

**WHAT MATTERS AT WORK:
AN ETHNOGRAPHY OF NURSES' SOCIAL RELATIONS
IN A NEONATAL INTENSIVE CARE UNIT**

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**A thesis submitted in fulfilment of the requirements for the degree of
Doctor of Philosophy**

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August 2020

STATEMENT OF ORIGINALITY

I certify that this thesis does not incorporate without acknowledgement any material previously published or written by another person except where due reference is made. I also declare that to the best of my knowledge and belief this thesis does not contain any material previously submitted for any degree in any university.

Signed: Shobha Nepali

Date: 15 July 2020

In memory of my Granny

Samundra

1927–2011

Thy love, kindness and blessings

shall follow me all my life!

ACKNOWLEDGEMENTS

‘A teacher teaches by her life, by her daily acts, by her most casual words, sometimes even by her silence – not only to inform the intellect, but to purify and enrich the soul.’

Upanishads

Thank you so much, Professor Trudy Rudge, for accepting me as your disciple and leading me beyond the sea of ignorance. You know very well how to give an appropriate shape to a handful raw clay. You let me swim in the sea as far as I could see the way out. My gratitude falls short for your patience and faith in me.

Thank you unlimitedly, Associate Professor Sandra West, you chose to share your expertise with a novice researcher, challenged me through your constructive critique and guided me towards being able to see farther and wider. You even acted like an external in providing me with independent feedback.

Thank you very much, Dr Rochelle Einboden, you became a key to the completion of this thesis. Equipped with a breadth and depth of expertise, you genuinely pointed out holes in my arguments and helped me smooth them out. You shared the secret of successful acquisition of knowledge and I felt the comfort of learning with you.

A big thank you to Adjunct Associate Professor Kaye Spence, without your support and sponsorship this thesis would have remained in the womb.

I am grateful to Dr Virginia Mapedzahama, who introduced Quirkos, a data management software, and showed me how to make a path through the jungle of data.

My words feel limited in appreciating the openness and generosity of the Department Head of Neonatology and Nurse Manager of the NICU. You decided to nurture the unit with Research.

No limits to the thanks to the beautiful nurses who let me enter your work lives and forgot that I was watching you. Without you sharing your everyday worlds with me, I would not have been able to tell your stories now.

Gratitude extends to Professor Donna Waters (then Dean) for your warm hug every time I see you, no matter where we happen to meet. It meant a lot to me.

Much appreciation goes to the Research Support team, the Nursing Library team, and Facility Coordinator Lorrae Hawke and fellow PhD candidates including Sarah Lake, Jeanine Moreau, Sybele Christopher, Teha Pun and Joseph Pendon.

I also appreciate the excellent work of Elite Editing, for their professional editing of my thesis in accordance with the Australian Standards for Editing Practice.

Thank you, family and friends, especially John Mellowship, Dr Trudi Mannix, Dr Shamsheer Singh Thapa, Saraswati Ghimire and Roma Ale, for encouraging me through the journey and waiting patiently for the fun times to come.

Thank you, Paris, my chubby baby, you pushed me to my desk, sacrificing your longing to be with me, saying, 'Go study, aama (mum), otherwise you won't be smart.'

Thank you, Sanu (Krishna), for taking care of our daughter well, fulfilling family needs and being content with what we had together during this long journey. You are a proud husband for sure.

ABSTRACT

In line with global migration, nurses in Australian workplaces come from a variety of social and cultural backgrounds and have various levels of skills and experience. The Neonatal Intensive Care Unit (NICU) provides an interesting context to study the complex and challenging social relations among the diverse nursing workforces. Drawing on Budd (2019), social relations of work are understood as shaped by social exchanges, organisational culture, and power relations. To explore what matters at work for neonatal nurses, this study examines how such social relations are constructed, guided by the following research questions: What are the cultural practices of the NICU? How do nurses experience their everyday work life in the NICU? How are nurses' social relations of work affected by the NICU?

An ethnographic approach was adopted as the method because of its ability to examine every day social practices in the workplace. Data collection involved 18 months of fieldwork, including observation of 76 nurses working in the unit and interviews with 65 of these nurses. Intersectionality theory was used as a framework to analyse and interpret the subtleties of social relations between nurses across various social positions.

How nurses relate at work is central to this thesis. Relations based on trust and reciprocity assist nurses to work together. Opportunities to learn and grow within the workplace and the support of senior nurses are essential. Being recognised, included, encouraged, and looked after at work allowed the nurses to 'have a good shift'. However, the disparity in trust, along with a lack of support, was found in workplace relations with nurses of colour. These nurses experienced systematic disadvantage and were subject to deskilling and barriers to career progression. Diversity in the workforce was narrowly practised, as nurses of colour seemed to merely make up workforce shortages rather than appreciated for their expertise. Following Ahmed (2012), this analysis demonstrates how diversity policies programmed for inclusion are instead a veil for continuing discrimination. Such practices build an unhealthy workplace culture experienced by nurses and have implications for social relations of work and patient safety. Considering how cultural safety might guide social relations between nurses at work offers opportunities for authentic engagement among nurses.

LIST OF ABBREVIATIONS

AHCP:	Allied Health Care Professional
CATSINaM:	Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
CEO:	Chief Executive Officer
CNC:	Clinical Nurse Consultant
CNE:	Clinical Nurse Educator
CNS:	Clinical Nurse Specialist
CRN:	Clinical Resource Nurse
ENM:	Executive Nurse Manager
ICU:	Intensive Care Unit
IV:	Intravenous
IMU:	Inter-mediate care Unit
HOD:	Head of Department
HREC:	Human Research Ethics Committee
KCP:	Key Contact Person
LNR:	Low and Negligible Risk
NBM:	Nil by Mouth
NE:	Nurse Educator
NHMRC:	National Health and Medical Research Council
NICU:	Neonatal Intensive Care Unit
NM:	Nurse Manager
NMBA:	Nursing and Midwifery Board of Australia
NUM:	Nurse Unit Manager
OCB:	Organisational Citizenship Behaviour
PI:	Principal Investigator
PICF:	Participant Information and Consent Forms
RG:	Research Governance
RGO:	Research Governance Officer
RN:	Registered Nurse
SAC:	Scientific Advisory Committee
SSA:	Site-specific Assessment
UK:	United Kingdom
US:	United States

GLOSSARY

Accreditation: Certifying the skills of nurses to be able to practise them

Anencephalic: A baby born with congenitally absent skull or cerebral hemispheres

Bassinette: A normal baby bed with low rails that are fixed, also called cot

Baby: A new-born infant admitted as patient in the NICU, usual term used by nurses

Bedside Nurse: A Registered Nurse working at bedside caring for patients

Cannula: A thin tube inserted into the blood vessels or body cavities for IV medication, nutrition supplement, internal observation, or drainage of body fluids

Carer: A family member or paid worker caring for a child, elderly, sick or differently able

Cares: Hygienic care of a baby including mouth care, eye care and nappy change

Cribette: A baby bed with high side rails that can be lowered and opened

Cot: A baby bed with low rails that are fixed, also called bassinette

Global North: Part of the globe that was considered first world politically and economically

Global South: Part of the globe that was called third world in terms of development

Incubator: An enclosed bed for prematurely born baby with controlled environment

Infant: A young baby less than 12 months of age

IV Cannulation: A procedure of inserting peripheral intravenous catheter into the baby's vein to administer medication

Junior Nurse: A nurse with younger age and/or with less experience

Kala-azar: A tropical disease called leishmaniasis caused by sand fly bite that affects the internal organs such as liver, spleen and bone marrow

Neonate: A new-born infant from birth to 28 days of age

Neonatal: Related to neonates

Obs: Speech shorthand of observations meaning the condition of vital signs of the patient

Registered Nurse: A nurse with required qualifications and licenced to practise

Restraps: Shorthand of re-strapping, meaning replacement of Endo-tracheal tube attachments

Senior Nurse: A nurse in the most senior role such as NM, CNC, NE, NUM

Senior Bedside Nurse: CNS and CNE working at bedside either caring and leading the team or educating the bedside nurse in clinical issues

Sucrose: A sugary liquid in 1ml ampoule used in neonatal patient during painful procedures

Ultrasound: A procedure of examining internal organs of the body by using special sound waves to make an image

Ventilator: A machine that provides mechanical movement of air in and out of baby's lungs

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CHAPTER ONE: SETTING THE FOUNDATION

HOW THIS INQUIRY EMERGED

I was so passionate to work in a neonatal field that I gave up a very worthy and rewarding job in another state to come to work with neonates. Prior to moving to Australia, I had a lucrative job in the United Nations, but as a neonatal nurse, my longing to care for new-born patients led me to the NICU. At home, I was respected and consulted as a versatile professional, perhaps because I was confident and developed my professional skills at a fast pace to be able to work across a variety of roles. However, in my Australian workplace, I found my initial experience very different culturally and difficult technically and linguistically. Below, I recall an incident in my initial days that I believe serves to contextualise the point I am trying to make in this thesis.

When is Nil by Mouth (NBM) not NBM?

I had three patients to look after that early shift. One of the patients was NBM from the night in preparation for an ultrasound. After the handover, a senior bedside nurse gave me an information sheet, which had instructions about preparing a baby for an ultrasound. As I was new, she went through the paper and stressed to me that the infant should have an empty stomach and that I had to take him down for the procedure. At mid-morning, I had a phone call from the ultrasound department: 'Has he been fed?', the technician asked. I replied, 'No.' She said, 'Bring him in 20 minutes.' I quickly attended to the other two patients and recorded their observations in the computer. I then informed the support nurse of my absence, requested her to look after my patients with a brief hand over and went to that patient to prepare for the move. The mother was at the bedside so I told her that she could come with the baby. When we got to the x-ray department, the ultrasound technician asked again, 'Did you feed the baby?' I replied confidently, 'No.' She started shouting at me: 'I gave you time to feed the baby, don't you know the baby has to be settled for the ultrasound?' I was shocked and confused but tried to defuse the situation: 'He's been breastfeeding so mum can feed now.' She seemed to get even madder: 'I don't have time for all this [swear word].' After a moment, however, she waved to a chair behind a portable screen. The mother threw a furious look at me and started breastfeeding.

Up in the unit,¹ the mother complained about me, I learned of the complaint at the end of my shift when the acting manager called me back from the door as I was exiting. There were four senior nurses in the manager's office. The senior bedside nurse softly admitted that it was her fault, but the others did not pay attention to her admission of 'fault' and she did not speak up for me again. They did not trust me when I described the conversation as not having a clear instruction to feed the baby. They all blamed me for not carefully listening to the instructions over the phone. Instead of trying to understand my circumstances and supporting me, they 'proved' it was my fault in having a problem communicating in English. However, it should be noted that these gaps in communication occur very often within a homogeneous language group as well, but as I was new and from a different background, it was easy to pick on and blame me. They could have simply explained to the mother how the confusion happened and given me constructive feedback, but they made 'a mountain out of a molehill'.

I felt awful. I blamed myself for not being an English-speaker, not noticing the technicality and style of message delivery. I became depressed and isolated, and did not want to speak to anyone, fearing that I might not hear properly. My interest in learning and confidence at work were paralysed, and I soon realised I would not grow in such an incapacitated state.

Reflections on Education and Experience

I reflected on the education, experience and skills that I had gained over the past decade. I had a Masters in Neonatal Intensive Care Nursing from a renowned university in Australia, which was directly relevant to the work I was doing. The degree was a scholarship opportunity, and therefore, I had competed with numerous talented professionals from various fields across my country of origin for selection in different stages. Gaining entrance into my bachelor's degree was also challenging, because there was only one institution offering this course in Nepal (a 2-year course as I was already a nurse with a 3-year certificate). We have a 10-year schooling system, with tuition fees incurred after Year 5. As a top student, however, I had secured free education throughout. I had therefore brought knowledge and learning ability with me to my workplace.

Another important asset I brought to Australia was professional experience across a variety of specialty areas, ranging from clinical work to teaching, high- to low-resource settings, and

¹ 'Unit' refers to the Neonatal Intensive Care Unit—the research setting for this study. The abbreviation, NICU, and 'unit' are used interchangeably for ease of discussion.

common to rare practices. As my nursing training included a full-year midwifery component, I worked in the labour room of a regional hospital, where I repaired many episiotomies and perineal tears related to childbirth that may not be the part of a midwifery practice in many countries. A delivery of an anencephalic baby was a very rare life experience. I also taught Auxiliary Nurse Midwife students in the remote countryside for four months. There was a tough process in place to enter the public service, which brought me to the central referral hospital to care for adults with medical problems. After two years in the hospital, I trekked to a remote alpine district for several days to gather information on the status of public health, awareness levels and the need for and feasibility of community health programs; as part of this process, I went back and forth for planning, implementation and evaluation. After graduating from my bachelor's, I worked in a district hospital in the low-land countryside, where my roles spread from management to obstetric care, from running treatment for tropical diseases such as Kala-azar² to assisting with caesarean sections. I remember clearing a woman's womb where the placenta had been stuck for four hours when the doctor was away. The three-month special training on complex maternity problems under the Safer Motherhood program enabled me to do the job efficiently. The hospital staff later told me that the family came to reward me when I was off on another training (on Intrauterine Contraceptive Device Insertion). However, it was already rewarding and satisfying when someone's life could be saved.

After a year, I was deputised to the central children's hospital, where I worked with sick neonates. Before commencing the job, however, I helped establish an institute for nursing education in a remote far-western region. After two years of work in the NICU, when I was in Australia for my Master's, I dreamed of making a difference in national neonatal care in Nepal; however, this was halted due to the ignorance of bureaucrats about neonatal health services. My wish to contribute to society then drove me to a poverty-stricken community near my home, where I started a health awareness and income generation program with the help of an Australian anthropologist. I worked as a faculty member in a new university, running Bachelor of Nursing (BN) and Bachelor of Science in Nursing (BSc) programs. A year later, I joined the United Nations Development Programme and later moved to the Peace-keeping Program. These multidimensional work experiences had enriched my skills, professionally, socially, and personally, and were applicable in many workplace situations.

² Kala-azar means Black Fever, a visceral leishmaniasis that affects internal organs (see Glossary).

The Migration Process

Although I had been granted an Australian practising licence at the completion of my master's degree in Neonatal Intensive Care Nursing, I was required to do the English test again for the migration process. My skills were assessed by the Australian Nursing and Midwifery Council, and although I had more than enough points for migration, it was a time-consuming and expensive process, including health clearance and skills assessment for my accompanying family member as well. Recruiting countries such as Australia obtain selective professionals under this skilled migration scheme (Hawthorne, 2001, 2005); however, despite the rigorous process of the scheme, I was surprised to find that immigrant nurses are often not trusted, nor supported, in Australian workplaces. Workplaces such as NICU hire immigrant nurses to resolve their workforce shortages but make assumptions that undermine them from the start. They are not supported in a culturally friendly manner to facilitate their adaptation to a new work environment (Tregunno et al., 2009). Workplaces are not culturally safe for immigrant nurses, and in many cases, they are perceived as 'problematic' at work.

The Beginning

I wondered how other new nurses coped; had they had similar experiences of exclusion and isolation or had they experienced transition differently? How did they adapt to the new work environment and how did they relate to the culturally different colleagues and settings? While exploring the literature, I discussed ideas with colleagues from both Australian and immigrant backgrounds. It was evident from the published literature and lived experiences of my colleagues that while the extent varied, everyone had bittersweet experiences of their workplace relations. Brought up and disciplined with the Buddha's principles of compassion, I have skills in winning the hearts of difficult people and turning harsh situations into opportunities. Both the bedside nurses who were very experienced but considered bullies and the new ones who appreciated my gentle constructive feedback became my friends. My interpersonal skills facilitated connections and sharing of experiences. These experiences, together with insights gained from the literature, prompted me to find out more about why immigrant nurses are not trusted in the workplace. I first conducted a literature review on the experiences of immigrant nurses, which became my Master's (Honours). I then decided to conduct an empirical study, as I had witnessed, read and heard of more events, occurrences, interactions and relations, which enriched my knowledge, heightened my awareness of what was going on and enabled me to think about what really matters at work for nurses.

The description of my initial experiences in the workplace set the scene for how this inquiry emerged. Skilled migration, workplace studies of social relations in the workplace, cultural safety at work, and the nature and culture of a NICU nursing are key concepts that form background knowledge relevant to this study and describe the status and experiences of immigrant nurses in the workplaces of different recruiting countries around the world. This brief examination of the literature leads to the aim and significance of the thesis. The last section explains how the thesis is organised, including what each chapter contains.

NURSE MIGRATION

Nurse migration started in the colonial period (1788–1901), when people from India, South Africa, Ireland and the Caribbean were taken to other colonies as workers (Smith & Mackintosh, 2007). The movement of people from one nation, society and culture to another continued into the post-colonial era, in which nurses have been the major group of professionals moving around the world. The trend of nurse migration is from the Global South to the Global North (Kingma, 2008; World Health Organisation, 2012) because of shortages of skilled workers in the developed countries. The Global South refers to the less-developed regions of the world and the Global North refers to the industrialised and modernised regions (Kingma, 2007). In line with the shortages of nurses worldwide in recent decades (Kingma, 2007), recruiting countries such as Australia have been successful in attracting immigrant nurses. Australia is one of the nations of the Global North, for which, of a total of 261,044 nurses, 38% [n = 99,320] were born overseas (Australian Bureau of Statistics, 2016). Such an influx of immigrant nurses coming into the Australian health care system has continued to internationalise and diversify the nursing workplace. Thus, an Australian NICU, like other wards of hospitals, hires nurses from a variety of nationalities, backgrounds and cultures as well as personal and professional experiences.

Cultural plurality emerged in post-colonial Australia, in its search for, or maintenance of, identities within the new society (Clarke & Clarke, 2010), implanted roots of disadvantage, discrimination and stratification (Smith & Mackintosh, 2007). These effects of colonial power relations are what immigrant nurses experience every day in their workplaces. Moreover, since a diverse nursing workforce contributes to complex social relations involving both immigrant and local nurses, these categories intersect to bring further complexities of inequities in opportunities and support in the workplace. Such inequity is recognised as a result of an imbalance in power relations caused by the operation of white privilege in the

Australian health care system (McGibbon et al., 2014). These operations are linked with the inability of local nurses to cope with the influx of immigrant nurses coming into their space and to understand the existence of the 'other' in the workplace (Bain-Selbo, 1999).

Immigrant nurses are hired not only to overcome workforce shortages in hospital units such as NICUs but also to address the health needs of an increasingly diverse patient population (Nease, 2009). As 33% of the Australian population is born overseas (Australian Bureau of Statistics, 2016), a health workforce of a similar background can be helpful in addressing immigrants' cultural, linguistic and religious needs, and hence immigrant nurses offer cultural capital. Also, immigrant nurses comprise highly skilled, highly educated, resilient and resourceful 'human capital' (Abittan, 2010). They continue to develop in a new and often more technologically advanced work environment. As they require extensive experience to migrate, they bring much expertise to the workplace, though this form of cultural capital is often not employed properly (Paperny, 2010). The expertise immigrant nurses bring is an important asset for the operation of NICUs as this discipline requires a high-tech and highly expert workforce to care for its neonatal patient population. However, as Paperny (2010) argued, such expertise can be either utilised or suppressed by the power and politics inside the workplace. The following experience describes an example of how skills of immigrant nurses are wasted, with the potential to lead to deskilling.

In the treatment room, I was assisting a doctor to cannulate a baby. I found a good vein for her while she was preparing for the procedure. She took over the baby's hand and inserted the cannula, but no blood appeared in the cannula shaft. She drew the cannula back by about three-quarters and then re-inserted it. The baby cried in pain, even though I had swaddled him well and given him drops of sucrose. I dropped more onto the dummy from the corner of his mouth and held the baby for comfort. As the baby demonstrated, the most painful part of the procedure is when the needle travels outside the vein, hurting superficial tissues and nerves under the skin. This attempt failed, and the doctor took out the cannula, picked up another one and went on to a brachial site. Blood appeared in the shaft this time, but the site did not bleed when she pulled the needle out from the cannula at the end. This might have been because she had advanced the cannula without drawing the needle slightly back, and therefore, the needle might have gone off and punctured the wall of the vein. She repeated the same action and made the otherwise settled baby cry again. This trial migrated to the baby's legs but went

wrong five times altogether. One millilitre of sucrose was used, and the baby was really unsettled; I was more distressed than him, because I could not use my expertise to help him.

While considered advanced in Australian NICUs, intravenous (IV) cannulation is a basic skill in many other countries. Many times, I have wanted to use my expertise, but was not offered the opportunity to become accredited. When I expressed an interest in becoming accredited, my name was put on a list. I waited for two years but was still not given an opportunity for accreditation. This is where workplaces such as the NICU err; instead of exploring and seizing the expertise that immigrant nurses bring, they restrain them from practising existing skills by managing advancement according to seeming progression due to time in nursing in this NICU, where immigrant nurses, however experienced they may be, is viewed as a novice (Deegan & Simkin, 2010). I was taught passivity. Frustrated by this, one day I wrote of my concern to a forum where nurses' clinical questions were presented to be answered by the unit consultant neonatologists in front of multidisciplinary team members. I did not hear my question and wondered what happened. As it turned out, my question had been presented in a modified version and, to my surprise, the meaning was completely different to what I had intended. Early in my NICU days, I felt guilty at being silent; later, I was forced to silence. This is a representative instance of how immigrant nurses are prevented from practising their skills and discouraged rather than empowered.

SOCIAL RELATIONS IN THE WORKPLACE

As Budd (2019) asserted, work occurs within a social context. This means nurses' work of caring takes place amid a network of communication and interaction. Nurses interact and relate with fellow nurses as well as various other health care professionals, administrative and support staff and parents or carers³ of neonates during patient care, which builds cooperation, coordination and collaboration in the workplace. Teamwork has an impact on nurses' work through reciprocal respect and benefits; organisational citizenship behaviour (OCB) and reduced use of social power are part of social exchanges (Budd, 2019). However, today's diversity in the workforce, brought about by a social context of migration, poses challenges in collegial interactions due to complex intersections of the social structures of race, ethnicity, gender and background.

³Carer is a person who regularly look after a child, elderly, sick or differently able (see Glossary)

Social relations between colleagues are challenged by differences in skills and style of communication among those who were born and educated in Australia and immigrant nurses, born and educated in non-English-speaking countries. Blythe et al. (2009) identified word stress, correct intonation, timed pauses and locally recognisable body language as the biggest challenge for immigrant nurses in Canada. The literature also suggests that these nurses found it challenging to interact with health care team members while rendering nursing care to their patients. In their grounded theory study, Deegan and Simkin (2010) highlighted difficulties in exchanging clinical information, especially during the handover process, where local nurses use culturally defined forms of colloquial expressions, speak rapidly and use acronyms or speech shorthand usually local in use. Challenges also arise in understanding culturally directed non-verbal communication forms, such as eye contact, during conversations (Hunt, 2007; Okougha & Tilki, 2010). Similarly, Xu, Gutierrez, and Kim (2008) in their phenomenological study of Chinese nurses' experiences pointed to the inability of these nurses to mingle with local colleagues in their workplace in the United States (US) due to communication difficulties. This lack of sociability had a direct impact on social relations with colleagues.

Challenges occur not only with collegial interaction; effective communication with parents of infants is beset with cultural differences as well. Some authors have discussed how such differences are addressed. For example, Beheri (2009) provided valuable insights into respecting and accommodating differences related to race and ethnicity as well as age, education and experience in social relations. Although Beheri, in this quantitative study examines diversity impacts on nurse–nurse interaction, job satisfaction and turnover, the findings can address the issues of nurses' social relations with their patients' parents that are influenced by racial and cultural differences. Duddle and Boughton (2007), in their Australian study adopting an explanatory multiple case study method, discussed the challenges that both new and experienced nurses faced in interacting in the team, their fit in the workplace and ability to relate with colleagues. Though workplace relations were difficult, some managed to adopt ways to adjust to the complex nature of the workplace, while others developed the power to resist conflicts that arose in social relations. Thus, in facing challenges in establishing and maintaining constructive social relations in the workplace, multiple inequalities intersect (Walby, Armstrong, & Strid, 2012).

