whole. These practice changes were aimed at improving patient care and enhancing patient safety. Examples of these changes included
assessing patient’s fall risk at admission; caring for patients with dementia differently; updating transfusion practices; and lowering bedrails to improve patient safety. Through participation in CoPs members were provided an opportunity to contribute their practice perspective, devise practice solutions, make practice decisions and coordinate practice change.

Many participants shared stories of how they enact or think about their practice differently because of something they heard or learned through the CoP. One study participant talked about how her practice had been “totally changed” after attending a CoP learning session on care of the elderly and dementia. She went on to describe how a “couple of things tweaked [for her]” and helped change her approach in practice. A participant, in rural practice, explained how she took information she learned during a CoP teleconference and introduced some “simple” changes to the collection of patient information at the site she worked “reducing the risk” of patient falls while not “adding to the [staff’s] workload.” Another participant stated that the CoP often provides her with that “one little nugget” of information that she could take back to her practice area and improve patient safety. Embedded in one participant’s practice was a different safety message when working with or educating nurses on bedrails and patient safety because of research that had been presented at one of the CoP meetings:

So we were trying to sort of change the practice and it went on a big pendulum sweep so it was like ‘all bed rails up’ on everyone and I believed that for a while too, and then ‘all bed rails down or at least the bottom bed rails down. …and then [name] brought forth some research and then people started talking a little bit about times when they needed the bed rails up and also the risk of entrapment, which isn’t
something I’d ever thought about of because it’s so rare. So I started thinking about that a bit more and now when I’m educating I share a different message with the nurses that I work with or I’m educating.

Since the focus of the CoP discussions were “clinical and about how to improve clinical and improve the things that we’re doing”, one participant suggested that clinical practice is inherently influenced and improved.

The ability of members of the CoP to deconstruct a broad variety of knowledge-related issues and promote practice improvement was evident in the data. This was done through raising awareness, within and outside the CoP, of practice standards, practice updates and new initiatives. A participant in rural nursing practice shared that she was able to take the new practice information about transfusion care that she learned at a CoP meeting and pass it on to nurses throughout the hospital so that all the nurses received information about the updated standards. Other participants described how they took what they learned at a CoP and shared it with their staff, co-workers and educators at staff meetings, during educational sessions and through communication books or posters. One participant suggested that “the community of practice is there to …support the standard and keep it alive” by “reminding the staff” of the standards and by “building more and more [care standards] into the job and into the documentation.” In one group, clinical and equipment standards were set by the CoP, implemented and evaluated. This ability of the CoP to broker knowledge was mentioned by many.

Changing practice through CoP participation was suggested by some to also be shaping organizational culture. By building, sharing and applying knowledge through practice
changes the work of the CoP was becoming visible to the organization. One study participant involved in a number of CoPs commented that the CoPs she was involved in “we’re not just changing practice” but that they were “changing the organization” through “persistence and doggedness and just shaping how people do their work, how they view their work.” This was similarly suggested by another participant who said “the community doesn’t just assist with practice issues, but we’re also a strong change agent within the health authority and provincially.”

**Recommendations to Improve Communities of Practice**

Recommendations to improve the effectiveness of CoPs in the health authority focused around the need for support from all levels of administration in the health authority. Tangible supports included suggestions of paid release time to attend meetings, travel budgets for in-person meetings, clerical support and multilayer involvement of shift workers and support staff. Some participants proposed a central listing of all CoPs be created so that people had awareness of optional communities and could attend ones that interest them. Another idea was for the community members to receive acknowledgement or a token of appreciation from administration for their work. Some suggested the health authority simply “need(s) more of them.”

Alongside these tangible supports was the identification of the need for strategic supports. Intentionally raising the profile of CoPs and legitimizing their contributions with senior leaders was felt to be necessary to increase the organizational validity of CoPs to the same importance awarded “official committees that are officially part of the job.” It was suggested by one participant that by raising the profile of CoPs organizational “support, validity and
honor” would be gained which in turn would encourage more involvement of CoP members. Implied in some descriptions was the notion that the importance of CoPs to its member was poorly understood by administrators creating inequities in the value awarded to work groups/teams compared to CoPs.