The intersections of multiple inequalities are related to diversity, which, in this thesis, is discussed in terms of workplace and social relations. Diversity is defined as heterogeneity in people working together, where they are different in their race, ethnicity, cultural identities, values, beliefs and experiences (Chidiac, 2018; Gröschl, 2011). Diversity in the workplace attracts increasing debate and interest in social and political sphere as it harvests societal and organisational consequences as different forms of discrimination (Gröschl, 2011). Since today's workforce is diverse, with various cultural and ethnic identities, the social interactions between the workplace and these categories are complicated. Two studies (Batnitzky & McDowell, 2011; Mapedzahama et al., 2012) demonstrate that nurses of diverse racial and social backgrounds experience discrimination and domination in their workplaces. This means they have unequal social exchanges and power relations with the senior nurses managing their workplaces. However, as this affects the social relations of work, workplaces are required to adopt ways to establish an inclusive and respectful work environment to accommodate diversity (Beheri, 2009). This is where the need for cultural safety is justified.

Diversity issues such as race and ethnicity seem to be constant challenges to social relations in the workplace, despite that migration of nurses has addressed shortages and contributed to the effective delivery of health care (Beheri, 2009; Ohr et al., 2010). Batnitzky and McDowell (2011) reported that immigrant nurses in the United Kingdom (UK) experienced stratification and discrimination that stopped their career progression, and continued to face stereotyping behaviours from their colleagues, managers and patients. Their knowledge, skills, abilities and experiences were misjudged and undermined and they were forced to perform low-grade and dirty work (see also Mapedzahama et al., 2012 regarding the Australian case). These are the results of unequal social relations in the workplace, which are hegemonic and oppressive in nature and have drawn the attention of researchers arguing how such relations mitigate against the setting up of tolerant workplaces. Beheri (2009) argued that understanding of multiculturalism within the workplace would 'increase awareness of cultural diversity, improve communication, and establish an inclusive, respectful work environment in which diversity is leveraged as an asset and not as a liability' (p. 217). Such an approach supports cultural safety of nurses, so that nurses feel valued and trusted in their original identity and beliefs and the work environment has an organisational culture that respects and values a person's worth and identity (Richardson, 2012b).

CULTURAL SAFETY IN NURSING

Cultural safety concerns the recognition of the culture of the person receiving care, the culture of the nurse as a care provider and the culture of the organisation within which nursing care takes place (Richardson, 2012b). Culturally safe care implies a person feels protected and respected in terms of who they are in times of illness; feeling culturally safe at work requires being valued and trusted in the context of one's identity and beliefs. While many health care settings emphasise patient safety (Aiken et al., 2011), the safety of nurses is often ignored. Patient safety refers to the quality, effectiveness and timely access to health care that reduces risk of being harmed (Aiken et al., 2011; Vincent, 2010). Patient safety in any clinical setting echoes on clinical safety, which is kept to the fore among competing priorities and clinical safety is linked to nurse safety that has an important role on safe and quality care to patients (Richardson & Storr, 2010; Vincent, 2010). Nurse safety occurs only when nurses feel trusted and confident in their workplaces can they provide quality care and ensure patient safety. Cultural safety of nurses involves recognition and respect of cultural identities, beliefs and practices, where nurses from different categories such as race, class or gender feel culturally safe in their workplace (NMBA, 2020; Richardson, 2011).

The concept of cultural safety was introduced by Māori nurses in the 1980s and formalised by Irihapeti Ramsden in the 1990s through the written guidelines of the Nursing Council of New Zealand (Nursing Council of New Zealand, 2005). Cultural safety addresses the safety of Māori nurses practising nursing; and the safety of Māori patients receiving health care in Western-dominated health care institutions. It emerged in New Zealand's bicultural setting to address cultural matters in mainstream health care organisations. Due to a shared colonial history, concepts of cultural safety are very relevant and have been adopted in healthcare in the US, Canada and Australia. Although cultural safety was initially aimed to address the cultural needs of Indigenous peoples, it is also useful to consider issues and guide support for immigrant nurses within the increasing complexity of today's multicultural societies. Culture-friendly health care that respects the culture of nurses as health care providers across ethnicities is thus an important aim of cultural safety (Browne et al., 2009; Mackay et al., 2011; Phiri, Dietsch, & Bonner, 2010). Culture-friendly health care means access to culturally responsive, sensitive and appropriate health care that aims for improving the social and therapeutic relations between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians (Liotta, 2018). The culture-friendly health care also includes the

culturally competent care to culturally and linguistically diverse populations to address their beliefs (Handtke, Schilgen, & Mösko, 2019). The culture-friendly health care is derived from culturally competent, culturally sensitive or culturally appropriate health care as described by Handtke et al. (2019) and Liotta (2018). While the issues of cultural safety for patients are relevant to Australian health care and continue to require priority action at policy levels and practice, matters pertaining to nurses are the focus of this thesis.

Cultural safety is linked to postcolonialism, which, as an intellectual approach, critiques the after-effects of colonial power and politics of representation (Childs, 1999; Jazeel, 2018). Jazeel (2018) claims that postcolonialism is a geographical enterprise that addresses the issues of identities and culture that are hybridised and exploited on the colonized geographical territory. Such erosion and exclusion of culture and identity for the colonised can cause lack of cultural safety in postcolonial society and workplaces. For example, Ramsden (2002) outlined the effects of colonial powers on Māori people in New Zealand, where she strongly pointed out that the western-dominated health care was imposed on Maori people erasing their cultural values and beliefs, and Māori nurses similarly experienced disrespect and distrust in their workplaces. This was where Māori nurses along with Irihapeti Ramsden justified the need for cultural safety in nursing education and practice through the Nursing Council of New Zealand (2005).

Although the concept of cultural safety was developed in the 1990s, it expanded across the academic and intellectual literature only after Ramsden (2002) conceptualised it as a nursing educational framework for culturally safe care of Māori in her doctoral thesis. She adopted it in analysing power relations between mainstream health care providers and Māori patients, and pointed out that the specific healthcare needs of Māori people should be addressed through the development of cultural safety, arguing that ‘only when trust has been established can exotic differences be revealed, discussed and negotiated in the actions of giving and receiving nursing care’ (Ramsden, 2002, p. 179). A similar argument applies to the social relations between nurses: respect, trust and reciprocity (Budd, 2019) are the keys to achieving and maintaining cultural safety among care providers. Through this thesis, I intend to unpack what makes immigrant and coloured nurses feel culturally safe/unsafe in their workplaces, which has an impact on their mental health and the safety of the patients they care for.

In the 1980s, the concept of cultural competence emerged with a focus on social justice and service delivery, beginning in social work and expanding across the health care industry

(Cross, 2013). Cultural competence emphasises attributes such as awareness, understanding, sensitivity, knowledge and skills related to cultural diversity (Burchum, 2002). This has meant immigrant nurses were enculturated to the host culture so they could provide culturally competent nursing care (Cowan & Norman, 2006). This was valuable in the sense that the immigrant nurses were oriented and trained in local culture, and therefore, adapted to the new culture and gained confidence in providing nursing care in the local environment. Similarly, the ‘practical reconciliation’ introduced in 1996 was important for the Aboriginal and Torres Strait Islander peoples as it helped them overcome disadvantage and benefitted in health, education and employment to some extent (Working with Indigenous Australians, 2020)⁴. Later, with the beginning of 21st century, the cultural competence included cultural needs of Aboriginal and Torres Strait Islander peoples as evidenced by development of policy directives and health and education frameworks in various states of Australia. Although the perspective of cultural competence is used to address the cultural needs of patients in health care settings, this did not address nurses’ cultural needs, nor did it consider that nurses from diverse backgrounds were a resource in a multicultural health care society, able to understand and address the needs of patients from a variety of cultures. This meant the concept of cultural competence was not enough to appreciate nurses’ cultural identities and values within the workplace—nurses worked for cultural safety of patients, but their cultural needs and safety were mostly overlooked and sacrificed.

Cultural safety stands out from cultural competence in that it refers to the safety of both providers and receivers of care. The scope of cultural safety also extends from the indigenous patients and nurses to immigrant clients and workers. Thus, the concept of cultural safety not only supports culturally safe care for patients from diverse backgrounds but raises cultural safety as an issue for nurses at work as well as the setting where the work of caring takes place. The issues of nurses’ cultural safety include ‘power imbalances and inequitable social relations in health care, the interrelated problems of culturalism and racialisation’ (Browne et al., 2009, p. 167). Racism, bullying and other discriminatory treatments on the basis of skin colour and cultural diversity exist across health care settings in many countries of the Global North (Allan, Cowie, & Smith, 2009; Hagey et al., 2001; Larsen, 2007; Milera, 2013). Racism is a behaviour or treatment exerted by a dominant race so as to harm, dominate or deprive another race that is considered inferior (Cole, 2015; Memmi, 2014). Racism is considered a doctrine in literary world and attracts much attention in today’s multicultural society,

⁴ The term ‘Indigenous’ refers to the Aboriginal and Torres Strait Islander peoples in Australia.

especially in workplaces as it influences how racial and cultural differences are seen and received. Racial difference comes from race, a concept that is ‘understood as a collection of biological and psychological characteristics’ transferred from ancestors (Memmi, 2014, p. 184). Race is a political entity that carries judgment and discrimination in postcolonial diversity (Cole, 2015; Memmi, 2014). Ahmed (2012) observes that racism and discriminatory behaviour are hidden using language that alters the meaning of what is said. People who speak out about racism are considered troublemakers: especially if the person involved is an immigrant or of colour, they are constituted as a problem. Ahmed (2012), as a coloured diversity worker and an academic, experienced such behaviours within her institution, where issues of racism were considered as causing damage to organisational reputation. While she was invited to write a race equality policy, once it was written, she felt powerless: ‘It ceases to have an official existence, even if it still exists in electronic and paper form’ (Ahmed, 2012, p. 6). This indicates that institutions like to keep good policies in place but do not necessarily act on them.

In her ethnographic study exploring the experiences of diversity workers in two higher educational institutions across Australia and the UK, Ahmed (2012) discusses how resistant the authorities of those institutions were to the work of diversity practitioners, describing diversity work as ‘banging your head against a brick wall’ (p. 26), especially when as a staff member from a diverse background, such was Ahmed’s situation. She described her difficulty in speaking up during encounters and how she chose to write instead, which is indicative of the challenging nature of diversity work and the severity of institutionalised whiteness. The whiteness of a system of institutions is derived from a human race, that is, white. Dyer (1997) described white as a skin colour that represents ‘a currency of communication and power’ (p. 44). However, it is often ignored as a difference and normalised as legitimate privilege (Moreton-Robinson, 2000) that is accorded normalcy and therefore, it has licence to speak or do things in the world that are not afforded other races (Dyer, 1997; McIntosh, 1988). Haraway (2004) takes race as problematic because it does not remain neutral, biology is always interpreted. Another thought about racialisation is that while it involves immigration, democracy and liberty, it is also a root to slavery, deprivation and uproar. Haraway (2004) demonstrates that the societies in the United States enjoy multiculturalism, yet, continue to harbour conservative view of racial purity, all illustrated by partisanship through policies against migrants and refugees. The race-based inequity and discrimination are practised on a daily basis that are subtle and remain unreported (Raghuram, 2007). Racial discrimination is a

result of systemic whiteness that dominates Indigenous peoples residing in the colonised territories and immigrants of colour who have been invited by white settlers. Indigenous peoples suffered more as the social construction of whiteness captured the rights on their land and natural resources and confined them in their own territory (Moreton-Robinson, 2000). While the indigenous, dominant white and migrant people make up the diversity in the society and workplaces, they face the complexities of racial and cultural differences because it is easier to talk about cultural diversity than meaningfully acknowledge cultural differences (Bhabha, 2004). Appreciating the cultural difference is what cultural safety does, which is hard in institutions that have whiteness as a political power, however, keeping the diversity has been a matter of pride (Ahmed, 2012). Hence, whiteness is a system, ideology and political power relation constituting race and racialisation. Whiteness is institutionalised and operationalised in Global North to dominate and disadvantage Indigenous and immigrant population.

Ahmed's (2012) analysis of the complexities faced by diversity workers included inactivity of policy as well as how diversity work is positioned as a means of repairing past injustices. Rather than creating equitable futures, institutions seem busy masking racism by using their apparent diversity to show that they have an inclusive policy. In taking pride in a policy written by diversity workers of colour, the authorities were mesmerised in the belief that they were doing well yet avoiding constructive discussions about the opportunities for institutional transformation from the inside out (Ahmed, 2012). Ahmed's points imply that diversity is accepted by virtue of its requirement but the issues around diversity remain problematic. Racism, for example, is linked to the reputation of the organisation, and therefore, the language around it is manipulated to hide it (Ahmed, 2012). Ahmed's experiences of exertion and resistance to doing diversity work indicate that organisations may point to diversity policies but lack evidence of their implementation. Implementing diversity policy can mean enacting cultural safety, which is relatively new in the health care organisations.⁵ The Code of Conduct for nurses has now clearly outlined the need for advocating for and providing quality and culturally safe health care to Aboriginal and Torres Strait Islander peoples by recognising their family and community values, beliefs and practices (NMBA, 2020). The Code of

⁵ In Australia, the Nursing and Midwifery Board of Australia (NMBA) has adopted cultural safety of indigenous people in its code of conduct. The NMBA has also published joint statement with Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), Australian College of Midwives (ACM), Australian College of Nurses (ACN) and Australian Nurses and Midwives Federation (ANMF) in 2018, which is after the completion of data collection for this thesis.

Conduct also addresses cultural needs of nurses as health care providers, as their culturally safe and respectful practice should include interrogating how their own cultural values, beliefs and attitudes affects their communications and interactions with their colleagues and patients as service receivers (NMBA, 2020). Cultural safety offers a way of respecting and acknowledging the cultural differences including experiences, gender and races of both health care providers and receivers so that they feel culturally safe. The cultural safety of nurses involves recognition and respect of cultural identities, beliefs and practices, where nurses from various cultural backgrounds feel they belong and accommodated. Thus, the concept of cultural safety incorporates diversity within cultural groups such as social, religious, ethnic, racial and gender categories (Nursing Council of New Zealand, 2005), whose structural intersections create inequality, discrimination and marginalisation in the workplace and have a role in determining nurses' social relations of work.

NATURE AND CULTURE OF THE NICU

The nature and culture of the workplace have a role in constructing social relations between nurses regarding how the workplace environment is created to support nurses' work. The NICU differs from most other areas of clinical practice in terms of the unique patient population with unique health care needs and the more complex nature of care provided due to the size of the patients with very narrow error margins (Thomas et al., 2004). The differences also lie in the developmental care needs of the patients (Nightlinger, 2011) and the requirement to establish early parent–infant relationship. The general intensive care norms of prompt and accurate decision-making for the potentially rapidly changing conditions of the patients is also part of NICU culture, which neonatal nurses practise in their everyday work.

Wilson, McCormack, and Ives (2005) analysed the workplace culture of an Australian special care nursery using survey, participant observation and semi-structured interviews. They identified key cultural aspects such as teamwork, learning environment, the inevitable practice change and family-centred care. While these were perceived positively as core values to be practised daily in the nursery, issues such as disharmony in teamwork, resistance to change, passive and submissive communication styles of nurses, and inconsistency in parental involvement in baby care served as challenges. These were taken as negative workplace practices associated with differences in individual nurses' values and beliefs, reflected in their interactions and relations. These findings suggest that the workplace culture has both positive and negative aspects, which has impacts on nurses' experiences of work and social relations.

An ethnographic study by Vermeulen (2004) described the nature of the NICU as crowded with ultra-modern equipment, many specialist staff and parents, relatives and visitors of sick babies. Several incubators and warmers holding premature and sick babies also carry wires and devices that are connected to the babies to measure their vital signs and supply nutrition, oxygen and medication. Bright ambient light and noise from investigative and therapeutic equipment and chaos from people moving around is distressing not only to patients in their very early lives but also to nurses working to care for them. Vermeulen (2004) suggested that such an intensive work environment can affect the social relations between nurses.

Moreover, NICU nurses have a sense of specialness, pride and superiority because of their expertise, autonomy and power. They position themselves as ‘rescuers’ or ‘lifesavers’ because they save babies born with complex health problems and support life or death decisions with the help of advanced bio-technology (Vermeulen, 2004). However, another side of this is a baby who may have to live with lifelong impaired ableness, which is rarely spoken about. NICU nurses have a considerable sense of control over the NICU environment and ownership of the babies. Lupton and Fenwick (2001) revealed the power struggles between mothers of the babies and nurses caring for them, such that nurses were found to directly prevent ‘mothers and their partners from touching their infants by admonishing them’ (p. 1017). Similarly, Wilson et al. (2005) found some nurses were not supportive of family-centred care—they would refer to the baby as ‘my baby’ and control the care of the baby thereby minimising the role of parents. This behaviour was described as an ‘attitude problem’ that made social relations difficult with nurse colleagues who worked towards an inclusive workplace culture. Such over-protection and excessive ownership are paternalistic relations, which are problematic for a nursing workplace.

The catchphrase ‘my baby’ describes a behaviour among neonatal nurses that leads them to say, ‘don’t touch my baby’ or ‘I’ll tell you when to touch my baby.’ Such ownership and control leading to interprofessional autonomy may affect social relations with doctors and allied health care professionals (AHCP), as nurses often negotiate the timing of procedures and care with them according to the routines for care and babies’ sleep–rest cycle. Such feelings of ownership and control also apply to new, casual and immigrant nurses, leading to impaired social exchanges between them. Such practices are about territoriality and power relations that the senior and experienced neonatal nurses in the workplace tend to secure,

which can marginalise immigrant and coloured nurses as well as other nurses of categories: new, casual or male nurses.

SIGNIFICANCE AND AIM

In Australia, nurses count for the largest part of the health care workforce [52.6% of 496,438], and 38% of them are immigrants (Australian Bureau of Statistics, 2016). Given the diversity in the workforce is related to challenges in social relations because of differences and how they are accommodated in the workplace, this thesis focuses on examining social relations between nurses. The aim of this study is to identify what matters at work for neonatal nurses by exploring how their social relations of work are constructed in the NICU as a workplace. An issue of inquiry is thus how these relations operate on a day-to-day basis, where nurses work with the potential for offering ways to enrich their social relations of work. Ethnography as a method and methodology is a way of looking at the everyday subtleties of social relations in the workplace. Ethnography works with intersectionality to make explicit how different categories of nurses interrelate day-to-day to construct social relations. Intersectionality also helps to see the problems of social relations: exclusion, discrimination and marginalisation in the workplace and is considered a key concept in interpreting findings. Hence, this thesis is a unique experiment in the use of intersectionality and ethnography together, which considers how the inclusion of an analysis of how the application of cultural safety might guide nurses' social relations of work by offering opportunities for authentic engagement among nurses.

THESIS OVERVIEW

This chapter has introduced how the inquiry emerged from my practice in the NICU, the key concepts of social relations of work and cultural safety, and briefly outlined the aims and significance of the thesis. The second chapter offers the theoretical background that frames the thesis. The chapter describes how nursing is understood as work and nurses' work as social relations because nursing work is accomplished via various social interactions. Since social relations occur in the work of nurses, they are considered social relations of work. The chapter also discusses how intersectionality is used to explain the findings, and how the context of nurses relates to the concepts brought forward in the chapter. The third chapter talks about theoretical assumptions around ethnography as a research methodology. The chapter also explains how ethnography helps with researching the everyday workplace by providing principles, tools and techniques and how these methods assist the ethnographer in

dealing with challenges of fieldwork. The fourth chapter describes how I conducted ethnographic fieldwork to gather information through observation and interviews and how I carried out the work of constructing and managing ethnographic data following fieldwork to produce this thesis. This chapter thus largely described my experiences in the field including hitches and hinderances in the research process.

The fifth chapter details how social exchanges based on trust and reciprocity assisted nurses with how they work together. This chapter particularly argues how knowing where colleagues are from, respecting and recognising their qualities and skills and supporting their endeavours contribute to developing a sense of belonging and nurturing the social relations between the senior and bedside nurses. The sixth chapter demonstrates how support and expertise from senior nurses are viewed as clinical resources and opportunities to learn and how these resources are mobilised across various categories of nurses working in the workplace. This chapter further explains how the distribution of resources and opportunities make a difference on nurses' social relations of work. The seventh is a discussion chapter, where the findings presented in chapters five and six are discussed in relation to social inclusion and justice, and power and patronage relations. This chapter demonstrates the link between how nurses practise trust and reciprocity between them and how they support each other at work to build the understanding of what makes a good shift, where immigrant status is a major disadvantage among nurses. The eighth chapter concludes the thesis by arguing what really matters at work for nurses to keep them working together. The chapter displays reflexivity of the researcher in explaining how the thesis was born and shaped to argue how nurses' social relations of work are important. Through recommendations, the chapter offers options of considering how best to support diverse nurses through equity in opportunities, cultural safety, recognition of skills and identities and constructive communication.

CHAPTER TWO: THEORETICAL BACKGROUND

The way we imagine discrimination or disempowerment often is more complicated for people who are subjected to multiple forms of exclusion. The good news is that intersectionality provides us a way to see it.

— Kimberlé Williams Crenshaw⁶

As Crenshaw avowed, ways or means are required to see and examine what is happening in the individual, society or workplace. Theoretical, conceptual or philosophical perspectives serve as ways of seeing social practices. Building on the review of nurses' social relations of work in the previous chapter, I discuss how nurses' social relations with co-workers are central to their work. In Chapter One, I described how as an immigrant nurse I experienced a blaming culture in my workplace, which made me ponder whether there was structural discrimination to immigrant nurses and led me to study what was actually happening. The published literature on migration demonstrated that nurse migration as a by-product of post-colonialism and the shortage of skilled workforce in affluent nations such as Australia creates diverse societies and workplaces. However, diversity in the workplace not only causes adaptation and recognition problems among immigrant nurses but brings complexity to their social relations of work. The literature also pointed out that while the nature and culture of the NICU have an impact on social relations, neonatal nurses' personal values, beliefs and attitudes also seem to challenge their ability to relate. This challenge concerns ownership of patients and resultant power relations. Intersectionality provides a theoretical lens to analyse the complexity of social relations caused by intersections of identities, social positions and relations between nurses.

The first section explores how nursing is conceptualised as work in comparison to concepts of profession and practice; thinking of nursing as work creates a view of such work as more autonomous, ethical and theoretically rich. The second considers how viewing work as forms of social exchange, norms and power relations leads to a conceptualisation of work as social relations. The third explains how characteristics of work environment and the quality of social relations between nurses influence their social relations of work. The fourth discusses how the theory of intersectionality supports an analytic focus on social relations of work through an examination of the structural positions of nurses brought about by intersections between those positions. The final section provides the contextual relevance of thinking through the social

⁶ Found in a newspaper quoted by Miller (2017), no page number

positions of nurses working together to accomplish care of patients and how this contributes to the social injustices that occur in the everyday work of nurses.

NURSING AS WORK

In contrast to contemporary conceptualisations of nursing as a profession or practice, this thesis aligns with Liaschenko and Peter's (2004) conceptualisation of nursing as work. These authors argue that the concepts of profession and practice are inadequate to capture the social realities and moral challenges of modern health care, and therefore, these conceptualisations are no longer pragmatic. Current health care work involves multiple social relations between care providers and with patients, where differing organisational and worker goals bring conflict, the ever-changing context of health care work and a lack of control over expertise (Liaschenko & Peter, 2004). These characteristics can make representing nursing work difficult and contribute to its invisibility; thus, the understanding of nursing as work 'more aptly answers nursing's concerns, more readily reflects the current health care context, and holds the potential of an ethics more suited to these than either the ethics associated with profession or practice' (Liaschenko & Peter, 2004, p. 489). Central to this argument of nursing as work is the assumption that work is governed by a set of social relations that produce the workplace and its outcomes.