**Summary**

In conclusion, an interpretive description of the experiences of healthcare clinicians in clinically-focused CoPs has been presented in this chapter. These findings represent the analyzed data of the participant’s narratives. Three main dimensions of CoPs that emerged from the data have been presented and unpacked: constructions of CoPs, experiences, and outcomes. Participants constructed CoPs as a learning community, a means to cope with organizational life, a mechanism to get organizational work done, or an elite group. Participant experiences within a CoP included supporting one another, helping each other in practical ways and staying on top of things. The two main outcomes of being in a CoP were perceived by the participants to be a sense of belonging and practice changes. Although participants talked very positively about their experiences in CoPs there were also challenges and frustrations that came through in the interviews. These challenges and frustrations along with all the positive experiences represented in the data and presented in these findings are just one possible interpretation that is historically, culturally and socially constructed.
Chapter 5 – Discussion

This thesis concludes with a discussion of the main findings of this qualitative interpretive description research study. The chapter will begin with a brief summary of the findings. Following this, the main findings related to study participant experiences of being in a clinically-focused CoP will be discussed in relation to existing literature. The study limitations will be presented and recommendations based on study findings will be discussed. Finally, the chapter will end with a conclusion.

Summary of the Findings

The purpose of this qualitative study was to explore healthcare clinicians’ experiences of being a member of a clinically-focused CoP. A small body of literature exists on healthcare clinicians experiences in CoPs. This thesis expands our understanding of CoP members’ experiences and socially constructed learning achieved through participation in a CoP. Analysis of semi-structured interviews with 15 CoP members revealed constructions of CoPs as a learning community, a means to cope with organizational life, a mechanism to get organizational work done and as an elite group. Membership in a CoP provided an opportunity to develop a sense of belonging and participate in changes in practice. Practice changes ranged from individuals thinking about and enacting practice differently to organization-wide changes in practice standards. Additionally, CoPs provided the opportunity for members to support one another, provide practical help to each other, and learn what was going on in the organization and in practice so that they could stay on top of things. Although participants talked very positively about their experiences in CoPs there were also challenges and frustrations. The findings will be discussed in relation to the following: a) contributions of CoPs in shared knowledge b) contributions of CoPs in
engendering belonging and coping, and c) tensions between CoPs and organizational structures.

**Contributions of communities of practice in shared knowledge.**

The notion of CoPs contributing to knowledge stewardship because of their ability to combine tacit as well as explicit knowledge has been well documented in the literature (Brown & Duguid, 1991; Buyesse et al., 2003; Lave & Wenger, 1991; Wenger, 1998; Wenger et al., 2002) and figured prominently in our study. Like Lave and Wenger (1991) theorized 20 years previously, the findings of this study illuminate the social character and situated processes of learning and provide additional insight into the usefulness of CoPs and their potential for enhancing the sharing of knowledge. Rather than looking for information or solutions individually, CoP members connected with one another across the organization and coordinated efforts to address problems, debate issues, share stories and work on projects effectively accumulating their experiences in a shared knowledge base. Additionally, the community of practice members determined what knowledge was important to be shared, based on their understanding and experiences, improving the richness and relevance of the knowledge shared (Wenger et al., 2002). It is interesting to note that of the five research studies that were identified during the literature review as having collected data on the experiences of being in a CoP, all five created CoP structures as mechanisms to steward knowledge (Barwick et al., 2009, Chandler & Fry, 2009; Fung-Kee-Fung et al., 2008; Gabbay et al., 2003; White, et al., 2008). Knowledge sharing as an outcome was similarly found in three of the five studies, exclusive of Barwick et al. (2009) who studied individual uptake of knowledge related to a specific mental health assessment tool and Gabbay et al. (2003) who analyzed how knowledge was processed and applied, potentially suggesting that
knowledge sharing in a CoP is not dependent on the additional resources and support that commonly accompany a research study.

The importance of knowledge sharing cannot be understated as large healthcare organizations grapple with ways to create and disseminate knowledge effectively and efficiently. National research institutions are also looking for strategies to improve the sharing of research knowledge and are considering CoPs as a potential option (CHSRF, 2005). The findings of this study support proponents who advocate that CoPs, whether organically or intentionally formed, provide a promising venue for knowledge exchange to occur.

**Contributions of communities of practice in engendering belonging and coping.**

An important finding in this study was that the participants held the general view that CoPs provided practical and social support that enabled them to cope with change and organizational life. The role of CoPs in providing a mechanism to negotiate with and within the broader organization and to manage change, chaos and hectic environments while creating a sense of belonging and connectedness has not been widely recognized. The connections and sense of ‘community’ among participants facilitated by participation in CoPs seemed to enhance their ability to cope with the demands of new and evolving roles and deal with feelings of being disconnected, confused or isolated. The study findings suggest that the effect of building relationships went beyond increasing the effectiveness of CoPs. For example, as rural nurses struggled with isolation and nurse practitioners pushed forward in their new role, CoPs provided a place of belonging, a sense of self worth and a strong sense of team. The main reason many of the CoPs came together was to improve
clinical practice, however, the interaction of the members and their experiences, shared in this research, gets to a much deeper meaning of value for each other and consequently shared experiences. These findings are similar to those reported by Chandler and Fry (2009) and White et al. (2008) who found, among other things, that when they intentionally developed CoPs as part of their respective research initiatives cultural barriers lessened, social supports emerged, relationships were enhanced and team cohesiveness improved potentially suggesting that the application of the CoP model itself rather than the additional resources and notable research interest in the initiatives contributed to the outcomes.

It is important to recognize that the study findings are influenced by the unique characteristics of the health authority, and the historical and sociocultural norms that operate within it. At the time of this research the health authority was undergoing a significant re-organization. It was surprising that none of the participants focused on these changes. Given that CoPs appear from our findings to have some benefit for those who are trying to find their way in an organization and fulfill new roles, it could be suggested that the CoPs provided a buffer against the organizational changes. Alternately, it could be suggested that the participants interviewed for this research were, for a variety of reasons beyond the scope of this thesis, the least vulnerable to the organizational changes. Nevertheless, the fact that the CoP experiences of those who perceived themselves to be significantly affected by the changes occurring in the organization were not represented in this research may be a limitation. It is interesting to consider the potential benefits CoPs might provide those individuals and groups in coping with the organizational change.

As suggested previously, people participate in CoPs for different reasons. Some participate because it brings direct value to them, others for the opportunity to build skills and others for
the personal connection the group offers. Our findings suggest that CoPs influence feelings of belonging in an organization. Feeling connected to an organization has been suggested by magnet hospital data to increase job satisfaction and performance providing a direct benefit to individuals, groups and the organization at large (Kramer & Schmalenberg, 2004; Upenieks; 2003). While magnet hospital data does not specifically include CoPs as a social structure within their organizations, CoPs may represent another strategy to achieve the same end point.

The findings of this study suggest, however, that although this connectedness has positive benefits there were indications that some groups were perceived as elitist. For example, the CoP was viewed by some as excluding others who might have wanted to join. An elite group can bring enormous satisfaction to the people in the group in terms of developing a strong sense of affiliation; however these groups can become dysfunctional when they exclude others purposefully. Roberts (2006) in her paper on the *Limits of Communities of Practice* hints at the possibility of CoP being elite when she talks about “witnessing the development of a divide between...the knowledge worker and the unskilled worker” and those that work “primarily within communities of practice and those that work within hierarchically controlled structures” (p. 635). A cautionary note is therefore extended to CoPs to pay attention to their potential for elitism and its effect on the CoP and the organization.