Tracing the history of nursing as either an occupation or a vocation, Liaschenko and Peter (2004) argue that to be considered a profession, nursing is required to have certain characteristics: a unique body of knowledge, an altruistic service to society, a significant education and socialisation, a code of ethics and autonomy in practice. While nursing has the first three characteristics, it is lacking the latter two—which comprise the major determinants of a profession. While professional codes of ethics exist for nurses, the authors argue that these codes do not regulate the conduct of professionals and are 'of limited use in the everyday morality of practitioners and their work environments' (p. 490). They offer the example of informed consent from the patient at a time of crisis, which is motivated to protect the care provider rather than the patient, and therefore, does not directly affect professional ethics. Power and autonomy also determine the status of work and whether it may be characterised as a profession. While some aspects of nursing are autonomous, nurses almost always share decision-making power with a health care team and do not have full control over their own work. The ethics associated with the concept of a practice are also limited as institutions are not the sources of social circumstances, but rather, depend on the practice or

activity itself, limiting the scope of nursing as a practice. Thus, Liaschenko and Peter (2004) conclude that understanding nursing as a practice is also an impractical moral endeavour.

Unlike concepts of profession and practice, work is open to conceptualisations (Liaschenko & Peter, 2004). This means nursing as work is theoretically rich and can broaden its scope and critique in a meaningful way. Applebaum (1992) regards work as ‘the spine which structures the way people live, how they make contact with material and social reality, and how they achieve status and self-esteem’ (p. ix). This definition supports Budd’s (2019) notion of work as various aspects of human life such as identity, autonomy, service and caring for others. Of the 10 different conceptualisations of work offered by Budd (2019), work as caring relates to nursing and contextualises the work of nurses as caring for patients and the social relations of work in this thesis.

Melon (2013) explores the organisation of nursing work in a Canadian emergency setting. Using institutional ethnography, Melon unpacks how triage nurses manage the safe passage of patients and how the rapid flow of patients affects expert nursing work. Melon (2013) defines nursing work as:

Any work directly or indirectly with or about patients ... coordinating work, monitoring and surveillance work, consulting work, relationship work, the work of creating physical treatment space, technical and physical interventions, intellectual work, communication work, and so on that goes on around the clock, every day and every night. (p. 7)

This definition explains how nursing work is devoted to patients and what its peripheries are. Melon (2013, p. 190) goes on to note that ‘as nursing work is relentlessly restructured for maximal efficiency, productivity and the continuous (never stopping) ‘flow’ of patients through emergency and hospital beds, nurses’ focus on patients is diverted to the demands imposed by the system efficiencies’. This statement means time pressures influence the attention given to patients and co-workers, affecting their social relations of work. The work of nurses also requires quality, which is linked to the efficiency of the workplace. This shapes the social relations between the nurses and their seniors; that is, the workplace. Thus, what nurses do and who they relate with in coordinating care in the emergency room is their work, and social relations are part of this work.

Latimer (2000), in her book *The Conduct of Care*, provides insights into what nurses do, conceptualising nurses as ‘conductors of care’ and identifying the relational aspect of nursing

work. This ethnography illustrates how, in an acute health care setting, nurses work to organise patient care and implement medical treatment. The author describes the wide range of nursing skills that comprise nursing work and the daily activities of nurses that go beyond caring for patients. What modern nursing is, what complexities nurses face while conducting the care and who they work with in coordinating care and implementing change in care are also discussed to understand nursing work (Latimer, 2000). Although nurses' work requires social relations at every angle and whoever nurses interact with in providing, organising and coordinating care of patients, this book does not specifically explain social relations between nurses in nurses' conduct.

In *Changing Shape of Nursing Practice*, Allen (2001) examines the work of nurses from a sociological perspective, which corroborates the argument that nursing is best conceptualised as work. This ethnography is based on the author's doctoral thesis, with substantive content on division of labour in hospital patient care and the jurisdictional boundaries of nursing work. In this book, Allen (2001) conceptualises nurses' work applying sociological theories, such as division of labour by Durkheim and Hughes, and professionalises the occupational nature of nursing work via Abbott's idea of jurisdiction. While the book lacks the emotional and psychological aspect of nursing role in the discourse of division of labour and professional boundaries, it mentions the need for negotiation and interaction among the participants of work running the system, which are part of the social relations of work. For example, in examining the intraprofessional division of labour in her fourth chapter, Allen illuminates how senior nurses control the work of junior nurses and how the latter try to resist that control. This shows social relations among nurses are linked with the hierarchical and power relations between the seniors and juniors. Although Allen does not distinctly address the social relation of work in this book, what she examines is nurses' work that involves social relations, which is relevant to this thesis in terms of how they are practised in the workplace.

Since nursing is not limited to knowledge coming out of practice in recent technologically advanced decades and ethics and autonomy are less relevant to consider for professions, as Liaschenko and Peter (2004) argue, this thesis agrees that nursing should be (highly) regarded as work. The examination of nursing work by Allen (2001), Latimer (2000) and Melon (2013) using ethnographic approaches has relevance to this thesis as they support the approach of this study and the argument – that nursing is work within a web of social relations.

WORK AS SOCIAL RELATIONS

Social relations are at the heart of the accomplishment of nurses' work. The section above discussed a few research studies exploring nurses' work that rely on exploration of the network of social relations. While Melon (2013) explicitly discusses the social relations of nursing as work, Latimer (2000) and Allen (2001) demonstrate the webs of social relations in nursing work rather than focusing on that attribute. This study extends these ideas by drawing on Budd's (2019) conceptualisation of social relations themselves as aspects of work.

Budd (2019) refers to work as a human activity requiring social interactions and relations within networks of co-workers, stakeholders or beneficiaries. As mentioned above, Budd conceptualises work as 10 different notions to explain the various aspects of this part of human life, such as work as a source of income providing a socio-economic ladder, a path to identity or independence, a path to personal achievement, a method to serve or care for others, or God's curse as the need to work is forced upon the worker and the disutility of work done as goods and services. Although all these aspects are associated directly or indirectly with social relations, Budd also discretely conceptualises work as social relations in his book *The Thoughts of Work*. While these conceptualisations broadly include all types of work, work as caring for others and work as social relations can be correlated with nursing work and its social relations. Budd (2019) defines social relations as human interactions 'experienced in and shaped by social networks, social institutions, and socially constructed power relations' (p. 108). He presents three key approaches to how work is thought of as social relations: social exchanges; norms, social institutions and organisational culture; and the unequal power and class relations of work.

The notion of social exchange, according to Budd (2019), is based on a set of interpersonal relations. This involves trust and reciprocity that embrace an open and enduring relationship between the employer and employee, and co-workers and teams. They have expectations of each other about thinking of ways to progress and work together towards the achievement of work. As this type of relationship features reciprocal obligations and multiplicity, it goes beyond the monetary purpose of work, to find identity, status, respect or satisfaction among its aspects of social exchange. For instance, while the employer supports employees in their work to attain personal and professional objectives, employees work hard towards the organisational goals and stay committed to the workplace. This loyalty is in expectation of rewards and more care in the long run but is also more motivated than concerned about the

daily effort attached to specific rewards. Budd (2019) further argues for the social relations attached to work, saying ‘None of this is to say that financial compensation is not important; rather, if work is (partly) a social exchange, then the bonds between employee and employer are more complex than short-term financial self-interest’ (p. 109). What is more important to seeing work as a social exchange is the idea of OCB, which extends the usual duties of employers and employees (Budd, 2019; Wan, 2016) and offers reciprocal support among co-workers. Since mutual assistance nurtures social relations among workers, an exploration of how reciprocity and support are practised in the workplace and how social exchange can be promoted among nurses is necessary.

Budd’s second notion details how norms, social institutions and organisational culture at work influence social relations. He defines norms as socially sanctioned human behaviours, social institutions as social systems governed by sets of norms, and organisational culture as a set of values shared by members of social institutions as usual work behaviours. The ‘norms governing work in a particular organisation can, therefore, be seen as a form of a social institution and is popularly referred to as corporate or organisational culture’ (Budd, 2019, p. 112). In relation to healthcare organisations, Mannion and Davies (2018) describe organisational culture as a shared way of thinking, feeling and behaving that become norms that nurses as workers follow to carry out their work. There is one overarching culture running the organisation and multiple subcultures across different units or disciplines. For instance, a hospital unit such as a NICU is a unit driven by a set of norms that govern the care of the neonates and their family. Thus, norms are the standards, social institutions and organisational culture that regulate the workplace and workers’ behaviour, which in turn shapes social relations among workers.

Normative control, as Budd (2019) points out, involves the nature of workplace norms that reflect similar interests between the employer and employees. These norms include psychological contracts where employees believe in hard work, loyalty and dedication, which are recognised by their employer. They also include an organisational culture of training, mentoring, social events and teamwork that enrich workers’ motivation and capability. Budd (2019) believes that theories of normative control of work can manoeuvre norms, culture and identities to shape employees’ behaviour, rather than economic or psychological theories; thus, ‘if work is a social relation, then norms, social institutions, and organisational culture can be important determinants of worker effort and cooperation’ (p. 113).

Budd's third notion of unequal power and class relations is borrowed from the ideology of social stratification between the capitalist and proletariat, which is considered a signature of work under capitalism. Referring to Karl Marx, Budd (2019) discusses how hierarchy emerges out of industrial society and how it brings about inequality in social relations between the employer and employees. Budd argues that the nature of the work does not cause the unequal distribution of labour, production and ownership of wealth and commodities; instead, it is socially constructed laws that define the rights to and power over production and resultant wealth. Thus, it is the capitalist system of society that creates class and power differentiation between the owner and the worker. Over time, proprietors accumulate power and rights over resources and production, while the labour-power of workers is expended and continuously required. The injustice of the gap between the two classes creates class conflict, and results in working-class resistance. To weaken that resistance and continue proprietary power over employees, capitalists have been reflexive enough to design measures of structural control, including rewards, training, performance assessments and punishments. Over time, this has led to discrepancies in rewards and punishments between classes, which is relevant to social inequities in health care workplaces.

Although the current nurse labour market may not be identical to that theorised by Marx (2013) as representing power and class relations between the bourgeoisie and proletariats, Budd's argument of impaired social relations in line with unequal power and the power relation between the employer and employees is relevant to this thesis. Since the power and rights of capital and labour are socially constructed, Budd's conceptualisation of work as social relations feels appropriate and relevant to social relations and measures of structural control used in the workplace by senior management to ensure organisation and compliance of nurses, who work as direct care providers at the bedside. How power relations are practised and how structural control is used within the organisation to affect social relations among nurses is thus a subject of inquiry in the context of the nursing workplace.

Nurses' work is multidimensional. While they work for a living, their work is driven by many factors including identity, satisfaction and caring. As this is a service-rendering job, nurses' work is based on social interactions with people who they work with, who they work for and who they care for. Therefore, nurses' interactions are multidirectional: above, below and parallel. All these vertical and horizontal interactions within a hierarchical structure and social sphere can substantiate Budd's (2019) argument of work as social relations. Moreover, the

NICU as a workplace has organisational norms that workers including nurses follow to regulate their work behaviours. This is in line with what Budd (2019) states about the norms that control an organisational culture and are reflected in workers' behaviour, which justifies the use of the concept of work as a social relation. The social exchange Budd discussed as the first notion of work as a social relation is even more closely related to nurses' work. Helpful colleagues and supportive senior nurses act as pillars for social exchange, as they promote trust and reciprocity among bedside nurses and with their managers. Further, as Budd (2019) emphasises, OCB in both management staff and bedside nurses and organisational culture influence these social relations. Hence, as all these connections and dealings are organised by institutional structures, social relations can be understood as a central aspect of nurses' work.

SOCIAL RELATIONS OF WORK

The conceptualisation of nursing as work and work as social relations means that what nurses do for their patients in a hospital unit or community setting is nurses' work and how they relate with the people around them to do that work is their social relations. Because social relations occur around nurses' work, they are considered social relations of work. Liaschenko and Peter (2004) justify this consideration, noting that 'Nursing is relational not only at the level of the nurse-patient relationship, but also in terms of the work nurses do in facilitating and coordinating care within complex organisational networks, whether these networks are hospital-based or community-based' (p. 491). Similarly, nurses' work entails not only the acts of providing care and interpersonal relations involved in coordinating care among members inside and outside the team, but also the skill of incorporating modern technologies into that care and activating intellectual texts in the course of routine clinical practice (Melon, 2013). These processes reveal how nurses' work constructs social relations in their workplace.

Therefore, the discussion about social relations of work includes characteristics of workplaces that have an impact on social relations of work, the quality of social relations among colleagues and the diversity of nurses working together. This diversity can range from personal characteristics such as values and attitudes of nurses to broad societal structures such as race, class and gender. These categories incur power relations, influencing the distribution of resources within the workplace, and thus, affecting the social relations of work.

There is much literature offering strategies for bettering social relations of work and 'fixing' negative workplace relations that are of interest to those in management and human resources

(Buzzanell & Dohrman, 2009; Manion, 2004; Moore et al., 2013; Sias, 2009). Other research reveals that the problem lies in an inability to identify the causative factors including nurses' attitudes, work environment and organisational characteristics (Blackstock et al., 2015; Padgett, 2013; Peter, Macfarlane, & O'Brien-Pallas, 2004). This thesis attempts to draw attention to the sources of problems nurses face that affect their social relations of work.

Blackstock et al. (2015) used an Australian model of workplace bullying developed by Hutchinson et al. (2008) to study how organisational characteristics affect the work experiences of Canadian nurses. This Canadian study found that flawed organisational processes were often responsible for nurse bullying and increased turnover in the workplace. Such structural processes include informal structural alliances, misuse of institutional processes and organisational tolerance and rewarding of bullying. The informal organisational alliances serve as social and hierarchical networks that support and protect bullies from challenge or reproach. The misuse of organisational processes indicates how the perpetrator of bullying is tolerated and facilitated through organisational processes such as unreasonable scrutiny or assessment of the victim instead of the bully. The organisational tolerance and rewarding of bullying, as seems clear by the term, involves the tendency of health institutions to condone or support bullying behaviours, where witnesses of bullies stay silent, or the nurses who are involved in the act of bullying are rewarded instead of warned or punished. This systematic tolerance includes hierarchical structures that provide pathways for bullying behaviours that in turn are hidden within the structures. As a result, the nurses who are victimised have decreased self-esteem, confidence and efficacy at work and the sense that they are held to unreasonable surveillance or performance standards (Blackstock et al., 2015). These negative workplace practices form an organisational culture that has a negative impact on nurses' social relations of work.

Peter et al. (2004) found the environment in Canadian workplaces under study to be morally uninhabitable for nurse participants. The authors located four categories of work atmosphere in their secondary analysis of focus group data that were influential in the formation of nurses' social relations of work. First, they suggest, was an oppressive work environment, where nurses felt powerless, exploited and marginalised and suffer violence. Second, incoherent moral understandings were experienced as lack of clarity in understanding of moral responsibilities. Third, moral suffering occurred where nurses experienced emotional exhaustion, compromise of their values, lack of respect, feelings of abandonment and lack of belonging. Last, moral influence and resistance were the means nurses adopted to resist these

social and spatial vulnerabilities and overburdening by going casual or part-time, focusing on self-care, being assertive, group forming and retaining professional values and ethics. Peter et al. (2004) analysed these findings using Walker's (1998) feminist ethics, which considers moral practices as responsibilities and negative workplace practices such as oppression as a moral wrong. There is a clear distinction between the first three themes and the last; the first three have similar content and concern what nurses experience in the work environment, while the last concerns coping strategies to explain how nurses cope with such uninhabitable environment. It is evident from this article that when nurses experience an unfavourable work environment, they tend to flee from the situation or develop coping strategies at personal and collegial levels that sustain what they value in the social relations of work.

Padgett (2013) in his ethnographic study unpacks how nurses regard teamwork, getting along and mutual respect as part of their work of collaborating in the delivery of care. Workplace friendship, which nurses identify as collegiality or social relations among themselves, is considered essential for the accomplishment of patient care, to maintain patient safety and quality in care and for professional regulation. Valuing collegiality, nurses in the study were found to avoid actions or communications that could be perceived as personal challenges and threats to harmony and group cohesion. Although not being 'harsh' or 'accusing' can help collegial relations and lessen the blaming culture that exists in many workplaces, these approaches may indicate that nurses are avoiding conflict, and lack constructive ways of dealing with conflict. Because nurses mostly work in groups, collegial relations may either be healthy or have turned into bullying, intimidation, alienation or marginalisation. As Blackstock et al. (2015) point out, some nurses are involved in wrongdoing such as bullying or complaining about other nurses to the higher ranks, leading to scrutiny and other troubles for them from the senior management. However, awareness and capacity to deal with criticism and negative workplace relations is more productive for social relations of work. Padgett's (2013) work clearly shows that nurses avoid conflict, and therefore, cannot work well together, which means they are prepared to work as individuals and not in a team. Thus, nurses' work and experiences in the workplace such as bullying and discrimination are worth study; however, capabilities for respectful disagreements are not explored in most research into nurses' work (Padgett, 2015).

Social relations of work are important and to-be-attended-to matters because nurses spend 40 hours per week at their workplace—often more time than they spend with their families and

friends. The research evidence shows that social relations among nurses determine the health of a nursing workplace (Moore et al., 2013), which has a direct impact on the quality of patient care, as emphasised by Aiken et al. (2011). Since nursing is best conceptualised as work and work is considered social relations, social relations of work are even more important in today's multicultural and diverse work setting as the categories nurses come with intersect to result in inequities in access to resources in the workplace. Similarly, abusive organisational cultures (Blackstock et al., 2015), uninhabitable work environments (Peter et al., 2004) and nurses' attitude of avoiding conflicting relations with colleagues (Padgett, 2013) directly or indirectly affect social relations of work.

INTERSECTIONALITY AS A THEORETICAL FRAMEWORK

Post-colonialism elucidates how cultural plurality emerged and how power relations operated between the colonisers and colonised to create and widen the gap between them: powerful and the powerless (Azim, 2007; Bain-Selbo, 1999; Childs & Williams, 2013; Young, 2016). During colonisation people were taken from one colony to other as handymen, technicians and professionals, (Smith & Mackintosh, 2007), which added multiculturalism in those colonies and those categories attracted intersectionality to emerge consequently and work synergistically by explaining the effects of post-colonialism. The colonised movement later became the trend of skilled migration especially in Global North (Raghuram, 2004). Nurses are the large part of such migration and the literature on nurse migration (Hawthorne, 2001, 2005; Kingma, 2001, 2008) demonstrates how migration and recruitment of nurses brought diversity to nursing workplaces. Workplaces such as NICUs thus display complex intersections of different values, beliefs and attitudes, life and work experiences, social and racial backgrounds, gender, language and religion. As these intersections can create various inequities and injustice (Aguilar, 2012; Beal, 2008; Crenshaw, 1991; Davis, 1983), it is important to understand how these multiplicities interconnect and interrelate with each other to construct social relations in the workplace (Walby et al., 2012), how local nurses cope with the existence of these 'other' nurses in the workplace (Bain-Selbo, 1999) and how these diversities share privilege and suffer oppression in the workplace (Samuels & Ross-Sheriff, 2008). In line with the dominant social positioning and power, the intersectional categories have differing levels of power relations, and thus, intersectionality can afford a view on the complexities of these workplaces' social relations. Hence, this section considers what intersectionality means from the viewpoint of different scholars, how and when it emerged as

a theory, how far it has travelled in academic and research fields, and why it is important in analysing the social relations of nurses at work.

Although Kimberlé Crenshaw coined the term 'intersectionality' in 1989 (Cole, 2009; Nash, 2011; Phoenix & Pattynama, 2006; Yuval-Davis, 2006), the concept is present in the earlier works of feminist scholars who studied gender, class and race as co-occurring. The perspective 'emerged from the writings of women of colour during the 1960s and 1970s' (Samuels & Ross-Sheriff, 2008, p. 5) when women from Africa, India, the Caribbean and Latin America were involved in feminist activism that challenged the wisdom of mainstream American feminists (Coleman, 2019). While Beverly Guy-Sheftall and Angela Davis were the lead feminist activists engaged in 'kitchen table conversations' to speak for economic and social justice of 'sister comrades', Linda Carty and Chandra Talpade Mohanty noted that the diversity in feminism was ignored in the discourse of historical and cultural experiences of white middle- and upper-class women (Coleman, 2019). During this period, the work of a group of black feminists called Combahee River Collective was published in 1977, who found race, class and sex oppression to be inseparable as these were the most commonly experienced phenomena in their lives (Cole, 2009). By the 1980s, women scholars of colour such as Davis (1983), Giddings (1984), hooks (1984) and Bell-Scott, Smith, and Hull (1982), who, without naming the concept, used intersectionality in their research (Cole, 2009). The women scholar activists of this decade also include Moraga and Anzaldúa (1983), who published the experiences of racism faced by women of colour from white women feminists. Their work was a steppingstone for feminist writings because of the interrelating multiple identities kindling the emergence of intersectionality. In the late 1980s, when the concept took its shape, it increased its scope and served as a framework for examining today's diverse society and workforce and the complexities of social relations within them.

Crenshaw (1989) formulated the concept of intersectionality to explain how race and gender intersect to form the various aspects of employment experiences that black women face. In her writings, she illustrated how the US law treats black women's cases and fails to address issues of race and gender, forcing them into further exclusion, subordination and discrimination in their workplaces. Thus, Crenshaw (1989) featured structural and political intersectionality: the former concerning unequal social groups and the latter concerning political agendas and projects. In her subsequent writings, Crenshaw (1991) explored the structural, political and representational aspects of violence against coloured women, and highlighted identities such as women of colour, black women or ethnic minority women, to

make them visible through feminist and anti-racist discourses. She also emphasised that class and sexuality should be included in accounts of multiple identities when considering how the social world is constructed. For instance, battering and rape of women were considered private, family matters and not recognised as part of the social system of domination of women as a group. These issues of hiding are systemic and have wider consequences, and therefore, should be given broad attention. On the other hand, recognition of these issues could relate to identity politics of African Americans, other coloured people or categories and become a source of power for community development. The other coloured categories include Chicano, Latino, Indian and other Asian communities living and working in Global North, who face racialisation in everyday life in society and at the workplace. While these identity categories have sought their existence and rights in the literature if not in everyday lives (Davis, 1983; Giddings, 1984; hooks, 1984; Mohanty, 1988, 2003; Moraga & Anzaldúa, 1983), there is another identity category that is colonised, imperialised and marginalised at large in its own territory, that is, Aboriginal populations. The feminist notion of their identity is rarely discussed in comparison to white feminism. In Australia, Aileen Moreton-Robinson (2000, 2006) has interrogated whiteness for its dominance to coloured and Indigenous feminism. She stands out as an Aboriginal feminist for Indigenous sovereignty and to point out how whiteness is not considered a difference or the differences within the whiteness are centred and normalised. She also argues that whiteness is not questioned as a race, privilege or a social construction, which is also supported by an argument made by McIntosh (1988) regarding male and white privilege that is considered a passport for undeserved advantage. Moreton-Robinson (2000) questions, ‘how any discussion of decolonisation could occur within a colony, without reference to Aboriginal sovereignty?’ (p. x). This question is poignant and disturbs Australian Aboriginals constantly to find Indigenous identity being disregarded and dominated. As an Indigenous feminist Moreton-Robinson (2000, 2006) adds the importance of intersectionality in Australian critical Whiteness literature not only to challenge the white feminists to realise white is a race and thus a category, but also to throw light into how Aboriginal womanhood values ecofeminism rather than capitalist feminism.