**Tensions between communities of practice and organizational structures.**

Important tensions were evident in the findings when members of CoPs perceived that their group was being co-opted to achieve organizational goals that took priority over the needs of the group and in some instances undermined group effectiveness. Communities of practice
are autonomous self-governed groups that have the potential to enhance knowledge, foster learning and manage change. However, in traditional bureaucratic and hierarchical healthcare organizations their development can create tension because their organic and informal nature requires minimal, if any, organizational supervision (Smith & McKeen, 2003, Wenger et al., 2002). Not surprisingly, our study findings illuminated how these tensions played out in one large health authority.

Organizations commonly develop teams and work groups to enact their priorities. Communities of practice, even if intentionally created, are not primarily intended to move operational issues forward. Rather, they are designed to serve participants in moving their areas of professional interest forward, in a way that meets the needs of the membership. Unlike committees or groups, CoPs have an integrated ownership of work, knowledge and accountability. In healthcare organizations, the ‘ground up’ community development approach of CoPs provides an avenue for individuals in clinical practice to be heard in organizations and has the potential to influence the broader system and support sustainable change. This is not to say that CoPs cannot be cultivated by organizations. In fact, Wenger et al. (2002) stated that organizations must become strategic in cultivating CoPs and they emphasized that the most successful CoP thrive when the “needs of [the] organization intersect with the passions and aspirations of [the] participants” (p. 32).

Organizations may benefit from understanding the potential and limitations of CoPs. Leveraging the value of CoP without over managing them is critical. If CoPs become too operationally focused and surreptitiously become an expectation of clinicians in similar roles to be a part of, the original intent of the group (obvious or not) can be jeopardized. The more a CoP moves away the professional interests of its members to meet organizational and role
expectations, the less the group functions like a CoP and is at risk for diminishing their original purpose. The findings of this study support others who contend that the emotional connection that helps CoP members develop a sense of belonging and consequently an enhanced ability to cope with the demands of their roles has the potential to be undermined when the organization directs the work of a CoP and enhanced when participants can follow their own passions and interests (Smith & McKeen, 2003, Wenger et al., 2002).

In many situations, operational or local project teams are better suited to meet the needs of organizational agendas. These teams may include participants who are also members of a CoP. Others have described boundary spanning between operational teams and CoPs to combine the needs of the organization with those of community members as crucial to enhancing knowledge stewardship while creating value for both the members and the organization (Wenger et al., 2002). This approach has been argued to have the potential to create a vibrant work and learning environment (Burgess & Sawchenko, 2011; Wenger et al., 2002).

**Study Limitations**

The findings of this study represent the socially, historically and contextually constructed experiences of 15 healthcare clinicians in a large health authority in a Western province of Canada. Although the study provides some important insights into the experiences of members in clinically-focused CoPs, it is possible that the full range of experiences may not be represented because of the practical constraints associated with a thesis project. The sample included a relatively small number of participants from a few clinically-focused CoPs in a single health authority. This study did not capture the experiences of CoP participants
who had joined a CoP and then left. Those who perceived they were minimally involved in CoPs were also not among the study volunteers. However, participants in the study were asked to describe their experiences of others in the group and compare their own experiences with others they knew. This “shadow data” (Morse, 2000) augmented the range of experience available for analysis in this study.

**Study Implications**

There are important implications for CoPs, organizations and research that can be drawn from this study. This knowledge will enable future planning, resourcing and support of CoPs within Interior Health.

**Implications for communities of practice.**

The findings of this study have implications for individuals or groups considering if a CoP may be the right structure for them and for current CoPs as members reflect on ways to enhance their community. Study findings also provide direction for efforts to enhance CoPs. Ensuring there are opportunities for CoP members to offer support to one another, help each other in practical ways and stay on top of things would serve CoPs well. In addition, creating a sense of belonging and ensuring groups are open and not seen as elitist is essential. One strategy to accomplish this may be adjusting the time of day of meetings to ensure there are opportunities for people to participate regardless of their place in the organization. Another strategy might be creating a repository of all the CoPs in the health authority and posting it in a common, easily accessed place so that interested staff can gain more information about CoPs that interest them.
A cautionary note for new and current CoPs is to be aware of and pay attention to issues and challenges reflected in the study findings. The very nature of CoPs can make them difficult to manage. A self-governed voluntary group that is somewhat informal may be a foreign concept for some members and they may have difficulty resisting the urge to shape the CoP like a work group. In order for the necessary elements of a CoP to not get lost, communities themselves must ensure they have shared understanding of their group’s purpose. Reviewing the terms of engagement in CoPs as they relate to attendance and participation in meetings and revisiting these throughout the lifespan of the CoP may be helpful to ensure common understanding and provide members an opportunity to (re)consider the ‘fit’ of the CoP for them. Additionally, ‘checking in’ with members and openly discussing what growth in the membership of the community means to individuals and the community as a whole may help in the maintenance of trust among the members.

Finally, understanding how the aims and goals of the CoP relates to (or not) the organization’s understanding and goals for the group is critical. It cannot be assumed that administrators, who primarily organize their teams through project and work teams, have a clear understanding of the purpose and function of CoPs. Community of practice leaders and members must be ambassadors for their communities, articulating the purpose and goals of the community broadly; showcasing their successes; and demonstrating the value they create for their membership and the organization at large.

**Implications for healthcare organizations.**

The study findings highlight important implications for healthcare organizations. Communities of practice can be challenging for traditional hierarchical and often siloed
organizations because of their autonomous, practitioner oriented and informal qualities. Study findings indicate that the benefits of CoPs may not be realized if the groups are co-opted into working on projects or priorities that are organizationally determined. Rather, nurturing CoPs and offering direction and support when it is requested offers organizations the potential to strategically manage knowledge as an asset, through the collaborative activities of the communities (Brown & Diguid, 1991; Wenger et al., 2002).

It may serve organizations well to purposefully look for opportunities to cultivate a CoP that would benefit them, the members and the communities themselves (Burgess & Sawchenko, 2011; Lesser & Starch, 2001; Wenger et al., 2002). This research has demonstrated the value of connecting professionals that are new to a practice area; work in isolation; or are trying to address a similar practice concern. It also indicates the importance of CoPs in helping clinicians cope with organizational life and organizational change. Organizations may want to consider creating CoPs or at the very least foster their development as a mechanism to help clinicians deal with change and create a sense of belonging.

A particular goal and challenge for most healthcare organizations is improving quality care. Communities of practice, as found in this study and suggested previously by others, offers the potential for individual, organization wide and system wide changes in practice aimed at improving patient care and enhancing patient safety (Barwick et al., 2009; Burgess & Sawchenko, 2011; Chandler & Fry, 2009; Fung-Kee-Fung et al., 2008; Gabbay et al., 2003; Wenger et al., 2002; White et al., 2008). For this and reasons stated above, organizations may want to take a closer look at nontraditional strategies, like CoPs, as viable social structures to enhance quality care and work environments through collective knowledge sharing. Not
only can changes in practice occur, a sense of belonging and a renewed ability to cope within organizations can be discovered.

Implications for research.

Several directions for further research emerge from the findings related to experiences of CoPs provided in this study. These include, but are not limited to, gaining a better understanding of how learning takes place through and among the relationships that form within the CoP; the ways CoPs influence practice and determine which knowledge (if any) is privileged over others; and the best approach to assess the effectiveness and quality of a CoP. In addition, understanding the variables that support or hinder knowledge sharing and/or success and understanding what conditions foster practice changes or enhancements would be valuable.

Along with the suggested areas for further research alternate methodological approaches to studying CoPs are also recommended. These may include, but are not limited to, participatory action research and ethnography. Participatory action research holds potential for studying CoPs because of the involvement of research participants in the research process from the initial design of the project through data gathering, analysis, final conclusions and actions. Using this approach may provide some interesting and alternate insight into CoPs. Ethnography may also provide a unique inside look at the values, beliefs, practices and culture of the group and the influence of organizational norms, contexts and structures on CoPs.
Conclusion

This thesis contributes to a small but growing body of information about CoPs in healthcare by providing some useful information in terms of the benefits and challenges of initiating and sustaining a CoP model in complex hierarchical and often siloed healthcare organizations. This research extends previous understanding of how engagement in CoPs influences members’ practice by focusing on organic and intentionally developed CoPs within large healthcare organizations rather than those constructed to support research projects as previously reported in the literature. Moreover, the study findings provide a better understanding of the value CoPs hold for their members as well as perceptions regarding the usefulness of CoPs in stewarding knowledge, making practice changes, connecting clinicians across its vast geographic boundaries, and increasing engagement in the organization.