The term ‘identity’, according to Shields (2008), refers to a personal image of self or a sense of self that identifies an individual and differentiates a person or group from others. Shields offers some terms related to social identities that construct social relations between differing identities. First, by ‘mutual constitution’ she means that one identity category is relational with another. Second, ‘reinforcing’ means that everyone is actively involved in the dynamic

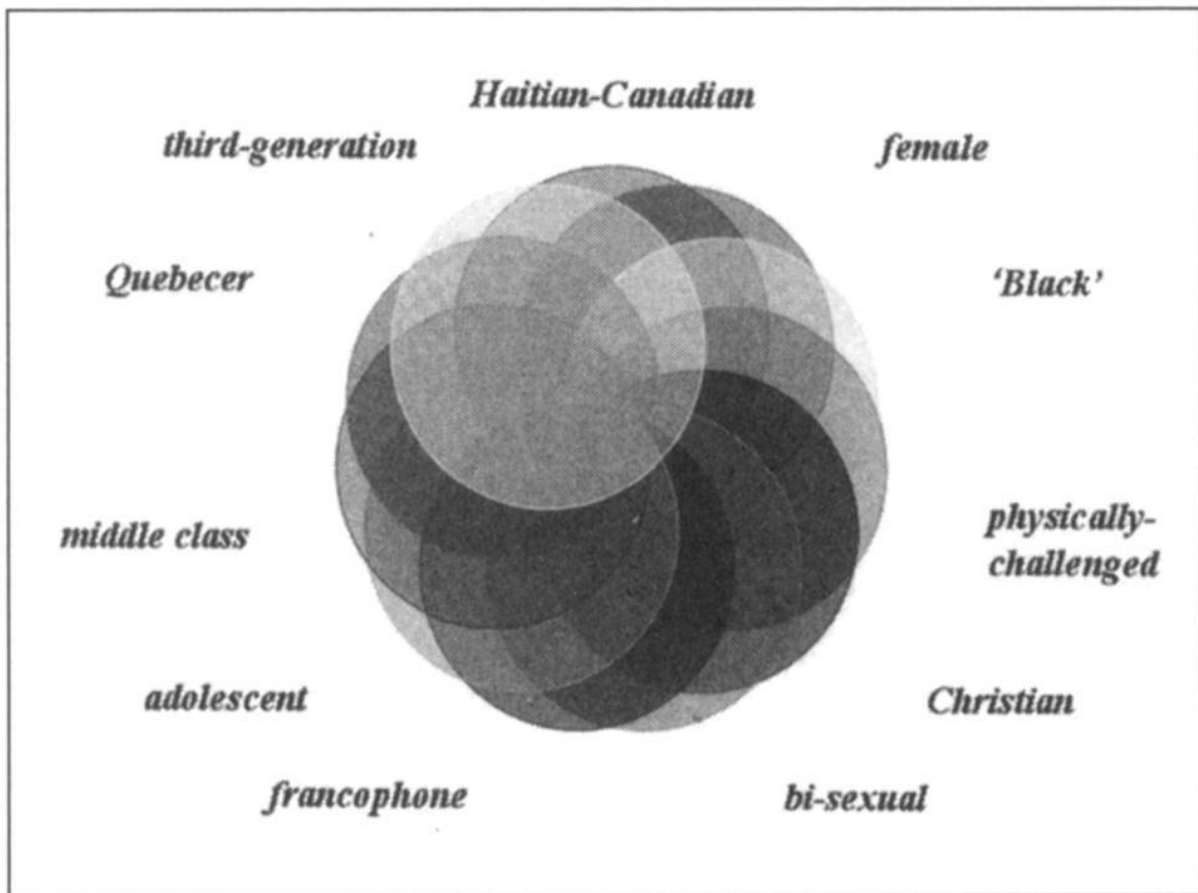
process of identity category formation and maintenance. Third, 'naturalising' means that identities of one group are seen as natural by other groups. These terms can be related to the identities of nurses of diverse social and racial backgrounds as ways of 'constituting' 'reinforcing' and 'naturalising' their differences in nursing workplaces. Shields (2008) also highlights the fact that intersections of multiple categories cause both privileges and oppressions. This means that one group or category may have opportunities, rewards and statuses, while another might be disadvantaged or oppressed. It is also possible that one intersection may be more privileged than another within the same intersectional group. Shields illustrates that a white lesbian might be disadvantaged in terms of socially accepted sexuality, but more advantaged because of her whiteness than her coloured counterpart. In the context of the nursing workplace, immigrant nurses who are white may have a social advantage compared with coloured nurses but may be disadvantaged relative to white Australian-born nurses because of other markers of difference such as accent, religion or nationality. Intersectionality is thus useful in explaining the experiences of coloured women's multiple jeopardies such as marginalisation, racialisation and subordination. It also helps analyse the issues of hierarchy and power relations in relation to recognising diverse identities within the nursing group.

There is a debate in the literature whether intersectionality is a theory, paradigm, or a method. Dhamoon (2011) presents five considerations when adopting intersectionality as a research paradigm. Although I do not agree with Dhamoon's (2011) views about intersectionality as a paradigm, I find these five considerations she presented are helpful as a tool to understand how intersectionality can support the analysis of nurses' social relations of work. First, the concepts and terminology used in intersectionality imply the intersection of many social categories at crossings where a 'crash' occurs because of double-, triple- or many-layered oppressions. Racism, post-colonialism, sexism, patriarchy, sexuality and slavery are the languages used in intersectionality, and these terms have to be consistently reviewed when developing new understandings of categories. The examples of categories of nurses that may be used in intersectionality include skin colour (race), creed (religious faith), culture (ethnicity) and nationality (citizenship) as well as personal and professional experience, expertise and ableness, which can intersect in many layers to build comfortable or conflicting experiences at work. The second consideration that Dhamoon (2011) presented is that identities, categories, processes and systems are subjects of continuous analysis as they are aspects of the socio-political life and have impacts on social and power relations. According

to Dhamoon (2011), identities are marked as distinctive of an individual or social group, categories are classifications of differences, processes are ways and practices of differentiating, and systems are organisational structures that operate to bring about a group or individual domination or oppression. Thus, blackness is the identity, black colour is a category, racialisation is the process of ascribing race, and racism is the system or set of social structures that result from how race is constituted. The complexity of how difference is constituted according to Dhamoon (2011) is a focus of analysis where some aspects are highlighted, and others are not, or even missed, such as the differing extent of privileges and disadvantages that people experience in society. In relation to nurses' experiences at work, the focus of analysis would shift from identities and categories to processes and systems because identities and categories are obvious and inevitable in today's diverse workplaces. What is important in any analysis is not the presence of diverse identities and categories but how they are handled in the workplace in constructing the social relations of work.

The third issue arises from the analytic complexity of subject formation, difference and vehicles of power, where complexity arises when the focus of analysis expands across many dimensions. The shift in focus of analysis causes complex relations between multiple processes and systems such as patriarchy, capitalism and imperialism. This means analytical complexity results from the expansion of analytical focus (i.e. a switch from one to many dimensions), the complicated understanding of subject formation due to the intersectional research paradigm grasping every day, subjective, structural and social variations, and a shift in understanding of difference from binary to multi-layered privileges and disadvantages. The issues of subject formation and power include personal biography, cultural context and social institutions or the organisational, inter-subjective, experiential and representational forms. For instance, one can be an oppressor, oppressed or member of an oppressed group depending on the degrees and forms of privilege and penalty that are interlocked. Fourth, the model describes a matrix where different identities, categories, processes or systems interact and relate with each other and constitute the dynamics of power. Dhamoon (2011) used Rummen's (2003) concept of pictorial examples to illustrate these intersections [see Figure 1]. The intersecting categories in a nursing workplace are epitomised in axes to capture the challenges of such multiple intersections and overlapping [see Figure 2].

Figure 1 Multiple intersecting identities (Rummens, 2003, p. 17)



The fifth and last, which interactions to analyse depends on the decision of the analyst and the criticality of the issue. The issues that attract analysis include political situations highlighted by the media or psycho-social injuries caused by social stigma; hence, other issues, as discussed above in the second consideration, may be missed and remain veiled. Dhamoon (2011), here, provides an important insight into how intersectionality can be adopted and mainstreamed into the research paradigm so that all cross-sectional issues are addressed. Although intersectionality may not be considered as a paradigm or a worldview as Dhamoon (2011) thought, these five considerations provide a roadmap to analyse the interactions of nurses with multiple identities and categories and the resultant complexities in their social relations of work, as shown in the core of the intersection in Figure 2.

Figure 2 Intersectional categories of nurses

	COLOUR	CREED	CULTURE	NATIONALITY	
COLOUR	<u>INTERSECTIONALITY</u> Crash at Intersection (Dhamoon, 2011), Multiple Jeopardy (Aguilar, 2012; Beal, 2008) Multiple Privileges and Disadvantages (Samuels & Ross-Sheriff, 2008)				VALUES
CREED					ATTITUDES
CULTURE					EXPERIENCE
NATIONALITY					EXPERTISE
	VALUES	ATTITUDES	EXPERIENCE	EXPERTISE	

Hence, since intersectionality as a concept emerged from the requirement to account for post-colonial effects, the framework can help unpack the racial and cultural nature of injustice and disadvantage (Van Herk, Smith, & Andrew, 2011). As today’s workplaces are diverse in their workforce that cause complex intersections between categories, the theory of intersectionality helps seeing how the workers experience everyday work and how they construct the social relations of work under the conditions of workplace diversity. The theory of intersectionality emerged with the writings of black feminists and widened its scope through many disciplines that study interrelations of multiple categories. As identities, categories, processes and systems are the four aspects of socio-political life that have attracted analysis of how they operate to create power struggles (Dhamoon, 2011), these understandings provide an insight into how immigrant and coloured nurses’ identities are respected and naturalised or not in the workplace.

THE CONTEXT: NURSES AND THEIR WORKPLACES

Due to global nurse migration and recruitment nursing workplaces are diverse in terms of faces, races, ethnicities and cultures as well as age, education and experiences due to global migration of nurses. In addition to these diversities, nurses have various personal values, beliefs and attitudes as well as abilities, areas of expertise and powers of assertiveness. An in-depth analysis using the theory of intersectionality enables an understanding of how these different identities and personal traits interact and interrelate to shape nurses' social relations of work. Importantly, immigrant nurses bring knowledge and skills to their new workplaces, but they often do not get to use those skills. Lack of recognition of prior skills is a common problem in studies of experiences of immigrant nurses, which is associated with power relations. Expertise, constructed by education and experience, or knowledge and skills, therefore, has been added to the intersectional categories in the context of this study of a nursing workplace where expertise is a currency for social relations of work. This section discusses experiences of immigrant nurses explored by various research studies and how they are relevant to the context of this thesis.

Allan et al. (2009) drew three interviews out of a UK national study of overseas nurses' experiences of racist bullying. In one case, an immigrant nurse of colour applied for a senior position, but did not get the position, and therefore sought help from the Royal College of Nursing. After a challenge, she obtained that position but was excluded by the manager and the whole team of colleagues in her workplace. Such exclusion included disregarding her inputs and decisions in patient care. Another immigrant nurse of colour reported that her manager would not look at her face while talking to her and made her work late before signing her time sheet at the end of her shift. Such treatment made her withdraw from chances of promotion at work. The other immigrant nurse of colour was complained about by carers and staff and fired from her job without warning or opportunity for improvement. She could not apply for another job as her passport was held by the UK Home Office. These three case reports demonstrate abusive power relations between the immigrant nurses and their British workplace authorities and colleagues; the findings are relevant to Beal's (2008) discussion of the treatment black women receive in American society. The status of black women was described as 'slave of a slave' as the American capitalist system enslaved and oppressed black men, rendering them powerless, and sexually abused and economically exploited their wives, sisters, mothers and daughters (Beal, 2008).

Another example of how immigrant nurses experience different treatment in the workplaces is provided in a critical paper by Mapedzahama et al. (2012), which discusses immigrant sub-Saharan African nurses' experiences of everyday racism and racial prejudice in Australian nursing workplaces. In this paper the authors demonstrate that the immigrant nurses experienced prejudice from their managers, colleagues and patients via overt and covert forms of racialisation resulting in low self-esteem, feelings of inferiority, loss of confidence and psychological and emotional trauma. Such a situation goes against ethical recruitment of immigrant nurses to address shortages in the health workforce (International Council of Nurses, 2019) as well as a [State] Department of Health (2015b)⁷ policy of zero tolerance of workplace violence. The black nurses were under constant surveillance, their competence questioned, and their skills undermined and rejected by patients. Such treatments, however, are not only prevalent among African immigrant nurses but, as many other studies reveal (Alexis & Vydelingum, 2005b; Tregunno et al., 2009; Turriffin et al., 2002; Xu et al., 2008), also among other racial, ethnic and national groups of immigrant nurses.

Whiteness is associated with the detrimental practices of racism, but considered neutral and situating at the centre of social structures such as nursing workplaces to other and marginalise the racialised group (Puzan, 2003). Raghuram (2019) argues that the skills and competencies of people that are racialised are undermined and questioned. She exemplifies a case of South African Tamil doctor, who was imprisoned for her Passive Resistance Campaign against the anti-Indian Land Act and asked by the prison warden if she was a witchdoctor. How her professional qualifications were undermined as a coloured doctor demonstrates how racialisation operates in the white institutions. According to Minh-Ha (2011), this undermining relates to the outsider position of those who are migrants and who are racialised. Such outsider position is the process of othering of non-white professionals in white space that occurs in two ways: either by being considered foreign via migration or by being constituted as foreign via colonisation in their own land. Both situations are common to post-colonial world, where the migrants are attracted as workers and the Indigenous peoples are displaced and incarcerated. Both groups are constituted as outsiders, and therefore, othered by the white cultural group, who constitute themselves as insiders (Minh-Ha, 1989). Indigenous nurses and midwives in Australia are made invisible in the health care system by contemporary racialised laws, which means that their history is erased, and thus, under-researched and under-published (Best & Bunda, 2020). The erased history means that the

⁷ One of the States of Australia that has been de-identified for privacy and confidentiality of the NICU.

Indigenous nurses and midwives continue experiencing racial discrimination in education and workplaces (Best & Gorman, 2016). Best and Bunda (2020) present the history of three Indigenous nurses and midwives, who were given opportunities to be trained but under abusive and restrictive environments. Although they experienced effects of colonialism and whiteness, they excelled in their work and contributed to historical representation of Indigenous nurses and midwives.

As Dhamoon (2011) suggests, intersectionality as an emerging theory and research paradigm can be employed to analyse the interactions and relations between different social categories. While race-class-gender constituted the catchphrase to describe intersectionality at the time of emergence, it has broadened its scope by travelling to various disciplines to address the intersections of other identities such as culture, language and social backgrounds as well as age, education and experience. Although some writers criticise it as a theory about black women, race and gender (Carbado, 2013), having no methodological approach to study multiple dimensions of social life (McCall, 2005), and causing imbalance in knowledge production and distribution because of its disproportionate practice in the Global North (over 85%) (Patil, 2013), I argue that it is a dynamic theory that started with women of colour outside the Global North and can provide a framework to address the complexities of social relations, and many other aspects of life that intersect to shape these relations. In the context of nurses' social relations of work, intersectionality provides insights into historical, social, cultural and structural dimensions of a workplace (Crenshaw, 1991); how multiculturalism, trans-nationality, and personal and professional diversities fit together (Walby et al., 2012); how group and individual identities are positioned (Shields, 2008); and how social interaction and interpersonal relations shape the everyday work experiences of nurses. It also captures the ways in which intersections of ethnic, national and religious differences as well as individual values, belief and attitudes construct the social relations of work. Moreover, how workplaces can address the cultural safety of these cultural multiplicities is another important aspect of nurses' social relations of work.

CONCLUSION

This chapter began with conceptualisations of nursing and nurses' work and closed with how intersectionality helps explain the contexts and complexities of nurses' social relations of work. Following Liaschenko and Peter (2004) I understand the pragmatic logic of how nursing is thought of as work—because of the nature of nurses' work, that is, caring for

patients. The open nature of the idea of work also supported this logic as most relevant to today's technologised health care system with a shift in the process of knowledge production from the nursing practice to the intellectual work of nurses, that is, research and innovation. As nursing is caring and caring is work (Budd, 2019), the communications and interactions, coordination and collaboration, and dealings and negotiations, incurred in nurses' work constitute social relations of work. These social relations are shaped by what lies underneath the culture of the workplace and the quality of the social interactions between nurses—social exchange. Since nursing work involves social exchanges based on trust and reciprocal help, compliance with social and organisational norms and power relations of hierarchies, Budd (2019) conceptualises it as social relations. This conceptualisation provides insights into how helpful colleagues and supportive senior nurses act as pillars for social exchange, how social norms shape individual nurses' behaviour and how organisational norms regulate structural conduct and influence social and power relations between the bedside nurses and with seniors.

The social relations of work are the amalgamation of nursing as work and work as social relations as these social relations take place to constitute nurses' work in the accomplishment of nursing care. Social relations of work involve characteristics of workplaces that have an impact on the quality of interactions and social relations occurring between nurses as workers in those workplaces. Because all the connections and dealings are organised by institutional structures, social relations can be an effect of, and affected by, structural inequities and injustice. The diversity of the nurse population contributes to social inequities experienced. Intersectionality as a theoretical perspective provides insights into how such social and structural violence occurs in the workplace, how nurses of immigrant categories experience the everyday workplace and what contributes to the constructions of social relations of work.

CHAPTER THREE: ETHNOGRAPHY AS A METHODOLOGY

To examine the intersectional complexities of diversity in the workplace, an ethnographic approach with intensive observational fieldwork was undertaken. The ethnographic approach enables in-depth and rich examination of diversity issues in the context of the NICU of an Australian hospital. Ethnographers are open to using a variety of theories to make sense of their data (Hammersley & Atkinson, 2007; Howell, 2016). They may also use multiple theories in a single study to conceptualise their findings. Furthermore, ethnography is both methodology and method working as research process and the product of the research (Hughes, 1992; Savage, 2000). Its use can uncover how social relations are practised and how power relations operate in the workplace. This chapter discusses how the principles of ethnography guided this research by introducing its methodology, history, scope and current approaches, main form of data collection, issues of access and the ethics of approaching the field. The chapter also outlines why this methodology was chosen in the context of exploring the issues of nurses' workplaces and their social relations of work.

UNDERSTANDING ETHNOGRAPHY

Ethnography is both process and product in the sense that it serves as a research methodology to explore a community or organisational units such as an orchestra, a hospital ward or a red-light area, but also in the end becomes the written account of the research project, reporting the findings (Hughes, 1992; Savage, 2000). Ethnography as a methodology provides principles and guidelines on how to plan and conduct fieldwork for data collection (Hammersley & Atkinson, 2007). It studies 'social interactions, behaviours, and perceptions that occur within groups, teams, organisations, and communities' (Reeves, Kuper, & Hodges, 2008, p. 512). As ethnography enables researchers to examine how 'people view the situations they face, how they regard one another and also how they see themselves' (Hammersley & Atkinson, 2007, p. 3), this methodology allowed me to tell stories about the daily lives of nurses working in a NICU, viewing and interpreting their behaviour and practices through a 'cultural lens' (Fetterman, 2010). Thus, this study adopts an ethnographic approach to critically analyse how the multiplicity of the nursing population and complexity of the NICU environment construct a workplace, shape the intersections of different social categories that develop power relations and build social relations among nurses.

History of Ethnography

Ethnography has a long history of application to the study of small-scale social settings. It originated with 19th century Western Anthropology, which normally studied the culture of a particular non-Western society and was, therefore, initially dominated by ethnology, the ethnographic stories produced by travellers and missionaries (Hammersley & Atkinson, 2007). By the early 20th century, researchers had begun to spend extended periods of time studying culture as the way of life, beliefs and values of a group of people in an exotic geographic area. At this time, Malinowski (1922), a prominent anthropologist, highlighted the importance of participant observation as an empirical process of learning about the daily activities of the people under study in a research setting. Through his work 'Argonauts of the Western Pacific', this formal process of understanding a different culture influenced the development of Social Anthropology, and thereafter, ethnography became the key method and methodology in anthropology (Macdonald, 2007). The root of ethnography was colonialist in nature. Rudge (1996b) referred Said (1994) exemplified how ethnographers would approach the field and tell heroic stories in an authoritative way. In keeping with its origins in the early 20th century, positivist ethnography dominated. As with other disciplines, anthropology moved towards post-structuralism, where the ethnographer was positioned by her/himself and the participants, and between the subjective and objective spheres (Rudge, 1996b).

During the 1920s, anthropologists began researching within Western societies, in a shift from exotic geography to researching the effects of urbanisation and industrialisation on their own (Western) villages and towns. There was also a developing understanding that 'culture' was everywhere, and hence the tools of cultural observation could be applied. Between the 1920s and the 1950s, sociologists at the University of Chicago carried out case studies of lives in the city affected by urban ecology (Deegan, 2007). At the beginning of this period (1921), two leading sociologists of this era, Park and Burgess (1969) published a book, that became known as 'Green Bible' for its guidance on the development of 'core ethnography' in Chicago. In the 1940s, Whyte (1943) studied social interaction and networking in everyday lives of young Italian-American men residing in an urban slum, which later contributed hugely to the establishment of the Chicago School of Ethnography. Since the 1960s, anthropological work, mainly influenced by Chicago Sociology, has spread across the world

and has been adopted by many disciplines and sub-disciplines. Thus, by the late 20th century, cultural studies flourished, and ethnography was a multidisciplinary enterprise.

In the 21st century, ethnography has become an integral part of qualitative research in a wide variety of disciplines and sub-disciplines, including Nursing and Midwifery. The emergence of organisational (Jiménez, 2007; Van Maanen, 1979, 2001, 2012; Watson, 2012) and hospital ethnographies (Long, Hunter, & van der Geest, 2008; van der Geest & Finkler, 2004; Zaman, 2008) are examples of modern genres of ethnography, which now also include visual (Jacobson-Hardy, 2002), artistic (Wilkinson-Weber, 2012) and religious (Lee, 2010) ethnographies. With the advancement of technology, virtual (Hine, 2000, 2017) and remote (Postil, 2017) ethnographies have also emerged. Thus, because of its complex history, for Hammersley and Atkinson (2007), ethnography appears not to have a clear, standardised meaning, and therefore, it is open to being recontextualised, reinterpreted and re-moulded according to the needs and dictates of particular disciplinary contexts.

Nursing Ethnographies

Nursing ethnography started in the late 20th century (see, for example, Latimer, 2000; Moreau, 2017; Rudge, 1996a; Toffoli, 2011) and are now widely practised by nurse researchers to research issues of nurses and other health care workers, patients and their carers, and public health issues. Nursing ethnographies follow the forms of hospital and organisational ethnographies in the sense that they are generally carried out in hospital units and wards, which have a certain organisational structure. They seem to study mostly clinical issues, related to patients; some are about nurses. Vermeulen's (2004) study of decision-making regarding life-prolonging treatment in a Dutch NICU and Panniers' (2002) study of refining clinical terminology for oral feeding in a North American NICU are examples of those reporting on patient issues. Other ethnographies such as a study of nurses' work in an Australian private health setting by Toffoli (2011) and the study of nursing practice in Australian emergency rooms by Fry (2012) focus on the work and practices of nurses. There are also other ethnographies that address matters of importance to both patients and nurses. For instance, Rudge (2008) examined the feelings of patients who are burnt and the experiences of nurses caring for them. These studies can all be nursing ethnographies as nurses carried them out in the context of health care provision, although there is no such specific grouping as 'nursing ethnography' within the broader context of organisational ethnography.

Characteristics of Ethnography

The history of ethnography has influenced its characteristics, rendering it a unique but widely applicable methodology. These characteristics include first, the study of people's actions and stories in their day-to-day settings; second, using a wide variety of data sources from descriptions of that day-to-day setting, population statistics, texts on the setting such as maps, the architecture and other spatial aspects; third, the unstructured nature of data gathering or data gathering that is influenced by talk and observations of the setting as this unfolds; fourth, the small scale of cases and/or settings, allowing in-depth study; and finally, the analysis of data via interpretation, resulting in descriptions, explanations and theories of the social situation (Hammersley & Atkinson, 2007). Howell (2016) expands these characteristics to include being more flexible and adaptable to wider social contexts, accepting the existence of theories to guide the research, approaching the research field with an open mind, and getting involved with the participants – all tenets of the methodological understandings of the nature of the evidence that comes from close relations with the studied.

Philosophical Considerations of Ethnography

All the characteristics of ethnography are based on how we understand how reality is known, which is understood as empiricism. Empiricism believes that sight and hearing are integral to grasping knowledge from events or evidence (Denzin & Lincoln, 2013). Ethnography works with these empirical ways framing its ontology, epistemology and methodology. While ontology is the state of being or nature of reality and epistemology is the relationship between the researcher and the being or reality, methodology is an approach to knowing the reality (Denzin & Lincoln, 2013), and therefore, these concepts are interrelated and consequential to understanding how a methodology sets up what is to be understood, explored and believed about a research question. In the context of this study, for instance, the reality of what exists as cultural practices in the NICU and what interactions and relations occur among nurses is ontology (Andina, 2016), which is positioned as existence of truth or knowledge. The researcher's observation in the field and interaction with the participants in the NICU to gain knowledge regarding the happenings is epistemology, which is described as field relations. What is understood from the observations and interactions with nurses and how it is analysed is methodology, which is ethnography that enables researchers to make knowledge through interpretation (Howell, 2016; Spencer, 2007). The web of these three philosophical understandings constructs paradigm (Denzin & Lincoln, 2013), which, combining with the

methodology, locates ethnography in the interpretive paradigm. This then makes the happenings, experiences, understandings and perceptions meaningful guiding the analysis and interpretation of findings (Hammersley & Atkinson, 2007; Schwandt, 2003).

How Intersectionality and Ethnography Work Together

Both intersectionality and ethnography have their roots in analysis of colonial power relations and address diversity and its complexities. Ethnography is open and works with a variety of theories (Atkinson, 2017; Hammersley & Atkinson, 2007). While intersectionality helps analyse the intersections of identities, social positions and relations (between for example oppressors and oppressed, managers and workers), ethnography supports critical analysis of how power relations are practised every day. Compatibility of theory and methodology matters because not all theories work with every methodology; however, intersectionality and ethnography work with each other to bring a deeper, richer and coherent understanding of the problem. For instance, with ethnography, I observe power relations caused by diversity in the workplace and interview nurses to explore their experiences of it; intersectionality helps me analyse those socially constituted power relations and their effects on nurses' cultural safety and social relations. Intersectionality is a theory, a method and a paradigm (Hancock, 2007; Hulko, 2009) that explains what ethnography does; that is, it helps with the interpretation of what is observed.

Critiques of Ethnography

Ethnography is problematised mostly for its characteristics. The lack of generalisability of the results that come from a small sample is sometimes raised as an issue. The depth and richness of the research, however, often outweigh this concern (Hammersley & Atkinson, 2007). It is often considered a time- and labour-intensive methodology because of its nature and method. These demands, however, add powerful stories to the study findings. Seemingly unstructured nature of data collection, initial and ongoing access problems and having to directly relate with people being studied are also considered challenges. Researchers with a strong interest in methodology and willingness to overcome such glitches, however, choose to do ethnography because the challenges are what enrich the processes and the data.

Since ethnographic studies are methodologically pluralistic, they collect data in multiple ways such as participant observation, short conversations, in-depth interviews, focus groups, discourse analysis, diaries, documents and archives (Angrosino, 2007; Howell, 2016). With

this in mind, Hammersley and Atkinson (2007) therefore assert that there is no exact method for ‘doing’ ethnography. This avowal is substantiated by a prominent organisational ethnographer John Van Maanen (2006), who writes that ‘despite attempts to develop a standard methodology over the last 20 years, there is still not much of a technique attached to ethnography’ (p. 13). The methodological pluralism and resulting indistinctness in methods can cause some confusion among novice researchers who wish to do ethnography.

Further, in line with the interpretive bend in analysis, ethnography has been criticised for studying cultures and meanings rather than social actions; because of the descriptive nature of writing, events and processes are sometimes not represented in ethnographic writings (Marcus, 2010). However, ethnographers have now moved from the study of cultures and tend to explore social activities, events and processes because they believe that daily activities reflect the culture of the organisation and that culture is ‘invented’ out of everyday activities. This development can be related to my study, which aimed to explore the activities, interactions and relations happening in a nursing workplace and how nurses make meanings of these relations. How they manifested in my writing of the study findings contributes to the materialisation of this recent movement in ethnography.

ETHNOGRAPHIC FIELDWORK

Fieldwork is the heart of ethnographic research, which uses empirical processes in gathering the data required by the researcher. Ethnography employs fieldwork that involves participant observation and interviews to gain knowledge from reality. These processes are available for exploration through empirical means that allow observation of the nurses’ actions and interactions, which form objective data; talking with them about their perceptions and experiences of such interactions and relations allows insights into the shapes and patterns of the subjective data or meanings of participants (Ryan-Nicholls & Will, 2009; Ryan, 2018). This section provides deeper insights into what fieldwork allows through ethnographic data collection and how its processes run in the field. The effect of insider and outsider roles of the ethnographer is also outlined.

Fieldwork in ethnography is both the trademark of ethnographic research and a process of ‘working with people for long periods of time in their natural setting’ (Fetterman, 2010, p. 33). The processes of fieldwork encompass the ways researchers gather data needed for their studies as well as the methods used to approach the field, establish rapport with people in the

field and gain information about their culture. Fieldwork starts when an ethnographer gains access to and enters a field and is completed when the researcher achieves the required data for the current questions and exits the field. Some researchers, however, return to the same group for years (Fetterman, 2010).

A field in ethnography is a research setting, location, site or geographical space where a researcher spends time undertaking fieldwork to gather empirical data (Fetterman, 2010; Hammersley & Atkinson, 2007). Fields can be socially occurring settings such as villages, schools, mines, temples or prisons (Bryman, 2012; Hammersley & Atkinson, 2007; Payne & Payne, 2004), within which people are living or working together and relating to one another. More recently, because of the digitalisation of everyday interactions among people, ethnographic fields are also located in virtual and cyber spaces (Carter, 2005; Drew, 2005). Characteristically, however, fields are demarcated socially or organisationally, and, as Dalsgaard and Nielsen (2013) argue, they ‘have remained fundamentally anchored in tropes of spatiality’ (p. 1). Ethnographic fields are therefore both spatial and temporal in the sense that spaces are delineated, and the time spent by the researcher to gather data in those spaces is defined and stipulated.

Ethnographic fieldwork, consequently, involves conducting participant observation in those temporal spaces, which requires not only gaining entry to the field and being immersed in daily activities of the people being studied, but also writing fieldnotes to substantiate the observations and generate data. It also requires interacting with the people to understand the sequence and logic of the events and actions taking place. Short interactions within the field form the basis for learning the details and contexts of the onsite happenings, and long interactions (in-depth interviews) allow gaining of insight into people’s perspectives on their being or working in that space. Written accounts are the only way of bringing versions of these happenings perceived by the senses to the outside world. These basics of fieldwork are illuminated in the following sub-sections.

Participant Observation

Participant observation, as a key approach for ethnographic fieldwork (DeWalt & DeWalt, 2011; Fetterman, 2010; Hammersley & Atkinson, 2007; Wolcott, 2008), lies ‘at the heart of ethnographic research’ (Atkinson, 2015, p. 25). It is an empirical process, in which the researchers use their senses to gain the information required by the study. The actions

resulting from these senses are mostly seeing/observing and hearing/listening, but also include taste, smell and feelings about observed phenomena and interactions. Observation of interactions are complementary to interviews, as the ethnographer uses these conversations to obtain from participants their perspectives on and experiences of those happenings to complete the data collection. This process of ethnographic data collection involves establishing rapport with the people under study, spending time with them and becoming immersed in their lives and daily activities while gaining understanding of their socio-cultural practices, interactions and social relations in their settings (Berger, 2017; Spradley, 1980).

Participant observation is categorised in terms of the researcher's role, position and extent of participation in the social activities taking place in the field. Types of observation determine the role of the researcher and affect ethnographic data collection and how different roles carry challenges for the researcher. The first category is complete participant, where the researcher is a fully functioning member of the setting under study (Bryman, 2016; Tham, 2003). This is a covert role, in that the members of the community do not know that they are under study. The second category is participant-as-observer, in which the role of the researcher is revealed to the participants, but the ethnographer still plays an active role in the research setting. Researching one's own colleagues involves a conflict of interest and is debated for bias despite the researcher's attempts to remain neutral (Neyland, 2008). The third category, observer-as-participant, involves the ethnographer being mainly an interviewer and observer, with less participation in the daily routines of the people under study. This role is commonly practised by ethnographers as it is associated with less bias and more legitimacy in gathering data. The last type is complete observation, where the researcher observes the events, phenomena and everyday activities of the people in the field but does not make contact or interact with them. This type of participant observation carries a risk of not knowing the participants' perspectives, resulting in incomplete data (Atkinson et al., 2007).

The third category of participant observation befits this thesis as it is considered ethical and legitimate in terms of the overt role and mostly outsider status. It is also assumed that the 'Hawthorne effect' diminishes with time, as the participants take the researchers for granted as part of their lives (Hammersley & Atkinson, 2007), forget that they are there or learn to ignore them. However, it is sometimes tricky for researchers, as it requires adjustment across active and passive roles. The participant observation and supplementary conversations with participants can only become the versions of stories from the field when the ethnographer

documents them as written records. Therefore, the following sub-section discusses what these reports do and why they are important in ethnographic data collection.

Field Notes

Field notes are regarded as the ‘bricks and mortar’ of ethnographic fieldwork (Fetterman, 2010, p. 116) in the sense that they reflect the picture of the place and people under study and produce textual accounts that form the data required by the study. Field notes are defined as ‘the written record of the observations, jottings, full notes, intellectual ideas and emotional reflections that are created during the fieldwork process’ (O’Reilly, 2009, p. 70), and therefore, include the initial encounters of the researcher in the field, before even accessing the field and the participants. Since writing field notes serves as a foundation of ethnographic work and is considered more important than writing the final ethnographic text, ethnographers nowadays pay attention to the nature of field notes, styles and approaches to writing field notes and the training of novice fieldworkers on how to write sensible and interesting field notes (Emerson, Fretz, & Shaw, 2007).

It is obvious, therefore, that ethnographers not only produce written accounts of what they see, hear or perceive in the field, but also make note of their experiences, emotions and analysis of the occurrences in the field. Emerson, Fretz, and Shaw (2011), for example, provide a detailed account of the processes of writing field notes, which includes how and what to write at the first encounter in the field and how to create the end product of ethnography. Van Maanen (2011), through his extended and critically analysed *tales of the field*, illustrates three forms of field notes, which he terms realist, confessional and impressionist. The first one, the realist tale, is the most direct way of describing the field and its happenings. The second, the confessional tale, focuses on the ethnographer, and consists of the experience of the field. The third, the impressionist tale, is a personalised account that includes elements of both the realist and confessional tales in a dramatic form, attracting ‘interest’, ‘coherence’ and ‘fidelity’ (Van Maanen, 2011, p. 105). What is important to understand about these types is that the realist tale makes the most of ethnographic data reflecting the events and occurrences, while the confessional tale composes how an ethnographer works and experiences the field as well as perceives and interprets the relationships with the field and participants. This type is complementary to the realist tale but carries much weight in ethnography because it not only ‘decorates’ the realist tale by adding

formal explanations on what happened in the field, but also provides very picturesque accounts of how the ethnographer conducted fieldwork (Van Maanen, 2011).

It is evident from the works of Atkinson (1995), Latimer (2000) and Whyte (1993) that field notes include observations of the participants' behaviours, expressions and body languages to aptly explain events and reactions. Wolfinger (2002) also recommends that the ethnographer determine what is important and relevant to the research focus while taking notes in the field. This is, therefore, an intellectual skill that requires care and attention to detail as well as recurring attention to the aims of the study (Hammersley & Atkinson, 2007) and the priorities of 'what I am here to see and explain'. Further, Bryman (2012) and Fetterman (2010) stress that the ethnographer must make sure the happenings are recorded as precisely and instantly as possible because of matters of recall and memory. However, it may not always be necessary or possible to expand right after the event; a fieldworker may have observed events in the middle of night and require sleep before writing up, or events and phenomena may be jotted clearly and thoroughly enough in the rough notebook for later detailed expansion. Importantly, field notes should include time, date, place and person involved to understand the events and people involved and ease the analysis. They should be written as clearly, vividly and copiously as possible, to make them complete and easily understandable.

Some fieldworkers write field notes comfortably while others find it stressful and difficult. Examples below suggest that there are physical, social, spatial and temporal difficulties in recording observations and producing field notes. Atkinson (1995), in his observation of doctors, medical students and patients, felt that the note taking was easier during the tutorials because he could sit among students and write, whereas in casual conversations during the coffee break, it was impracticable for him to record the dialogues. Similarly, Spradley (1970) struggled to write his observations of drunk nomads; he would go to the toilet after each conversation to record it—having time out in that way made his subjects wonder if he had an incontinence problem. The examples of Atkinson (1995) and Spradley (1970) suggest that while Atkinson seems to have had space and time to record his observations although he experienced physical and social space difficulties, Spradley's struggles appear to be everywhere. These instances had implications for where I recorded my observations for this study, what difficulties I experienced in having time out for recordings and how participants responded to my recordings of and absences from the scene.

Ethnographic Interviews

Ethnographic interviews are complementary to participant observation as they are considered means of validating the findings of observation and achieving completeness of data (Hammersley & Atkinson, 2007). Ethnographic interviews are processes of getting the study participants to talk about what they know about the space in which they live or work and what they feel about the events and occurrences happening in that space (Spradley, 1979). Ethnographers seek to establish respectful and ongoing rapport with their research participants from the beginning of ethnographic observations to enable a genuine exchange of views (Heyl, 2007). Hence, the pragmatism of ethnography is that these very exchanges between the researcher and the researched are inevitable (Evans, 2012).

Ethnographic interviews are interactions and exchanges between the researcher and the participant that produce the knowledge of those conversations together (Kvale, 1996, 2007). Therefore, ethnographers should invest enough time and openness in such exchanges to explore purposefully the meanings the participants place in events and occurrences in their worlds (Heyl, 2007). Since these spatial and temporal attributes of interviews contribute to obtaining rich data for analysis and theorising the activities in the setting, Heyl (2007, p. 370) emphasises that ethnographers should:

1. listen well and respectfully, developing an ethical engagement with the participants at all stages of the project
2. acquire a self-awareness of their role in the co-construction of meaning during the interview process
3. be cognisant of ways in which both the ongoing relationship and the broader social context affect the participants, the interview process and the project outcomes
4. recognise that dialogue is discovery and only partial knowledge will ever be attained.

With these considerations, Heyl (2007) implies that how ethnographers incorporate ways of interviewing that are respectful and ethical, where the quality of the relationship between the researcher and participant matters, are important for the co-construction of knowledge. Bourdieu (1996) supports these ways of ethical interviewing, suggesting that having extensive knowledge of the social space and situations where the research participants live or work, a genuine intention of knowledge and creating protected space for interviews can promote a

feeling of security in participants to share their stories and increase the ability of researcher to understand those stories.

Bourdieu (1996) argues, 'If the research interview relationship is different from most of the exchanges of ordinary existence due to its objective of pure knowledge, it is, in all cases, a *social relation*' (p. 18). Therefore, the interview as a scientific questioning should not exert any kind of symbolic violence against the research participant that can affect the conversation and the process of knowledge production (Bourdieu, 1989, 1996). Symbolic violence is a form of non-physical violence that can occur in researcher–participant social exchanges, where the latter agrees to participate and the former imposes their intentions (Bourdieu, 1996, 2003; Burawoy, 2019). To prevent or minimise this distortion of symbolic and linguistic power imbalance, Bourdieu (1996) emphasised that the researcher should adopt a reflexive approach of active and methodical listening midway between the *laissez faire* and directive questionnaire survey. Active listening refers to being attentive, while methodical listening refers to knowledge of the participant and their social situation and a focus on the objectives of the study (Bourdieu, 1996).

Fieldnotes are records of observations; transcriptions are records of interviews. Transcription of interviews is a time- and resource-consuming process, and arguable in terms of quality and authenticity of transcribed text (Kvale, 2007). Although interviews have been transcribed since their emergence as a data collection procedure, some researchers choose not to transcribe, and therefore, the voice/video recordings act as data (Hammersley & Atkinson, 2007). For Bourdieu (1996), 'transition from the oral to the written imposes, with the changes in medium, infidelities which are without doubt the condition of true fidelity' (p. 31). By this, Bourdieu (1996) means that the transcription may not be as precise as what is said in the interviews because many expressions including sighs, hesitations and ambiguities are omitted in written forms; a pause in oral and a comma in written forms can affect the meaning or interpretation, which is considered a risk of writing (Bourdieu, 1996). Transcription work is thus a craftwork that requires skill, patience, objectives and resources.

Role of the Ethnographer

The role of the ethnographer as insider or outsider has an impact on the fieldwork (Neyland, 2008). Over many decades, the ethnographic process has shifted from the unfamiliar setting to the familiar, which means the study of an exotic culture has changed to the researcher's own

society. This has brought new issues in establishing and maintaining rapport with the study population (Atkinson et al., 2007), as proximity of the researcher to participants in the process of rapport building can cause tensions that need to be balanced carefully (McGarry, 2007). These ‘tensions’ are related to becoming an ethnographer while moving between strangeness and over-identification (Cudmore & Sondermeyer, 2007). The issue of maintaining a significant distance between a researcher and a clinical colleague is also crucial and might otherwise affect the research process. Thus, the relative benefits and drawbacks of insider and outsider roles of the ethnographer have been weighed in the general sociological literature. In support of the insider view, it is argued that only those who are intently immersed in the field of study can ensure an accurate report. However, proponents of the outsider role make the counter claim that this means less bias as researchers do not have too close an attachment to the research subjects (Allen, 2004).

Rigour in the Fieldwork

Rigour is associated with a trustworthiness that encompasses credibility, transferability and reflexivity (Baillie, 2015; Finlay, 2006). As ethnography is pluralistic by nature, the methods of employing observations and interviews are triangulation, checking accuracy and ensuring the integrity of data (Reeves et al., 2008). Accuracy means maintaining the truth by producing true accounts of social phenomena happening in social spaces (Hammersley & Atkinson, 2007)—in this case, in the nursing workplace. Moreover, transferability is the potential for findings to be applicable other settings or contexts and can be ensured by producing detailed descriptions of the research setting (Baillie, 2015; Finlay, 2006). As ethnographic research values the events and phenomena that occur in the research setting (Atkinson, 2015, 2017), recording these as detailed as possible can ensure their integrity or credibility. This possibility of bias made me aware if I were missing or overlooking any events that occurred during my observation. Reflexivity is an awareness about bias and an agency of self-supervision that helps maintain rigour (Berger, 2015). Ethnographers reflect on their acts, experiences and dilemma to keep trustworthiness.

ACCESS TO THE ETHNOGRAPHIC FIELD

This section discusses the access process, how it is significant in approaching the field and reaching the participants and why it is often problematic in different stages of fieldwork. Accessing the research setting in ethnography is regarded as a relationship between the

researcher and the researched, where the researcher makes contact with the key people to gain access to the research site for data collection. The key people are those in ‘top positions’ within the organisational unit, who make decisions around whether to grant access to the researcher to carry out the research and, in the end, become informants for the study. As an important initial stage of fieldwork, the access process often reflects the features of the culture under study, and the process can itself be useful data (Carmel, 2011). Thus, it is a practice of seeking and using interpersonal relations and other resources and strategies, which, in the end, form knowledge about the social organisation and beliefs of the people under study as well as the identification of problems within the organisation and among people working together (Hammersley & Atkinson, 2007). Importantly, because it is relational and organisational relations are often political in nature, access can be problematic in different stages of fieldwork. As access problems are typical to ethnographic research, the following discussion illuminates both directly and indirectly how access can be problematic and problematised.

Gaining access is a consequential process that begins with contact with key people in a proposed research setting and expands through the network of initial subjects, although the process may not be smooth (Duneier, 2011). Duneier (2011) argues that becoming close to some people does not guarantee proximity to others, and information provided by some may not match the rest. Thus, ethnographers should adopt a cautious, proactive, non-judgemental and inclusive stance (Duneier, 2011). Further, ethnographers should not be satisfied with first encounters, nor should they consider their responses valid data (Duneier, 2011).

Access in ethnography is particularly problematic (Bryman, 2012; Duneier, 2011; Gobo, 2008; Hammersley & Atkinson, 2007; Toffoli & Rudge, 2006) as it requires negotiating and renegotiating at various levels or gates. Dealing with gatekeepers and gaining the trust of participants takes a toll on an ethnographer. Opsal (2011), for example, was granted permission to recruit women who were going to be released on parole for her study, whom she interviewed following their release, but when she asked to interview inside the gaol, she could not gain access from the local prison authority. Ortner (2010) experienced a terrible trajectory in terms of access in her attempt to study Hollywood, such that she could not have access any of the Hollywood elite, despite her struggles to do so; she ended up using film expos and festivals to collect ethnographic data. These examples suggest that ethnographers are resilient and determined in their intent to complete their fieldwork and attempt to surmount all hitches and hinderances on the way.

Ease of access in ethnography also depends on the role of the researcher and the nature of the social site. As discussed in categories of participant observation, in covert roles, for instance, participants do not know that the researcher is with them to study them and their culture, and therefore, there is less worry about access to individual participants. Conversely, in an overt role, the researcher has 'double the work': gaining access to the organisation and gaining access to the participants through informed consent. Access to an open or closed setting is also frequently discussed in ethnography. In comparison to a closed setting, an open setting may be easier in view of gaining access, as it comprises a public place that does not always require formal permission for fieldwork. However, the researcher has to be prepared for unexpected changes in circumstances and even to modify the aims and objectives of the research study. When Whyte (1955), for instance, asked a man and two women in a pub if he could join them, the man stared at him and offered to throw him down the stairs. This denial meant Whyte could not study the secrets of this group.

While access to enter the research field may be easy, hard or even impossible, as shown in Whyte's (1955) accounts, continuation of access for the whole data generation period can also be demanding. Hammersley and Atkinson (2007) and Neyland (2008) refer to this process as field relations, which requires establishing and maintaining personal relationships. It is the art of the ethnographer's work, and can be a physical and emotional labour (Carmel, 2011). There are strategies, as suggested by Bryman (2012), to secure ongoing access. First is to deal with suspicions and worries about the researcher and prove the sole role. Second is to use subjects' knowledge of the organisation and experience of work to handle problems. Third is to behave in a non-judgemental way about people and the organisation. Fourth is keep the information acquired undisclosed. Fifth is to adopt a role or a dress code to gain trust from the people in the organisation under study. The last is to 'be prepared for changes in circumstances' (Bryman, 2012, p. 409), as illustrated in Whyte's (1955) accounts above. Plankey-Videla (2012) was subject to a similar situation in a Mexican garment factory when she was researching participatory work arrangements. The closure of the factory eight months after her ethics approval meant her ongoing access was terminated and she had to change the subject matter of research and conduct her study at another site.

Further, the position of the researcher has an influence on gaining access. Nurses, for instance, are in a good position to secure access in their workplaces or other health care settings as they are considered insiders (Borbasi, Jackson, & Wilkes, 2005). However, this

may not necessarily be the case for every researcher, as other factors such as position in the organisation, power relations, nature of research, proximity to the health care setting and having gatekeepers and sponsors play a vital role in the process. Gatekeepers and sponsors not only allow smooth access to the field but also work as key informants and facilitate ongoing access for fieldwork (Bryman, 2012; Hammersley & Atkinson, 2007).