In this research, interviews with 15 healthcare professionals highlighted the experiences, practical implications, issues and challenges of membership in a CoP. Information from the perspectives of the community members about their experiences in clinically-focused CoP can be used by administrators for future planning, resourcing and providing support to CoPs within Interior Health. These findings provide a heightened understanding of the implications of this important and relatively new social structure in healthcare.
References


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Appendices

Appendix A: Letter of Intent for Community of Practice Facilitators/Leaders

Dear [Recipient Name]:

I am currently enrolled in the University of British Columbia Okanagan Master of Science in Nursing program, and preparing to complete the thesis component of this postgraduate degree. As you know, Communities of Practice has been an area of interest of mine for quite some time. I am conducting a study on Community of Practice and I am interested in recruiting members of the ______-Community of Practice to participate in this study.

The purpose of this research study is to explore how experiences in a clinically focused Community of Practice shape healthcare clinicians’ practice. It is my hope by turning our attention to understanding the value (if any) CoPs hold for their members we can begin to determine if organizationally more attention and support should be applied to forming CoPs.

I have obtained approval from the Interior Health Research Ethics Board as well as the University of British Columbia Research Board to conduct this study. I am seeking members of the Community of Practice that have been active with the community in the last 12 months. For those clinicians who consent, I will conduct semi-structured interviews, which will be arranged at a place and time that is convenient for them.

I would like to ask for your help in sending Community of Practice members a recruitment brochure (attached) inviting them to participate in the study. If a community of practice member is interested in participating in the study he/she will contact me directly. I have also attached the Consent Form for the study.

Please contact me at the email address or phone numbers above if you have any questions regarding this request.

Your support for this project is greatly appreciated.

Sincerely, Donna Mendel
Appendix B: Recruitment Flyer

Communities of Practice

“If you are a member of a clinically focused community of practice, we are interested in talking with you. We are interested in your experiences as a member of a Community of Practice and learning if and how those experiences impact your practice.”

Sound interesting? For more information about this research project and/or to participate in this project contact:

Donna Mendel, donnamendel@interiorhealth.ca
XXX-XXX-XXXX or cell XXX-XXX-XXXX
Masters of Science in Nursing Candidate, UBC-O
Regional Practice Leader, IH Professional Practice Office

Principal Investigator:
Dr. Joan Bottruff, PhD, RN, FCAHS
University of British Columbia - Okanagan
Appendix C: Consent Form

Title: Shaping Practice: Clinicians’ Experiences of a Community of Practice

Principal Investigator:

Dr. Joan Bottorff, Professor School of Nursing, University of British Columbia, Okanagan
Email: xxxxxx Contact Phone: xxx-xxx-xxxx

Co-Investigator:

Donna Mendel, RN, BScN,
Regional Practice Leader, Professional Practice Office, Interior Health
Master of Science in Nursing Candidate, University of British Columbia, Okanagan
xxx-xxx-xxxx or xxx-xxx-xxxx
Email: xxxxxx

Purpose:

The purpose of this study is to explore the experiences of healthcare clinicians in a clinically-focused Community of Practice and the way(s) these experiences influence their practice. You are being invited to participate in this study because you are a person who has participated in a clinically-focused Community of Practice.

This study is part of a graduate thesis in the Faculty of Nursing at the University of British Columbia Okanagan.

Study Procedure:

Participants in this study will be asked questions about their experiences in a Community of Practice in an individual interview. Interviews will take place at a time and place that is convenient for you. The interview will take about 30 minutes to an hour. Written notes will be taken during and after the interview. With your consent, the interview will be digitally recorded. After the preliminary findings are analyzed you may be asked to participate in a brief interview, either in person or by phone, to review and provide feedback on preliminary findings.
Participants will also be asked to complete a form that asks personal information such as your age, profession, years of practice and months of membership in a Community of Practice. A minimum of 10 participants are expected to participate in this study.

**Potential Risks:**

There are no anticipated risks to participating in this study.

**Potential Benefits**

There are no direct benefits. However, the findings of this study may help to promote organizational awareness and understanding of Communities of Practice.

**Confidentiality**

We will keep your name and information you provide strictly confidential. We will not use your name in the research reports and we will use number codes instead of your name in our notes and typed copies of the interviews. The results of this study will be communicated in written papers or oral presentations with all personal identifiers removed. All data collected in this study will be stored in a locked file cabinet or in computer files that will be password protected.

**Contact for information about the study:**

If you have any concerns or question or would like further information about the study, you may contact Dr. Joan Bottorff at xxx-xxx-xxxx.

**Contact for concerns about the rights of research participants:**

If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at 1-888-822-8598 or the UBC Okanagan Research Services Office at 250-807-8832. You may also contact the Interior Health Research Ethics Board through the Research Office at 250-870-4602.
Consent

Your participation in this study is entirely voluntary and you may refuse to participate or withdraw for the study at any time during the course of the study without jeopardy to your position or participation in the Community of Practice.

Your signature below indicates that you have received a copy of this consent form for your own records

Your signature indicates that you consent to participate in this study.

*Please note: For remote consent by telephone, a witness signature is not required. Please scan a copy of this consent form with your signature to the researchers.

________________________________________________________________________
Participant Signature
Date

________________________________________________________________________
Printed Name of the Participant

________________________________________________________________________
Witness Signature
Date

If you would like a report of the findings please include your mailing address in the space below:

________________________________________________________________________
Appendix D: Interview Guide

Introduction:

- Explain the study purpose and digital recording (reiterate confidentiality of the interview)
- Complete consent form and give one copy to the participant
- Ask participants to not to use names of persons during the interview. Names will not be entered into the written transcripts or data analysis.
- Ask participant to complete demographic sheet
- Offer to answer any questions

Research Objective: To explore how health care clinicians’ experiences in a clinically focused CoP shapes their practice through the following research questions:

Research Questions:

1. How do healthcare clinicians describe their experiences in a clinical CoP and the way these experiences influence their practice?

   Interview questions

   - Tell me about your experiences with this particular CoP
     - Probe: What were your initial thoughts about the CoP? What did you expect when you joined?
     - Probe: Have your thoughts/ideas about the group changed?
     - Probe: Tell me about your role and involvement in this CoP compared to other members?
     - Probe: When did you first think this group might be the right fit (or not) for you?
   - Is being in a CoP the same or different than other groups/teams you have been involved in? If different, how?
   - How would you describe the CoP to someone else?
   - I’m wondering if engagement in the CoP influences practice, or not. Can you think of any examples of practice changes that have occurred as a result of the CoP?
o Probe: Is there any influence from the CoP on your own practice that you notice when you go back to your workplace?

o Probe: Can you give me an example of when an experience in a CoP shaped/influenced/impacted your practice (either positively or negatively)?

o Probe: Can you recall any practice changes that occurred for you after learning something or hearing something at a CoP meeting?

Research question:

2. How do CoP members perceive the value of involvement in CoPs?

Interview questions

- From your perspective what is the primary purpose of the CoP?
- What would you say is the most important accomplishment of the CoP?
- Have there been any disappointments for you being a part of this CoP? If so, can you tell me about these?
- We are interested in learning about how knowledge is shared and created in a CoP. I’m wondering is there anything about this group (the CoP) that is different from other groups in terms of how knowledge is shared or managed or explored. If so, how?
  - Probe: Can you give me an example?
  - Probe: How is it determined what your CoP will focus on?