Access relies not only on the relationship of the researcher with the field and the key people in the field that are gatekeepers and sponsors (Hammersley & Atkinson, 2007), but also on ethics bodies, which requires the researcher collaborate between the two simultaneously. This means the researcher must work closely with both the ethics bodies and the field-to-be organisation in a parallel manner, following the protocols of both bodies to finalise the research setting. In fact, the access and ethics processes are intertwined in ethnography, and therefore, complementary to each other. As this interrelation is more specific to Australia, I will discuss the process of access and ethics in detail in Chapter Four. The following section discusses the nature of ethical issues in ethnography in general.

ETHICS IN ETHNOGRAPHY

‘Ethnography is among the most ethical forms of research’ (Atkinson, 2015, p. 172). This assertion rests on ethnographic fieldwork’s need for a much more personal, emotional and intellectual commitment of the researcher to the lives and safety of people in the field. Ethnographers not only employ a non-judgemental approach to the people they research, but also pay respect to their culture and social organisation as part of ethnography’s methodological attitude of cultural relativism (Atkinson, 2015). Thus, ethnography is ethically commendable, and ethnographers are commended for their no-harm approach and respectful attitude to their research participants and the hosting organisation (Atkinson, 2015).

Beauchamp et al. (1982) present four principles of ethics that guide the research practice. The first is non-maleficence, meaning that researchers should not harm participants. The second is beneficence, denoting that the research should produce a noticeable benefit to the participants or humans in general. The third is autonomy, meaning that the researcher should respect the decisions of research participants. The last is justice, indicating that the researcher should treat participants equally. Following Murphy and Dingwall (2007), the first two principles relate to consequentialism and the latter two to deontology—two ethical theories that address the ontological and epistemological foundations of ethnographers’ work. Consequentialism is

related to the outcomes of research; that is, whether the participants have been harmed and if so, whether the benefits of research outweigh that harm. Deontology relates to participants' rights to privacy, respect, self-determination and equal treatment. While Murphy and Dingwall (2007) see these two theories as contrasting and competing with each other, I find that they both focus on the rights of research participants and the moral conduct of the researcher in the field. It is also essential that the 'ethical theory and practical judgement should go hand in hand, and ethics committees have an important role to play in helping researchers to develop and exercise practical judgement that is informed and enlightened by ethical theory' (Madjar & Higgins, 1996, p. 132).

Despite respectful and commendable approach in the field (Atkinson, 2015), ethnographers can bring harm to their research participants in the forms of anxiety, stress, guilt or regret (Murphy & Dingwall, 2007). These are emotional harms, which, with a good explanation before the commencement of the study and after observation or interviews, may possibly fade away in most cases. Physical harm involves inconvenience, which can be minimised with good negotiations between the researcher and the participants. The requirement of informed consent also acts as a vehicle for information, as it explains the procedures of the study and the rights of the participants. Moreover, in research settings such as a NICU, having to read the information sheet and taking time off from intensive care routines for interviews can be taken as a physical and/or social inconvenience, but it also depends on participants' willingness and ability to accommodate these time outs at the workplace. These are the aspects of ethics that the ethnographer should be aware of when preparing for ethnographic fieldwork.

CONCLUSION

Ethnography, by virtue of its characteristics, studies people's actions and interactions in their everyday worlds, which can be at work, home, recreation places or worshipping spaces. As a methodology, it provides principles and guidelines on how to design and carry out a study, and as a method it becomes the report of what has been done: the focus of the next chapter. The methodological understandings enabled me to fathom the nature of the evidence that comes from close relations with the studied. The principles of ethnographic approach support an in-depth examination of how social relations are practised in a NICU and a social analysis of how NICU culture shapes those relations. Since ethnography allows the researcher to approach the field with an open mind, it enables an observation of nurses' daily activities to

gain knowledge about those activities and their perspectives on them. The analysis of these observations support learning about their experiences of events, phenomena or occurrences in the workplace. As ethnography uses observation, short conversations and in-depth interviews as data sources, this triangulation makes the data collection process rigorous. While the means of data gathering are mostly unstructured, they are guided by theory and research questions along with the researcher's reflexivity and responsible research behaviour to maintain the integrity. Ethnographic data are critically analysed and interpreted using theories and concepts, which makes it an open method adaptable and applicable to a variety of contexts and able to work with a range of theoretical frameworks such as intersectionality.

Access to the research setting in ethnography is typically challenging and requires ongoing negotiation. However, the knowledge of anticipation of the challenge has prepared me to deal with my access process. Although ethnography is considered a relatively ethical research method, it may cause minor harms to research participants, including emotional distress after interview and feeling of uneasiness when the researcher follows them during observation. These are the aspects of ethics that I, as a researcher learned to be aware of, and considerate about when approaching the participants. Hence, ethnography as a methodology provided me with an understanding of what it entails to be an ethnographic researcher and what skills are required to carry out an ethnographic research project.

CHAPTER FOUR: DOING ETHNOGRAPHY

Ethnography serves as practice of an ethnographer as a method, using the guidelines provided by the principles as a methodology on planning and implementation of the ethnographic study (Hammersley & Atkinson, 2007). Ethnographers first plan their actions and prepare for the events in the field, and then immerse themselves in the culture of a social setting to observe behaviour and everyday life; listen to, and engage in, conversations; develop an understanding of the culture, behaviours, everyday activities and interactions; and record a detailed account of those observations and conversations (Bryman, 2012). This chapter is thus about practising ethnography, that is, planning and conducting the fieldwork. First, I provide a description of how I designed the study based on the methodological understandings. Second, I explain how I approached the field and participants, how I carried out fieldwork for data collection, what I experienced in the field and what I discovered about using ethnography to research nurses' social relations of work in a NICU.

DESIGNING THE STUDY

Although methodological principles guide the approach of an ethnographic study, a good design is the framework that supports those methods. Designing research includes considering how to approach the field and the people therein—and to what end. A careful, strategic planning is important for shaping fieldwork and analyses. I planned this research project around exploring what matters at work for neonatal nurses, which I addressed through the guidance of associated research questions:

- What are the cultural practices of the NICU?
- How do nurses experience everyday work life in the NICU?
- How are nurses' social relations of work affected by the NICU?

The Field

The location for this study was the NICU at a tertiary-level referral hospital in Australia. The NICU is a high-acuity area of health care and is distinguished by the unique needs of its patient population, including the complex nature of care necessitated by their physical size, their developmental care needs (e.g. establishing early parent–infant relationships) and the accurate decision-making required for their potentially rapidly changing conditions. Consequently, registered nurses' duties and responsibilities include physically caring for

neonates with complex needs, promptly assessing situations and making critical decisions, managing and troubleshooting hi-tech life-saving equipment and supporting parents during an incredibly stressful time. In such an intense workplace, how nurses work together, how they interact with each other and who they relate with, were issues of prime consideration.

In ethnographic terms, the NICU is a ‘closed’ setting (Bryman, 2012; Fetterman, 2010; Pope, 2005; Warren & Manderson, 2008). This is because it is an organisational unit within a hospital, where a reasonably consistent group of nurses work very closely together. The closed nature of the setting warranted the study of the workplace and social relations among the nurses. However, the social relations are complex, as they are not limited to nurses, but include other health care team members such as doctors, AHCPs and even parents or carers of patients, who may change on a daily basis. These extended relations were not the focus of this study, but they influence nurses’ work and social relations because—unlike on a ward—in a unit, nurses interact with each other often and the patient care they provide frequently depends on the actions of the others. They also share the fun and grief in the work. As an insider—a neonatal nurse familiar with the workplace complexities—I chose to conduct this study in NICU to uncover the complexities of the workplace and nurses’ relations of work.

Participants

Nurses’ social relations of work were the focus of this study, so registered nurses working in NICU in a permanent, full- or part-time capacity were obvious choices for primary participants. However, as the social relations of nursing work also extend to other health care team members, doctors, AHCPs, support workers, casual registered nurses and parents or carers of the patients were considered secondary, or incidental, participants, to be observed alongside the primary participants (with verbal consent) but not interviewed.

Since ‘ethnographers rely on their judgement to select the most appropriate members of the unit or subculture based on the research question’ (Fetterman, 2010, p. 35), my strategy for selecting participants was to include all registered nurses working in the NICU in various hierarchical positions. This established a diverse group with various social, racial, ethnic and cultural backgrounds. Some were Australian born and educated, while others were born and educated overseas before immigrating to Australia. They also varied in work experience and expertise. Nurses’ differing social positions intersect with implications for how they interact with each other while working together to provide care for neonatal patients.

Gaining Access

Gaining access to the research setting and participants is an essential step in ethnographic fieldwork and was planned and initiated from the beginning of this study. As discussed in Chapter Three, in Australia, access processes are intertwined with ethics processes. Therefore, I followed the processes of the research site and the ethics bodies simultaneously, to seek their permission and formalise my access to the field. The next section introduces the ethics bodies in one Australian state and their roles in controlling and sanctioning research projects in public health care settings. The subsequent section details the process of simultaneously applying to the research site and the relevant ethics body.

The Ethics Bodies

National and local health district ethics policies and procedures follow rules set by the Australian Research Council, Universities Australia and the National Health and Medical Research Council (NHMRC). The Australian Research Council is a national body that provides the government with advice on matters related to research and administers research grant programs (Australian Research Council, 2015); Universities Australia, as ‘the voice of Australia’s Universities’ supports the university research system (Universities Australia, 2013); and NHMRC supports, funds and regulates research in health and medical fields. These bodies aim to grow knowledge and innovation for the benefit of Australian people and, as such, develop codes, policies and guidelines to guide and regulate research. They jointly issued the *National Statement on Ethical Conduct in Human Research 2007*, which is the most important guideline that the Human Research Ethics Committees (HREC) use to review research projects (NHMRC, 2014).

The HREC is a principal ‘ethics land’, where the ethics proposals for studies involving human participants are reviewed to ensure the conduct of the studies meet ethical guidelines (NHMRC, 2015). Research governance (RG) is a local addition to the ethics bureaucracy and RG committee is authorised, at a local level, to grant or deny site-specific authorisation for research projects and oversee their conduct to ensure that they are in accordance with ethical standards. In 2007, RG was introduced as a process for single ethical and scientific review of multi-centre human research in public health organisations and, from late 2010, it was used to review low and negligible risk (LNR) research studies ([State] Department of Health, 2010b).

Both HREC and RG committees exist in each health zone, which are areas defined to manage public health services for residents within their perimeters.

The Application Process for the Research Site and Ethics Body

The application process begins with a feasibility study for the potential research site. The researcher then makes initial contact with key individuals to plan the ethical process and proposed fieldwork. One individual at the research site agrees to be the Key Contact Person (KCP) and supervising investigator on site, for ethics purposes. The researcher then approaches the local ethics office and receives appropriate forms, templates and guidelines. The researcher determines the category of research and which forms to complete in accordance with the *National Statement on Ethical Conduct in Human Research 2007* (NHMRC, 2015). Then, the application is submitted to the relevant HREC, where the proposal is reviewed by a scientific advisory committee (SAC), who notify the researcher of the outcome. This committee may ask for further information about the study. Once any extra information is clarified by the principal investigator (PI), it goes to HREC for expedited ethical review and the PI is notified of the final decision, as well as the designated supervising investigator at the research site. If approved, the application is forwarded to the local RG committee for site authorisation. The researcher then goes back to the research site to obtain a signature from the head of department (HOD) on the declaration of support on the site-specific assessment (SSA) form, which declares their support for the research project being conducted in their space. The research governance officer (RGO) then reviews the SSA application and provides recommendations for the chief executive officer (CEO), or their delegate in the health zone, for their final sign off. After receiving authorisation from the CEO, the RGO signs the SSA form and notifies the PI of the outcome of the assessment, in writing. The RGO may be delegated by the CEO to authorise research that is no more than low risk ([State] Department of Health, 2010b; NHMRC, 2014; Online Forms, 2013). This process demonstrates that, in Australia, access and ethics processes for ethnography are interconnected and interdependent.

Recruitment

In ethnography, recruitment starts after the access to the field is granted and the researcher enters the field. It is a process of selecting appropriate participants and enrolling them in the study (Hammersley & Atkinson, 2007). The plan to recruit participants for my study was to

coordinate with key individuals in the research setting to arrange meetings with staff. In these meetings, I planned to explain the project through presentations, distribute information sheets with invitations to participate and provide time for potential participants to make informed decisions. Once they agreed to participate, I would obtain their consent on a consent form. This process of recruitment would apply only to the primary participants, that is, nurses working in the NICU on permanent full and part-time basis. The secondary participants, such as doctors, AHCPs and parents of patients, would be asked for verbal consent before observation sessions. I planned to elicit support for this process from key people in the setting (Travers, 2010), such as the nursing team leaders on each shift.

Data Gathering

As discussed in Chapter Three, data gathering in ethnography entails fieldwork, which involves participant observation. As DeWalt and DeWalt (2011) suggested, I planned to take part in the daily activities, routines, interactions and events of neonatal nurses to learn about the explicit and tacit aspects of their work practices and resulting collegial relations that represent the culture of their workplace. Plans were also in place to write field notes after each observation and interview as records of participant observations, experiences of interviews and observations and reflections on the data collection process (Bryman, 2012; Fetterman, 2010; Hammersley & Atkinson, 2007). These recordings would form my data which would consist of the routines and emergencies in the unit, interactions among nurses while providing care and social relations building between nurses.

The strategies I planned to gather data included timings to be negotiated with the nurse unit manager (NUM) and key informants to schedule observations to take place one to four hours at a time and one to two times a week at different times (Hammersley & Atkinson, 2007). I would also interview the nurses, both casually and formally, to gain insights into their perspectives (Travers, 2010), actions, interactions and relations. The casual interviews would be the short conversations and take place during or after observations, to explore the participants' views on the issues or events noted during the observations that required discussion in detail. The time would range from one to five minutes and be explained to them, as the high-acuity practice in NICU means that the nurses are busy. The formal interviews would be longer and in-depth. They would often be determined by issues that the participants raised during observation and short conversations. I would prioritise the interviewee's convenience when negotiating appropriate times, dates and places for this type of interview.

These data gathering processes would result in field notes and (interview) transcripts and form the data for this study. The plan of how they would be managed is described below.

Data Management

Data management is the process of handling data generated from participant observations and interviews to make them ready for analysis and interpretation. My plan for managing my data included transcription, deidentification, safe storing, categorisation and organisation. I intended to transcribe the interviews myself so that I would be familiar with the participants' responses. I prepared fictitious names to de-identify the participants at the time of writing fieldnotes and transcribing interviews. I planned to keep the two kinds of data separately for ease of handling and analysis. For privacy and confidentiality, as well as back up of data, I had strategies in place to keep data encrypted in a computer, in external drives and in the university's data storage system. I planned to use computer-assisted qualitative data management programs such as NVivo to enable storing, coding, classifying and numbering data, in addition to attaching memos, identifying similar concepts and showing relationships between major ideas (Bryman, 2012; Willis, 2010). I also considered sorting data by numbering the lines in-text to facilitate the location of specific ideas and enable me to refer to them during analysis and interpretation.

Data Analysis and Interpretation

The next step to plan was the critical analysis of the concepts discovered during data sorting and the development of emergent themes (Willis, 2010), which I assumed would be underpinned by intersectionality. I planned to group these concepts and themes into broader ideas that would shape the thesis chapters. The whole process was designed to address the research questions of the study. Data analysis would reduce data into pieces of information, out of which I would generate themes to make sense of, in terms of the research questions, aims of the study, the theoretical framework and the issues related to workplace and social relations among nurses—as discussed in contemporary literature.

Interpretation of data, according to Gobo (2008), and Silverman (2011), involves the process of translating themes from data analysis into conceptual and theoretical formulations. Based on this process, I intended to contextualise my data within existing literature and my own relevant experiences, while maintaining focus on the research questions and the study's unique contribution to the field. The data were thought to be illustrated at this stage to ensure

that the meanings attributed by participants would be retained and reflected in concepts developed (Willis, 2010). During this process, I considered selecting key events from the field and significant excerpts from the interviews and observations to use in the report writing phase (Fetterman, 2010). I would compare these with my existing theories and add reflective remarks to make sense of the complex data (Sangasubana, 2011). I intended that this whole process would lead to the emergence of new concepts and theories, as well as implications for workplace practice and future research on the subject.

IN THE FIELD AND BEYOND

This second part of the chapter details how I implemented the study design in the field and what I experienced in the process. This involved the process in the field including gaining access to the field, doing observation and interviews for data collection and writing fieldnotes. This also involved the tasks after the fieldwork including transcription of the interviews and data management, analysis and interpretation leading to writing of ethnography. Fieldwork began with gaining access to the field, information sessions to the participants and obtaining their consent. Data collection involved immersing myself in nurses' everyday work lives and producing records of what I observed about nurses' interactions and relations of work as well as conducting short and in-depth interviews to understand their perspectives of the events and occurrences. This section thus explains the procedures of the different stages of ethnographic practice, my findings about the topography and demography of the setting and my feelings of my time in the field. This also includes how I maintained rigour in ethnographic practice.

Access to the Organisation

As discussed in Chapter Three, access and ethics processes are intertwined in ethnographic practice. This means that the ethics process cannot proceed without a site access agreement and similarly, the site access is not granted until the project has fulfilled the requirements of ethics and governance. Thus, the access process in this study was challenging as well as time- and labour-intensive. The local access agreement initially went well, but the process involving one of the ethics bodies did not have a favourable outcome, which necessitated finding an alternate research site. This section presents an ethnographic account of my problems in the ethics process, the hurdles I faced while dealing with the bureaucracy of ethics bodies, and how I managed the loss of the research site and secured an alternative.

The Initial Approach

At the outset of my candidature, I e-mailed every NICU in the state, to explore the feasibility of the study. I received several positive responses detailing the workforces of several NICUs. I anticipated that accessing the research site would be easy and the key people would be the sponsors to facilitate my research activity. I chose a NICU based on its acuity in care and diversity in care providers. When approached via e-mail, the HOD responded, ‘we are just the place!’⁸ and ‘it is clearly an important topic’, which made me feel optimistic. However, they expressed concern that the study might ‘fuel racial behaviours.’ I addressed this issue with an assurance that the study would explore how social relations are constructed among staff within a workplace and how they can be nurtured and developed. I explained that this would align with the unit’s aims of inclusion and diversity, and contribute to their endeavour to be a productive, supportive, positive and vibrant workplace. However, I noted how quickly the interest in accommodating the study shifted to a fear of uncovering *something*. I wondered if, because of their diversity of staff, they might have race-related issues in their workplace.

The HOD delegated the decision to the nursing sector and, after negotiating a date and time, I met with the two senior nurses, both of whom appeared to have positive feelings about the project—indicating that they were likely to grant access. We decided that one of them, whose role directly involved research, would be the KCP for the ethics process and the supervising investigator on site for ethics purposes. The meeting concluded with an agreement that, after ethics approval, I would present the project to the staff, so that they could make informed decisions about participating.

Human Research Ethics Committee

After the research site was confirmed, I corresponded with the ethics manager at the HREC and received guidelines for the preparation and submission of an ethics application. Referring to these guidelines, the Online Ethics Forms (Online Forms, 2013) and *The National Statement on Ethical Conduct in Human Research 2007* (NHMRC, 2007), I determined that the category of my study was ‘LNR Research’. This category includes research that is non-invasive and causes no more than possible discomfort or inconvenience to participants. Therefore, I completed LNR and SSA forms. The SSA form was an appendage for seeking site approval in studies that involve in-person contact with participants. The LNR and SSA

⁸ Personal communication citation not given due to privacy of the person and the related organisation.

forms were to be accompanied by the scientific protocol (research proposal) and participant information and consent forms (PICF), for submission. The PICFs were designed to collect consent from the participants individually; one template was for the principal participants and another for the incidental participants.⁹ The ethics manager checked all the documents at the time of submission.

After the initial review by SAC at the HREC, the KCP and I received a letter, asking for clarification of a few issues raised by the reviewers. The first issue was the name of the PI mentioned in the LNR form. We declared that the PI would be the KCP from the research site, as suggested by the ethics office. The second issue was a question of whether the student researcher worked in the NICU under study and, if so, how that would affect the research and data interpretation. The proposed research setting was different to the NICU in which I was employed, so we did not have to explain further, at that point. The third issue questioned whether the study findings and analysis would be discussed with participants. We answered that it would not be possible to seek participant reflections or insight during the interpretation of the data. The fourth issue was about the use of a digital recorder for interviews. We clarified that a digital recorder would be loaned from the university and that the recordings would be uploaded to a password-protected computer file—at which point the recorder would be erased and returned. The last issue concerned the number of participants and privacy during interviews. We explained that a separate room in the office area would be arranged for in-depth interviews with nurses who agreed to discuss issues that arose during observations. The incidental participants would not be interviewed. We concluded our response with the statement that ethnography relied on time in the field, so the number of participants could vary, according to the circumstances (Hammersley & Atkinson, 2007).

I completed the preliminary stage in ‘ethics land’, which was the second step of the access process. Waiting for the outcome was full of uncertainty, as access is often problematic in ethnographic research. At the initial meeting, I had gained the trust of key individuals on the research site and received their support in the ethics application process. Therefore, it was necessary to maintain contact with them and ensure their continuous support for ongoing access (van der Waal, 2009). To this end, my research supervisor and I met with the site staff. However, to our surprise, the KCP presented us with a HREC approval letter. Our delight

⁹ PICFs were designed for both groups of participants, to collect their information and their consent to participate in the study. However, the incidental participants were not required to return their signed consent.

augmented their welcoming approach and they showed us around the unit and premises. We had an informal orientation in the research setting, which helped us get to know the ‘lay of the land’ (van der Waal, 2009, p. 31). Then, we planned in-service sessions to meet the staff and inform them about the project, with a view to recruit them in the study (Browner & Preloran, 2006). We agreed to prepare a simple, concise PowerPoint presentation that staff could easily understand. Even better, the PowerPoint slides could be displayed on the computers in the office for staff to read at their convenience. This supportive environment, with interest from the nurses and sponsorship—rather than gatekeeping—from key people, appeared to promise the ease of data collection and ongoing access (Hammersley & Atkinson, 2007; Pope, 2005). Therefore, we did not anticipate how challenging the process would be in the following stage.

Research Governance

Since I had HREC approval and the SSA was supported by the research site, I took for granted that the process at RG would be positive. I received an e-mail from the RGO, requesting additional actions and documents, which I understood as another layer of tough screening through which my project must pass. I complied with full effort. First, I addressed the issues in need of clarification, which were similar to those in the SAC review. Second, I asked the KCP at the research site to write to the RGO and confirm that they were willing to act as the PI in the study. Third, I asked the university to provide an insurance certificate to cover my research activity, which, after a couple of referrals within the university, arrived in my inbox. However, it was not relevant to my LNR study, as the requested indemnity was required for clinical trials only ([State] Department of Health, 2010b). The fourth task was to become accredited as a researcher within the health zone. To do this, I signed into the Health Education site and e-mailed my supervisors at the university. I was put in contact with the clinical education executive officer and then referred to the clinical placement manager at the nursing school. The clinical placement manager contacted the RGO, who responded to me, completing the circular process. At that point, the RGO advised me that she had realised the accreditation process was for coursework students’ clinical placements, not for the research.

The last action to was to contact the Executive Nurse Manager (ENM) for nursing sign off. I did not understand why I had to obtain the ENM’s signature on the SSA form because, according to the *Research Governance Policy Directive 2010*, the HOD responsible for the research setting should declare support for the research project, which was already done. It was clearly a deviation from the usual RG process, which was determined by policy directive

and the operations manual for RGOs ([State] Department of Health, 2010a, 2011). Clouded with questions and concerns, I asked the RGO why I had to seek the ENM's sign off for site authorisation when I already had the unit's support. She replied that the policy had changed, and it should be done by the ENM. I looked back at the policy; it was due for review in 2015, and, at that time, nothing had changed since it came into effect in 2010 ([State] Department of Health, 2010b). I was puzzled and felt like I was going to have to travel on an unsealed road. However, I had no choice but to obey and act accordingly. I contacted the ENM—copying to her secretary as instructed—to enquire about obtaining her sign off and an appropriate time to meet. However, I did not hear from the ENM for several days after the e-mail. I telephoned and found that the ENM had e-mailed the RGO and was waiting for the documents, which were not relayed. I also asked the ENM about my role in this process. She told me to provide information regarding the scope of study, data collection process, survey questions and desired outcomes, which I sent to her, including the LNR and SSA forms, scientific protocol, PICFs and a copy of the HREC approval. The KCP also had a conversation with the ENM and forwarded the relevant information about the study to her. Considering the slow progress of the process, we agreed to postpone the scheduled meetings with staff at the research site until the study was cleared by RG. By that stage, the amount of correspondence, telephone conversations and actions taken was enormous, but I kept complying with the requirements, as asked, to get the project approved and access granted.

I received an e-mail from the ENM, which proved to be the worst-case scenario. It read, 'After careful consideration, this study is not supported by the Nursing and Midwifery staff. This decision is based on aligning current NICU goals with organisational goals.'¹⁰ It was unclear how current NICU goals were out of line with organisational goals and why research with the potential to improve workplace relations was not aligned with the organisation's mission. These processes reminded me of playing Snakes and Ladders during my childhood, where ladders helped me progress, until a big snake at the high point swallowed my turn, bringing me down to the base. I lost the game. Access was denied, and I had nowhere to conduct my research.

My supervisors and I thought the decision was groundless, but we did not know the politics going on inside the organisation, behind the scenes (van der Waal, 2009). The KCP and the key people at the study site were in the dark, so it was evident that the decision was made

¹⁰Email correspondence not cited due to privacy of the person and the related organisation

solely by the ENM. We wondered if the initial concerns expressed by key people at the site might also be the concerns of higher-level nursing management. We continued to try to find the reason behind the decision. According to van der Waal (2009), it might be possible to study an organisation through informal contacts and the available literature, even when access is denied. It was in this way that we came to know, through an indirect source, that organisational and managerial restructuring was occurring within the health zone. Perhaps they banned social research out of fear that the process of organisational change would be exposed.

Searching for an Alternative

Although the field was ready for me with good sponsors, the RG halted my access. This meant that RG and SSA were tightly connected, and the site's permission proved to be useless, considering the RG's power in ethics approval. Since I had lost access to the proposed research site, it was necessary to seek an alternative to pursue my study. Therefore, I investigated all possibilities and approached some of the NICUs without success. One of the potential sites already had an ongoing research project, another had insufficiently diverse staff and the others belonged to the same health zone where access was denied. I was in despair, but a surprising solution came up in my own workplace. It meant that I could carry out my study where I was working. However, even though it was a good option for the project, researching one's own colleagues was obviously a conflict of interest. As Pellatt (2003) warned, such an arrangement carries unjustifiable analytic and ethical risks. To go ahead with the project, I was required to resign from my workplace. The solution proved a double-edged sword—causing the dilemma of choosing between the project and my employment. The loss of income was especially significant because I was the only wage earner in the family. After rapidly thinking through the consequences, I decided it was more important for me to take up the opportunity as a safe landing for my research project.

Access to the New Setting

As the new research setting was my immediate former workplace, and the key individuals offered it to me to pursue my study, the initial site access was effortless. However, although the ethics process at the new ethics bodies started sound, and I followed the exact process, as per the policies, I experienced some hiccups in the final stage. I was glad that I did not have to change the subject or aims of my research when I had to find an alternate research site. The

nature of the setting and the population were similar. Even better, I did not have to start the process from the beginning. I proceeded straight to the RG, as the KCP at the new site had said that it had been arranged for the transfer of the previous HREC approval to the new HREC. The SSA and PICFs were transferred onto the new templates and modified to align with the new guidelines. The HOD at the site suggested that I would not have to obtain formal consent from the incidental participants because it was impracticable, which I happily agreed with, as it would make my work lighter, and more importantly, the recruitment process easier.

With this amendment, I submitted my application for site approval, being assured that all arrangements had been made. However, it took considerable time, and when I enquired about the progress, an e-mail from the new RGO alarmed me, as it asked me to supply the approval letter from the new HREC, which I did not have. When I checked with the KCP, who had arranged the transfer, I was told to send them the approval letter from the previous HREC and, even after I clarified the request, I was insisted on doing the same. I did not feel that this was the appropriate course of action, and therefore, contacted the new HREC instead, enquiring about the process for obtaining their approval. I also supplied the letter of approval from the previous HREC, as asked. This reminded me of the process at the previous ethics bodies and I felt unsure about the outcome. Finally, the new HREC transferred the approval and sent a copy the KCP and me. I forwarded the copy of ethics transfer letter to the RGO, whose final sign off meant that the project was ethically cleared. This RGO worked according to the set guidelines and followed the exact process ([State] Department of Health, 2011). Comparably, the process of ethics and access was shorter and easier in the latter 'ethics land' and the research site.

Ongoing Access

Acceptance from the research site and ethical approval do not warrant the commencement of the study, nor guarantee the continuation of access for the whole data generation period. Therefore, I became extra cautious in maintaining relations with people at the research site, and kept in mind the strategies recommended by Bryman (2012). First, I addressed the questions and concerns raised by people in the unit, such as consultants, doctors, nurses and other healthcare professionals. I did this during meetings and information sessions, both initially and on an ongoing basis. Their main concerns were how I would control bias in the study, measure the interactions and relations and maintain validity and reliability, which were questions related to quantitative and clinical research. I explained the nature of a qualitative

study, how ethnographers gather data and how respondent validation, triangulation and reflexivity are practised in ethnographic research (Hammersley & Atkinson, 2007).

Second, as a past employee, I knew the layout of the unit and who to approach to deal with matters. Therefore, it was easier to move on. Third, I always maintained a non-judgemental approach when speaking to people. Fourth, I kept the information that participants gave me private, and did not discuss anything related to the study to anyone. Though, at times, I was asked to provide a briefing of my findings. Fifth, I could not conform with the advice to wear a high-visibility jacket, as participants would be alarmed with my presence, which would increase the risk of the Hawthorne effect. I also could not wear a nurse uniform, as I had resigned from my role in the unit. If I had worn the uniform, it would create confusion regarding my status, and I could end up assisting nurses and attending to the visitors of the patients, as Fine (2008) similarly experienced in his study of restaurant work. Therefore, I wore a smart casual outfit and a name badge indicating that I was a researcher, which was widely accepted, as people in the unit had various roles such as mine. Finally, I prepared myself for situational changes, like Plankey-Videla (2012) underwent in Mexico, and my own trajectory, described earlier.

The project was well received at the new site, as it was familiar to the Nurse Manager (NM) from when I was her employee, the medical HOD had a passion for research and respect for the efforts of staff and the KCP facilitated the ethics and access processes. The favourable reception was also due to a kind of collegial relation built between us while working together, and I did not have to take the time to establish a new social contact (van der Waal, 2009). Perhaps that is why the Heads of the NICU supported the research project without question, acted as sponsors at the initial stage of the fieldwork and assisted my settling into the field. Moreover, I had developed good rapport with the research participants (Borbasi et al., 2005; Creswell, 2007) as my past colleagues, and enjoyed relatively smooth, ongoing access for my fieldwork. However, I also experienced some glitches in the process, including being asked irrelevant questions about the safety of the patients, who were not the focus of the study.

Entering the Field

After gaining permission from the research setting and site approval from the ethics bodies, I could enter the field. This meant the commencement of my fieldwork to gather data for this research study. The research field was not new to me, but I felt strange in the new role. I had

gained access to the organisation to study its culture. However, as the culture is ‘invented’ from the everyday activities of nurses and other workers, I had to enter their daily working lives. This required their voluntary participation. This sub-section describes my experience of entering the field.

The experience of entering the field often makes an interesting story for an ethnographer. In my case, it was mostly easy because of my familiarity with the setting and the potential participants. Nevertheless, I experienced some hitches, which is expected in ethnographic practice. When I asked for help to organise information sessions for nurses, I found two sides to some of the nurses in senior roles, who demonstrated their niceness in front of their seniors, but did something else with me. For example, in the presence of two senior nurses, Ayla facilitated one of the information sessions, and told me to come at 15:00 for the next day’s session, as the tutorial room would be free after that time. However, when I arrived the following day and saw that the room was being used, I waited outside and she came out and said, furiously, ‘I had told you to do it in the second isolation room’. Her approach surprised me, as she appeared to be completely different from the previous day. She had not told me that the venue was unavailable, nor had she suggested an alternative. I guessed that she had either forgotten what she had said to me earlier or been unhelpful to me on purpose. Instead of talking in this way, she could have simply explained the change of circumstances.

I presented my project in the research meeting to inform those at the decision-making level in the unit. This was interesting in terms of the attendee’s responses to the research. The research meeting is a forum for researchers in the unit to share their studies, new knowledge and recent evidence related to neonatal care, which takes place once a month. The attendees included the five senior nurses as well as consultant neonatologists, neonatal fellows, registrars, AHCPs and others involved in neonatal research from both inside and outside the unit. I considered this presentation a formal entry into the field, as these were key decision makers for new research activity in the unit and, as such, they were gatekeepers and sponsors. I started my presentation as soon as I entered the room, as the other presenter had not arrived. As I carried on explaining my study, one of the audiences interrupted at the conceptual framework. They suggested that ‘colour’ was not the appropriate term, and that I had better replace it with race. They asked where they would fit into the study, as they had the same colour skin as white Australians but were of immigrant background. Another questioned how

I would quantify and interpret values and beliefs. The discussion continued, and the KCP told me to review my conceptual framework.

I moved on to methodology, but some people were still having side-talks, and some were looking to another direction. When I was describing ethical matters in research design, they asked for the number of participants, how I would minimise bias, how the validity and reliability would be measured and how part-time staff would be contacted and observed. Interestingly, one of the most senior people asked why I was anonymising the unit and the whole hospital. I tried my best to address their queries and provide explanations of the ethnographic processes. The session finally concluded, and I asked if anyone had more questions or suggestions. After a brief silence with questioning gazes to each other, suggestions followed, including ‘ensure mix of cultures’, ‘mix up variables—full and part-time’, ‘take both experienced and inexperienced’ and ‘do not video-record’ (a previous researcher had recorded in the unit). However, the questions were familiar and expected from people who had been reading and practising randomised controlled trials and quantitative research and had little knowledge of qualitative studies and social—especially ethnographic—research. I was glad that they asked questions and that I had a chance to inform them and explain these forms of research and their processes. Despite a lot of questions and concerns, my entry into the field was granted.

Workplace Policies

This section outlines the policies, guidelines and statements that this NICU had in place at the time of the study¹¹ to support and manage staff with various backgrounds and perspectives. These policies/guidelines/statements were categorised as broad and local: those adopted from the state, national and international organisations, and those specific to the NICU and the hospital. The state-wide code of conduct is for all healthcare staff to follow the professional and ethical standards of conduct to guide and regulate their behaviours at work and to raise and report unacceptable behaviours. The aim of code of conduct is to build a constructive workplace culture based on organisational values of collaboration, openness, respect and empowerment ([State] Department of Health, 2015a). The Nursing and Midwifery Board of Australia (NMBA) has also issued a code of conduct that outlines the principle of cultural

¹¹ Changes to NMBA code of conduct and Cultural Competence training took place in 2018 after data collection.

practice and respectful relationships, which emphasises on nurses' engagement in a culturally safe and respectful way (NMBA, 2018). This Code of Conduct is supported by the joint statement of the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) and the NMBA as these bodies are committed to addressing racism and provide leadership in promoting culturally safe care to Aboriginal and Torres Strait Islander patients and ensuring that the health professional standards clearly communicate the needs of cultural safety (CATSINaM & NMBA, 2018). Cultural safety of Aboriginal and Torres Strait Islander peoples is also guided by the joint statement of five organisations: NMBA, Australian College of Midwives (ACM), Australian College of Nursing (ACN), CATSINaM and Australian Nursing and Midwifery Federation (ANMF) (NMBA et al., 2018). The NMBA has issued even new RN standards of practice in June 2019 in conjunction with Australian Health Practitioner Registration Agency (AHPRA). The first of them clearly explains the need for respecting the cultures and experiences of Aboriginal and Torres Strait Islander peoples and the people of other cultural groups, that is, immigrants (NMBA, 2019).

Similarly, Fair Work Ombudsman (n.d.) as a national body, has delineated the entitlements of employees that are applicable to nurses and their workplace including breaks, information, protection at work. *Racial Discrimination Act 1975* is in place nationally for elimination of racial and other kind of discrimination (Australian Government, 2016). In addition, *Australian Human Rights Commission Act 1986* works against all forms of discriminations (Australian Human Rights Commission, 2013, 2014). This is a national human rights act affiliated to the International Labour Organization's convention of Discrimination in Respect of Employment and Occupation. Furthermore, International Labour Organization (1958) is an international body, according to which all human beings regardless of their race, gender or faith have the right to equal opportunity, dignity, economic security, social well-being and spiritual practice.

The hospital and unit-based policies were in place to support nurses in the workplace. Some are online modules that are mandatory to all staff. The training on Aboriginal Culture, for example, aims to promote cultural competence in clinical practice. While this training is very important to shift ongoing colonial relations within interpersonal health encounters in health care settings, it does not include components of cultural safety of nurses nor does it include the other cultures to address the cultural needs of immigrant nurses and patients. Important to note is that the discrimination from the white settlers might be different between the original landowners and the invitee immigrants. This difference in discrimination might be because

the Aboriginal and Torres Strait Islander people as the first landowners can create an anxiety that could unsettle land claims by settlers and the social order, while, the immigrant people of colour as invitees may not challenge the validity of the authority of whiteness in the same way. Similarly, immigrant people of colour have a place in the white settler city to engage in work, but the indigenous person may not be welcome in the same way. This thesis throws light on how immigrant nurses of colour may face racialisation in the similar fashion as the indigenous population because of the systemic whiteness, where they are ignorant of such relations in the Australian health care workplace before migration.

The unit-based policies included constructive feedback, mentoring and preceptoring, in-service education, annual performance appraisals, support shifts with CNEs and assessments and opportunities for promotion. The clinical progress ladder was designed to guide staff development, from the day they commenced work in the unit (see Appendix 11). The staff support policy in the unit emphasizes that training and education are continuous processes. Nurses are encouraged to attend online, and face-to-face training related to their work to renew and promote their knowledge and improve portfolios. They are also provided opportunities to take care of more complex patients and relieve a more senior position to learn and develop their career within the workplace. They have yearly performance appraisals to monitor their professional progress. Nurses are assessed clinically three to six months from commencement of employment and as necessary before transitioning to ICU from IMU, after a few months of practising in ICU to within a year and for going into a higher role within the unit. A support shift with a CNE is given prior to the formal assessment to identify learning needs and provide an opportunity to fill in the gaps in clinical practice. The purpose of the support shift is to prepare the staff for formal assessment, mentally and clinically.

Topography of the NICU

This sub-section briefly describes the layout of the research setting, that is, a NICU called Hope Unit, which was the workplace for nurses in this study. The NICU was a 'closed' unit in a tertiary-level referral hospital, with two separate clinical areas: intensive care (ICU) and Intermediate care unit (IMU). There were two entrances at each end, with swipe card access for staff and electronic bells (with staff surveillance) for visitors. The office areas were separate, which meant that the senior nurses were located away from the clinical area. The offices were for the NM, CNC, NE, the CNE, clinical nurse auditor, consultant neonatologists and administrative staff. Lactation consultants, the discharge nurse, and the AHCPs were

stationed in the rooms separate to the office areas. Besides these people an interview room for meeting with parents and a shared office for three NUM1s were also located. A tutorial room was a multipurpose space that could be used for nursing hand over, presentations or small workshops and meetings. The parent rooms were used for rooming in babies before discharge and supplied with basic facilities.

The ICU was a brightly lit area, crowded with high-tech life-saving equipment including ventilators, warmers, incubators, infusion pumps, feeding pumps, vital sign monitors, photo-therapy machines and nitric oxide cylinders. Frequent movement of an x-ray machine and lab trolley would also take up ICU space. In addition, doctors, specialists, nurses, AHCPs, social workers, support staff and visitors not only made the ICU traffic chaotic, but their movements and interactions also contributed to the noise pollution, over and above the constant jingles, buzzes and alarms coming from the machines. The tiny bodies of the ICU patients and their little beds carried a vast array of incoming and out-going wires, lines and tubes for life support, clinical measurements and supplement of air, oxygen, nutrition and medication.

The IMU was an intermediate care area that cared for babies who were more stable in condition, mostly off respiratory and parenteral support, although some might still require them. As these babies required less intensive observation and treatment and were at a stage closer to being discharged, they were mostly ready for developmental care. The baby beds on both sides were either cribettes or bassinets and sometimes incubators or a high-walled Dräger with base and overhead heating. Each bed spaces (irrespective of intensity of care area) were supplied with air, oxygen and suction connected to regulators and tubes ready for use, a digital screen on top to monitor the baby's vital signs and an alarm button for nurses to call for help in case of rapid deterioration of a baby's condition.

Besides ICU and IMU, there were isolation rooms, treatment room, medication room, sludge room, lab room and doctor's room. A main storeroom was where equipment and supplies were kept. A narrow passage led to the staff tearoom through staff rest rooms to the left, and a cleaners' room and staff lockers to the right. The staff tearoom was used for meal breaks, where much social interaction would take place. Other spaces for nurse interactions were bed spaces, corridors, nursing stations and the corners of the clinical care areas. This brief topography of the research setting may help understand the territory and nature of nurses' work and periphery of their interactions and relations.

Demography of the NICU

The sub-section describes the demographics of nurse participants working in the NICU under study. As the research setting was a tertiary-level referral facility for neonatal care, there were three levels of NMs who led and managed the nursing workforce and patient care services. On top was the level III NM, who co-led the unit with the head of the neonatology department. The CNC was responsible for development of clinical practice standards based on research evidence and evaluation of clinical practice. Another key position was nurse practitioner, an advanced practice nurse who would coordinate all aspects of patient care, including diagnosis, treatments and consultations. The level II NM assisted and was deputy to the main (level III) manager and assumed the excess responsibilities of level I managers. The level I managers, referred to as NUM1, were directly involved in leading the clinical care. This role was parallel to the nurse educator, who designed, oversaw and coordinated the clinical nursing education programs in the unit. Under this role were CNEs, who would implement clinical education programs and in-service sessions for nurses and carry out orientation and preceptorship for new nurses. The Clinical Nurse Specialist (CNS) was the advanced practice role responsible for providing consultation and support to registered nurses on patient care. And registered nurses were the ones to provide direct nursing care to patients at the bedside.

Described above were the hierarchies of nurses within the unit. The demographics provided below describe social and professional categorisations relevant to their social relations in the workplace, including age, gender, country of birth and education, work experience and position held in the unit. Out of 88 nurses working in the unit, 76 (86%) participated in the study, which meant they were observed for their interactions and relations of work. Of the 76 participants, two were males, who comprised the only male nurses in the NICU. Twenty-eight nurses were between 20 and 29 years of age and Twenty-seven were between 30 and 39 years of age. The age groups formed a pyramid, with Twelve nurses aged 40–49 and eight aged 50–59. Only one nurse was over 60. This means those who participated in the study were mostly (72%) under 40 years of age, which also reflects the young demographic of the unit.

Nurses born outside Australia numbered 25 (33%) and their countries of origin (in descending order) were the Philippines, India, the United Kingdom, New Zealand, Malaysia, Zimbabwe, Canada, China, Germany, South Africa, Sweden and the United States of America. Of these, seven were white immigrants and 18 were coloured. Of the 18 coloured, two were born in Global North countries to immigrant parents and migrated to Australia during their childhood,

four were born in Global South countries and migrated to Australia during their childhood and 12 were born and educated in Global South and migrated to Australia. Of those 12 immigrant and coloured nurses, three received nursing education in Australia. And one of seven white immigrant nurses also received her nursing education in Australia. Thus, collectively, 61 nurses received their nursing education in Australia. Of the remaining 15 who received their nursing education overseas, two received their nursing education in English-speaking countries like Australia. Of the 51 nurses born in Australia, two were identified as Aboriginal Australians, one was African, and another was from a Middle Eastern background. Since the Aboriginal nurses in this NICU were light-skinned, they were not identified without a deeper conversation, as was possible in the in-depth interviews.

Education-wise, of the 51 Australian-born nurses, 17 assumed Graduate Certificate in NICU, six did Graduate Diploma and five did a Masters degree. One of those five qualified with a Masters was from a coloured group of two. Of the 25 overseas-born nurses, two did Graduate Certificate, one Graduate Diploma, four Masters and one Doctor of Philosophy (PhD). The two Graduate Certificate holders were both coloured nurses but educated in Australia. One Graduate Diploma qualified was also a coloured nurse. Two with Masters were white immigrants, and the other two were coloured. The only PhD holder was a white immigrant nurse. This shows that highly educated nurses are from immigrant categories. Yet, the vast number of Australian-born Graduate Certificate qualified nurses makes it clear how support and resources are operated in this NICU because the course is supported by the workplace.

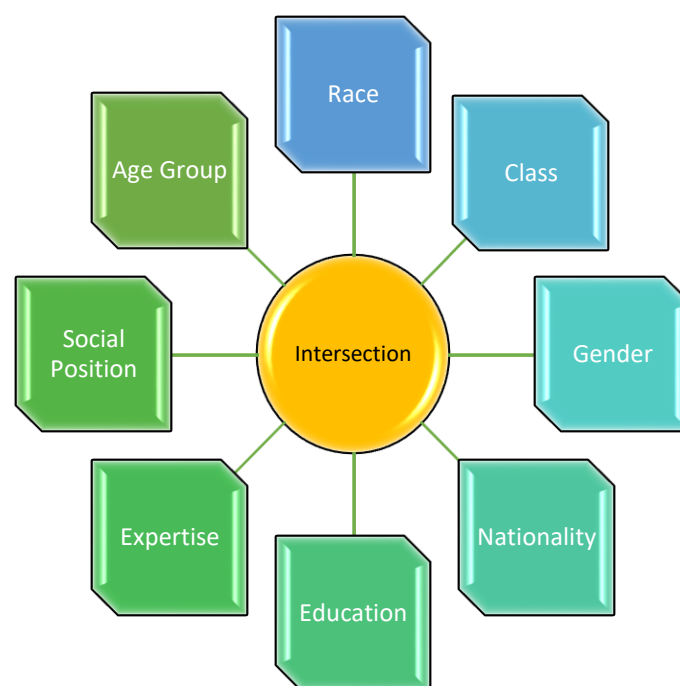
Most of the participating nurses were experienced, with 6–10 and 11–20 years of clinical work (n = 20 in each group). The least numbers were either experienced above 20 years (n = 11) and below three years (n = 12). This refers to total professional experience, including previous work and this NICU. Their work experience in this NICU was short, as evidenced by 28 nurses with 0–2 years' experience, 18 nurses with 3–5 years' experience, 12 with 6–10 and 11–20 years of experience each and only six with over 20 years' experience. This shows that the unit has a low retention rate.

Positions in the unit seem to be affected by race and backgrounds. Of the 76 participants, 51 were registered nurses, and 25 were in senior roles: Of the 25 senior roles 14 were CNSs, three CNEs, a nurse educator, a transitional nurse practitioner, five different levels of managers and a nurse researcher. Only three nurses from immigrant backgrounds held senior positions and only one of those was coloured nurse. The senior position she held was just one

step above a registered nurse. This has implications on how immigrant nurses were faring in the NICU and how the social exchange was practised between the workplace and them.