Research question:

3. From the perspective of participants in a CoP, what are ways the CoP that support changes in clinical practice and ways the CoP hinder changes to practice?

Interview questions

From your perspective as a participant in a CoP can you tell me about:

- What is the best part about being in a CoP?
- What are the challenges or most difficult parts about being in a CoP?
● What keeps you in a CoP? What appeals to you about a CoP?

*If the participant has talked about practice change under question 1, I would ask:*

● What are factors within the CoP that support your changes in practice?
● What do you think (is) was the most important thing about the CoP that contributed to your practice change?
● Do you think there are other more or equally effective mechanisms that could have helped you achieve this/these practice change?

*All participants would be asked:*

● Are there factors within the CoP that slow down efforts to change practice? If so, can you describe them?
  ○ Probe: What about for you specifically?
● Are there factors outside of the CoP that hamper or slow down efforts to change practice? If so, can you describe them?
● What makes you leave a CoP? Or would make you leave a CoP?

*Research question*

4. How can CoP become more effective in influencing practice?

● What suggestions or ideas do you have that might be helpful to improve or increase the effectiveness of a CoP?
  ○ Probe: What supports, if any, would be needed?
  ○ Probe: What would most contribute to CoPs’ influencing clinical practice?
● What advice or recommendations do you have about how CoP should be used, or be structured in Interior Health in the future?

*Ending questions*

*We are now at the end of the interview*

● What do you think is the most important thing that I should be taking away about CoP from this interview?
● Is there anything that you might not have thought about before that occurred to during this interview that you’d like to add now?
I’ve asked a whole bunch of questions. This has really been helpful. I don’t have anymore questions about CoP.

- Is there anything that you would like to ask me?
Appendix E: Demographic Form

Demographic Information: Healthcare Clinicians

1. Gender:  □ Female  □ Male
2. Age: _____________
3. What is your profession: __________________________
4. What is your current position/role: __________________________
5. Years in current role: ______________________
6. Years working for Interior Health: _____________
7. Years of experience working in healthcare: __________
8. Number of Communities of Practice you have been involved in: ________
9. Number of Communities of Practice you are currently involved in: ________
10. How do you participate in the current Community of Practice (tick all that apply):
    □ in person meetings  □ on line discussions
    □ teleconference  □ informally get updates from other members
    □ conferences  □ workshops
    □ read memos/minutes  □ Other (please specify): __________________________
11. Months as member in the current Community of Practice:
   - less than 6 months
   - 7-12 months
   - 13-24 months
   - 25-36 months
   - more than 36 months

12. Roles within the current Community of Practice (tick all that apply)
   - Member/participant
   - Chair or co-chair
   - Facilitator/coordinator
   - Secretary

13. Frequency of attending the current Community of Practice meetings/events____/per year.

14. Rate the level of your participation in the current CoP on a scale of 1-5.
    1= minimally involved          5= very involved
    1     2     3     4     5
Appendix F: Transcriptionist Confidentiality Agreement

TRANSCRIPTIONIST CONFIDENTIALITY AGREEMENT

The parties to this Agreement agree that all information whether in the form of data, or reports regardless of how communicated, recorded, or received by the research transcriptionist while employed on the graduate research project Shaping Practice: Clinicians’ Experiences of a Community of Practice by the Principal Investigator, Dr. Joan Bottorff and/or the Co-Investigator Donna Mendel is confidential and proprietary and will be kept as such.

The research transcriptionist shall use all the project information in confidence solely for the purposes of graduate thesis research at the UBC Okanagan School of Nursing and shall not -

(a) Make any other use of the information except as expressly first authorized by the Principal Investigator in writing; nor

(b) Disclose or permit or cause to be disclosed the information to any person except as are necessary to properly report on the transcription done and only then under terms of confidentiality of the same or stricter effect as these.

Signature: ______________________________________________________

Printed Name: ____________________________________________________

Date: __________________________

The University of British Columbia Okanagan, 3333 University Way, Kelowna B.C.

Masters of Science in Nursing