These demographics demonstrate hierarchical and social categories of nurses that influenced their social relations of work in the NICU. These categories intersected while they worked together and experienced the everyday work life, and therefore, constituted axes in the context of this unit and are demonstrated as race, class, gender, nationality, education, experience, position in the unit and age group as shown in the figure below.

Figure 3 Intersectional Axes of NICU Nurse Categories



Now, I introduce how these categories of nurses are talked about in the analysis of findings and discussions. The CNC, NM NUMII, NUM1s and NE are referred to as senior nurses. The CNSs and CNEs working, supporting, and leading the patient care are called senior bedside nurses. The registered nurses working in the unit are termed as bedside nurses. The nurses born and educated in Australia who have Caucasian skin colour are called white Australian. The nurses who are of immigrant background are referred to as immigrant, and those who are of colour other than Caucasian white are called coloured nurses. Thus, the nurses who are of immigrant background and coloured skin are collectively termed immigrant and coloured nurses, which are widely used in upcoming chapters. And the work experience, skills and knowledge of nurses are referred to as expertise of nurses and incorporated as an axis in intersectionality as shown in figure 3 above.

Consenting and Recruitment

After entering the field, the next step was to gain access to the participants to study their social worlds. This meant gaining entrée into neonatal nurses' everyday lives of caregiving, routines, procedures, and interactions. I was familiar with the setting, participants and daily activities, as I worked there previously, but the collegial relation I had developed with the other nurses had shifted to a researcher–participant relationship, which carried concerns and suspicions among some nurses. As a result, some of them would find excuses to escape from me and some even declined to participate in the study, which was unexpected and upsetting to me—perhaps because I was not detached from our previous relationship and had taken their support and participation for granted. This sub-section describes how I obtained informed consent from the individual nurses for their participation in this study.

Recruiting Primary Participants

Upon entering the field to conduct my research, I organised information sessions with the potential participants to fully inform them about the research and what it meant to participate in the study. These sessions were run 11 times, doubling up some days to cover the number of staff working different shifts. The presentation included a brief overview of the study, the aims and objectives, significance, theoretical framework, methodology and research design, followed by participants' rights and responsibilities, privacy and confidentiality matters, the possibilities of harm, my responsibilities as a researcher and who to contact if they had questions or concerns. The presentation slides were also uploaded to the desktop at the nurses' station for those who did not attend an information session.

During the information sessions, the nurses were given the four-page PICF inviting them to participate in the study. The first two pages contained study information, followed by a consent form to sign if they decided to participate in the study and a data collection form to provide their demographic information. The PICFs explained the role of participants and the responsibilities of the researcher in the form of frequently asked questions. They were also left in a folder at the nurses' station for nurses who did not attend an information session or who I did not get a chance to meet and provide with a PICFs. Once nurses agreed to participate, they signed the consent form, filled in the data collection form and were enrolled in the study. Thus, obtaining fully informed consent from each participant determined recruitment in the study.

I used my judgement to select the permanent full- and part-time registered nurses as the most appropriate participants (Fetterman, 2010), but I invited all eligible members in the unit and included everyone who consented, so that there was more representation. As a result, I had a vast number of participants for in-depth interviews, which is very unlikely in a qualitative study, but I did not begrudge the saturation, as the information was all new and interesting, which is of great value in ethnographic research.

The process of recruitment was sometimes fast and easy but, at other times, it was challenging and time-consuming. After the last information session, I did not go to the unit for a week, to allow the nurses time to read the PICF and decide whether to participate in the study.

However, when I went to check my pigeonhole, there was nothing for me, so I changed my strategy to be proactive. I started 'hanging around' (Browne & McBride, 2015; Bryman, 2016), making myself available for questions and reminding the nurses of the study through my presence. I also followed up with everyone individually, which resulted in some signing their consent on the spot and some putting it in the pigeonhole for me to collect. However, some required four or five attempts to follow up, and I gave up on others. While consent was easily secured from nurses such as Pearlie, Luna and Adele, others were difficult to obtain.

The friendship and trusting relations between us as immediate past colleagues worked on their decision to participate in the study. I also had this type of companionship and shared social situation with some other nurses, who, in defiance of my expectations, declined their participation. Misty, for example, wrote on the consent form, '...declines to participate', and left it in my pigeonhole. Sheila was another example, who kept her distance from me after the information sessions. When we happened to face each other on one occasion, she said with a darkened face and hard-hearted tone, 'I am not interested'. This refusal contrasted with Ashley's polite approach: 'I am sorry, I am not good at these things, I can't function when I am watched; it's not that I don't want to participate, but I can't help, I feel funny, will you understand me?' I found these responses to be individualistic, rather than relational, as some of my closer colleagues did not participate, but others who had not worked with me, or known me closely, agreed to be in the study.

Recruitment was a continuous process in my project. It started with the information sessions and continued until the fieldwork concluded, as many nurses were off work for reasons such as maternity and annual leave, and some joined after the study commenced. I also needed to continuously follow up with the nurses who had taken longer to consent and changed their

minds during the fieldwork. Some of them, who initially felt fearful and sceptical about participating, were convinced by my approach and observations of others. Examples of these participants are described in the following excerpts of fieldnotes.

After 2 months of commencing my observation in the unit, I saw Yara at Bed 6 in ICU, who had come back to the unit after some experience in another ward. We chatted about ourselves and families, and I asked softly if she knew what I was doing there then. She asked me, 'The research thing? No.' I then explained about the project, she looked attentive continuously making eye contact while listening to me. She said 'Fair enough, interesting! [Brief silence with head down] I don't know... I don't know how we can be nicer to each other', she laughed. I prompted her to the nurses' station to get the PICF for her. 'That's right', she followed me. (Fieldnote 2, p. 2)

Unlike Yara, Fiona took a long time to decide. She sounded interested at the beginning, and I imagined that she would be a good source of data as she was an experienced immigrant nurse. But then we lost contact, and when we met in four months' time, she had changed her mind.

She was caring for a baby in bed 7 when I approached her. We chatted about our whereabouts as it was a long gap of our seeing each other. I then asked her intention to participate in the study. 'No, I was going to but [looks down] actually I have so many things to work out, and I can't do them at once', she showed her problems. I described the process of observation and tried to assure that she would not be disturbed and asked to do anything special that would be time-consuming or mental labour. 'I know but... I am not good at doing many things', she was not convinced. I explained further that the only task for her was to read the information sheet and fill in her details if she decided to participate unless she agreed for a longer interview later and that I would not disturb her work and she would not notice that I was there to watch her. 'I will have a look... I have a look'; her face brightened up a bit. I was extra cautious not to pressure her, and so assured that the decision was totally up to her and even if she did not consent, our friendship would remain the same. (Fieldnote 28, p. 1)

I went onto a personal level in assuring her. I did not give up on her but kept meeting and talking to her whenever I saw her. One day, I asked her to come downstairs to have lunch with me. Sitting in a quiet corner of the staff cafeteria, we chatted in an informal manner. She then asked for the consent form and signed it, which happened spontaneously.

Obtaining the consent of the senior nurses was a real challenge. As they were the key people facilitating the study, I had expected them to provide their consent. However, despite my individual follow up and requests, they did not sign their consent, which made it difficult to observe the interactions and relations of staff with them, and other events and ceremonies in the unit. Therefore, I reminded them in writing:

I know you are busy so might have taken time to respond to my request letter that I had left for you for your consent to my study. I also understand that it is possible to forget in a busy time, so I am writing to you as a reminder.

Persistent follow up of potential participants is not coercion, rather is a standard ethnographic practice, as the researcher needs to ‘hang around’ and try to explain the study to people to demystify the process and their participation. Some people need more time, explanation and encouragement to think and decide. The patient and persistent approach worked gradually. I had 76 out of 88 nurses participating in the study, which was wonderful, as a survey research seldom gets such a great response. Importantly, I could observe almost everyone working in the unit, which offered a comprehensive and ethical approach to the field.

Obtaining Consent from the Secondary Participants

I briefly explained the study to the secondary participants, on the spot, when I felt they would be the part of the scene. I offered an informed option that they could deny or withdraw their inclusion. However, most of the time, they would come into the scene suddenly, and it was impossible to explain that they were being observed for the study, as it would interfere with the sequence of events and the interaction. Therefore, I adopted the strategy of informing them afterwards, which worked perfectly. This approach also included the parents of babies, as nurses interact with them in the process of providing care in the NICU. However, when they came in before the observation started, I asked their permission beforehand. Fortunately, both approaches elicited positive responses. I did not have to discontinue my observations, exclude anyone during an observation or discard any recordings. I discussed this with the HOD, who, not only agreed on the fact that it was an appropriate approach but also pointed out that it would decrease the risk of the Hawthorne effect in the participants.

Observing Nurses’ Interactions and Relations

As nurses were the focus of the study, my observations and conversations surrounded their interactions and social relations, both within the nursing group and with other health care team members incidentally in the observation. My observation focused on various subject matters in different stages of fieldwork, but the essence was the interactions and relations of nurses. At the beginning, I observed scenes of teamwork that involved procedures, routines and emergencies in the unit. In the middle, I observed events, celebrations and meetings held in the unit, which also included social outings. And in the later part, I concentrated on the

individual nurses and their periphery of interactions and relations. The difficulty in the early stage was deciding whether to observe consented nurses working with those who were yet to consent. Approaching the as-of-yet unconsented nurse for their decision in that moment would result in a loss, as the events and interactions would pass by. So, most of the time I left the scene and moved on to another that was taking place in a different location, with a different set of nurses. Sometimes, I found the same situation all over the unit, and so I waited for the consented nurses to be together. On a few occasions I had to quit and go back at another time of the day. In the middle, I struggled with gaining the consent of the senior nurses. However, in the later stage, I changed my focus of observation and the number of consented nurses increased, so it was easier to follow the chain of interactions around each consented nurse. In my recordings, I excluded the responses made directly by the unconsented nurses but included the ones made about them by consented nurses.

My observation position was close to the third category of participant observation described in Chapter Three—I was an observer, participating less in the daily routines and activities of the nurses being studied. However, I, at times, helped with small tasks, such as checking the alarming machines, and chatted with them, as an acquaintance (especially in isolation rooms). I did not want to lose contact with the participants and their perspectives, like a complete observer, so while observing their daily activities and interactions I asked questions regarding those events, interactions and relations. Moreover, I adopted both active and passive roles in the field. Especially during the initial days of fieldwork, the participants fell silent when they saw me in front of them, which I responded to by either picking up what they were talking about or starting a new conversation, based on the atmosphere. This would trigger their conversation, and as soon as they took over, I would stop talking and start listening, which changed my active role into a passive one—the one that I intended to have as an observer. This approach not only helped to relax the participants, but also facilitated gathering valuable data. Furthermore, my twofold native status as a neonatal nurse and a past employee provided me with professional knowledge and technical language, so I did not struggle to become familiar with the setting, terminology and participants. Conversely, there was a potential risk of bias in my judgement and a possible conflict of interest. I minimised this by resigning from the workplace prior to commencing the fieldwork in my role as solely a researcher.

During fieldwork, I experienced both positive and negative reactions from the participants. For an ethnographer, these were expected, especially in the early stage. On a preliminary day,

when I was explaining the project, Zara said, ‘Such a worthy project, wish I could be the star of it.’ Camilla made a satire out of seeing me around the office area, joking, ‘Are you spying [on] us?’ Heather, in an early morning in the ICU, expressed her distress, saying, ‘Go away, we are busy!’ Some nurses expressed their discomfort with my observations and required explanations and reassurance, regardless of the information I provided at the start and having given their consent to be observed. For example, when I approached Camisa one evening, she said, ‘I am not in the mood today, don’t observe me’. I had to assure Charlie that her part-time employment status would not be a problem regarding her participation in the study, and that the findings associated with observations and conversations with her would be entirely confidential. I also explained that the people in the supervisory team would not know who the observations and conversations were about, as I would de-identify the name and other identifying material before consulting them. It is evident, then, that the participants put me in all sorts of positions, but these kinds of comments, jokes, concerns and rejections are all accommodated in an ethnographer’s account.

I observed the nurses’ actions, interactions and relations across the 24-hours, to capture most of the occurrences at different times of the day. When I went to observe at 01:00, Jeana, an experienced bedside nurse, expressed her surprise, ‘What are you doing here in the middle of [the] night?’ Some looked at me with sympathy. It was indeed a big commitment to stay awake and visit a hospital unit at night to do ‘ghost work’. The observations ranged from 60 to 210 minutes at a time, but most were 120-minutes long, as I designed them in two-hour blocks. I did this so that it was easy to recall the events and occurrences and so I would not become tired from standing, which could affect my observations and recordings. Further, my observations covered the whole year, to form a complete picture of events and celebrations in different seasons and months of the year, as well as on different days of the week. The interactions and relations that occurred around those events reflected the culture of the unit and the practices of its members. The year produced 100 hours of observations, which was less four months of preliminaries of fieldwork including participant information sessions, consenting and pilot observations, and two months for completion of interviews at the end making 18 months in total. The observations included nurses’ daily routines, emergencies, education sessions, meetings, get-togethers and celebrations, and captured how nurses communicated with each other and with other team members, how they constructed their everyday worlds at work, and how different categories of nurses intersected in their social relations of work.

Short Conversations

Short conversations were part of observations and acted as supplementary information to complete the research data. I made short and informal conversations with participants during and after the observation of events and phenomena to understand the context and meaning of actions and interactions and materialise my recordings of them. In these conversations, I asked for any extra information that I needed, for clarification of things I did not understand during the observation or for the participant's thoughts on a particular issue. Most of the time, I conducted those chats at the bedside, whenever we had privacy, as it was easier to link the contexts and because it was inconvenient for nurses to leave the patients. When participants were busy, or there was no privacy, I jotted down my questions and waited for an opportunity. As it was hard for them to leave the bed space in such an acute care environment, I was only able to take them away for this purpose on very few occasions.

However, I spent considerable time not making conversations, as it would be intimidating for the nurses to be observed and asked questions at the same time. Initially, it was necessary to win their trust, as they were concerned about a previous researcher's approach. When I approached them individually, after the information sessions, Judy asked, 'Will you video record us?', Camilla inquired, 'Will you record our conversations?' and Barbie asked, 'Will you come between us when we talk?' Similarly, Cheryl expressed her worries, 'Can we continue our work when you are observing us?' Many other experienced nurses also raised these kinds of concerns, and I reassured each of them that I would not be using any digital media when observing them, unless they agreed to in-depth interviews. I promised to respect their space, to position myself wherever made them comfortable and not to interrupt their routines and emergencies. Therefore, instead of asking questions while observing them, I informally chatted with them, to start with, and showed them my records of their actions and interactions in the early months. Although this approach worked to develop rapport with participants and acted as a check for the accuracy of my observations, I became comfortable with not troubling participants following observations, which resulted in incomplete data. I then started questioning them about events and dialogues that took place during observation sessions. Although they had become familiar with my presence and the approach with time, I remained extra cautious, for their convenience and privacy. So, I asked questions immediately only if they were free, and as soon as possible if they were busy.

Writing Fieldnotes

Fieldnotes are the records of my observations of nurses' interactions and relations of work as well as the short conversations with them during and after those observations. I started writing fieldnotes when the access and ethics process commenced as these are central to ethnographic practice. I had a notebook with me to record the events, activities and social processes. During the initial observation sessions, I did not record in front of the nurses. I took time out after each segment of observation to record the actions and interactions that I saw and heard in the clinical setting. These time outs would be in the unit's interview room, resource room, tutorial room, tearoom or even toilet depending on the availability. I preferred to go to the interview room because it was private and closer to the observation areas. However, many times, I would have to move from this room as it was used for meetings of doctors and nurses with parents. The fieldnote writing required a quiet space for the recalling process and although I would show my recordings to the participants randomly at times, I required a private space for confidentiality. Tutorial and tearooms had intermittent traffic, so they were not the best places to write fieldnotes.

Choices in relation to what aspects to record and what not to record, were as difficult as what to observe and what not in the first instance. These choices were guided by the aim of the study and research questions. The consented and unconsented participants were part of this dilemma at the beginning, which eased with obtaining more consents. I recorded date, time, day and the people involved in each observation in view of covering 24-hour time slots and days of the week. With participants I recorded their body language and facial expressions that had significance in making meaning of their interactions and social relations with colleagues, senior or juniors. The fieldnotes also included my reflections and experiences of fieldwork itself. As the fieldwork advanced and the nurses trusted my research activity, they noticed my notebook less and I was more able to record their social relations of work on the spot. In the unit meetings and training sessions, however, I could record in my notebook instantly during observations. Often, I changed the people and scene when I came back from the recording, so nurses would not notice my absences. When I continued with the same group, they would ask me where I went. Thus, I recorded as many details as possible in a concise form in my rough notebook and expanded on these notes on the computer at home. Expansion of fieldnotes happened on the same day, except when observations were conducted in the late evening or night, in which cases they were written the following day.

Interviewing Nurses

After six months of caring and silent observation, we had developed trusting relationships with each other. The participants had become comfortable enough to be followed with questions, and I had gained the confidence to request additional information that I needed, following their activities and interactions. By this time, I was not only able to conduct short conversations, but I had also received consent from 65 out of 76 participants for in-depth interviews. While a nurse politely declined to be interviewed but did not withdraw from the study, some agreed to be interviewed after they left the unit. Thus, unlike other qualitative studies, I had a wide coverage of the nurses in the unit as participants and, more surprisingly, a vast number of in-depth interviews. However, as there was wide heterogeneity among participants, the individual nurses' experiences of working in the unit were unique and the events, interactions and relations, all provided interesting information for the study. The amount of data generated increased the depth and richness of findings, compared with other studies in similar contexts (Hammersley & Atkinson, 2007).

In-depth interviews were carried out in the latter stage of fieldwork, as 'oral accounts' of the participants' perspectives about the workplace and their social relations with colleagues. The interviews also functioned as a cross-check of, and complement to, the observational data, as they were subjective responses and helpful in reducing observer bias. Ethnographers, such as Hammersley and Atkinson (2007), refer to this as triangulation—a way of validating data. I used triangulation to cross-check the responses of nurses involved in certain observed phenomena. The interview questions were semi-structured and derived from the research questions, nurses' everyday affairs and experiences in their workplace, events and interactions requiring further examination and issues that arose during the interviews themselves.

Since getting nurses out of their bed spaces for interviews was a big challenge, I arranged appropriate times, dates and places of their choice. I was available 24/7, for their convenience, which meant that some interviews took place at midnight or four in the morning. Apart from agreed times, I would also go to the unit on the weekends and quiet hours, so that I could catch up with nurses, who had lighter workloads during those hours, and who required several follow-ups. Therefore, I conducted most of the interviews in the weekends and at odd hours of the night, when nurses had some free time between care. Interview locations were mostly quiet rooms around the unit, such as the interview room and the tutorial room. However, I conducted some at bedsides, for practical reasons, when the nurses were in isolation rooms by

themselves. Some nurses generously agreed to interviews in venues outside the unit outside working hours, which also included interviews with those who had left the unit.

To get the truest possible responses from the interviewees, I explained the procedure before each interview and assured them of the utmost privacy and confidentiality of their answers. The following excerpt from my field notes is an example of such an explanation.

A little bit of housekeeping before we start: I will record our talk if that's OK with you. If you feel uncomfortable to go ahead with our conversation, you can stop me any time. This interview is completely anonymous and confidential; no one will know it is your statement. Please don't struggle not to say names; I have fictitious names ready to de-identify them. I am the one who transcribe and analyse data, so I will de-identify completely before consulting with my supervisors. You can say anything you think about your work, colleagues, doctors, management or your experience in the unit; it doesn't have to be in any particular way. Your opinion counts, and it's really valued for the study. You are hugely contributing to the study by sharing your ideas honestly with me. (Fieldnote 49, p.1)

Yet, during interviews some nurses felt embarrassed and apologised for not answering some questions. I reassured them feeling responsible as a researcher for these minor harms caused by my ethnographic research. However, being emotional during the interview meant that nurses were speaking their experiences in the workplace, and I felt empathetic (and some responses related to my experience so much that made me distressed). Kitty, for example, burst into tears while talking about her colleague, who had left due to unbearable treatment from management. Crissy, who appeared to be happy at work and reported to have fun under my observation, revealed her painful experience of biased treatment in the NICU during the interview. Thus, the interviews were an excellent way to understand what was going on in the nurses' work lives, how they were feeling about their social relations of work and what really mattered to them.

Some nurses who oversaw shifts facilitated the interview process. For example, Judy was extremely helpful—she always looked for people who could relieve nurses for interviews. One Saturday afternoon, there were two nurses on the ICU Side A whom I needed to interview, and Judy told me that the support person would relieve them one-by-one. This meant that I was able to interview both participants. I also experienced hinderances, some days. For example, one Sunday evening, Debbie was in the first side room. I waited until 22:30 for our interview, as per her request. At 22:00 another person came in and took over from her, and she disappeared. She had already been busy in my previous attempts, so I left

the idea. However, after a week, on Monday, I met her in the resource room and she instantly offered to sit for an interview. There was another person in the resource room, so we went to the interview room. As soon as we sat down, someone knocked and asked if they could use the room for a minute, to examine a baby. We came out and waited for more than 10 minutes. After that, we resumed, but two minutes later, a senior nurse came in with parents and authoritatively removed us. I realised, once again, that weekends and off-hours were better for peaceful and uninterrupted interviews. Then we went out to an open space near the water fountain and sat under an umbrella. It was hot, but Debbie did not mind talking. I felt that my multiple attempts to get hold of her had come to fruition.

Some nurses readily agreed to come out for interviews, while others found it problematic. For example, Rosy, a Clinical Resource Nurse (CRN) of the shift, asked the other nurses if anything needed to be done in the ICU and followed me in no time. In contrast, Yara, when in charge of her shift, told me, 'If I'm in charge I can't do because it's stressful'. On a previous occasion she had said, 'I'm not in the mood, I have so much going on'. Generally, the nurses born and educated locally appeared to be easy-going and able to decide to come out if they wanted. Some even handed their babies (patients) over to colleagues to relieve themselves. Conversely, I found the immigrant and coloured nurses hesitant to leave the ward unless they were told to by a senior. Even when they were allowed, they had to feel comfortable before they would agree. A representative case is discussed in the following fieldnote excerpt.

Myrtle is a young nurse, born (to immigrant parents) and educated in Australia. She was assisting with a re-strapping at Bed 7 when I approached her at 20:00. She was aware of my presence as we had scheduled for an interview for tonight but didn't look at me until I particularly spoke to her. She said, 'I'm support, have two more "restraps" to do and then will see how it goes'. Kizzy, who was the nurse to that baby and was doing the re-strapping, said, 'I will help with one'. I hoped the re-strapping would take a maximum of half an hour and so waited at the nurse's station. However, even after two hours, she didn't seem to be ready for the interview. She did both re-strappings despite her colleague's offer to help her. After the job was done, she went to each bay and asked if they needed her to do anything for them. Then she came to the nurses' desk, picked a piece of paper, walked around to ask everybody for coffee, collected orders and went to the shop downstairs. She came up with a tray of coffee servings, distributed what she bought and chatted with colleagues while drinking coffee. She then signalled me to go with a coffee cup at her hand. Thus, she spent almost 4 hours before she came out to do a 72 min talk and it was 00:55 by the time we finished. (Fieldnote 47, p. 1)

Perhaps she wanted to make sure that she had finished everything she could before coming out, and be nice to everyone, so that no one would question her time off work. This indicates that she was not feeling confident about her ownership of, and belonging to, the workplace or her relationships with her colleagues. Why Australian white nurses were confident and able to leave their work during working hours for their participation in a research study and not the immigrant and coloured nurses, might have implications for how social relations would operate in the NICU.

Exiting the Field

When it was time to exit the field, I had observed nurses' actions and interactions on a 24/7 basis and gained insight into how they constructed their workplace and their relations within that workplace. I observed the events and phenomena of the unit, as well as the interactions and relations that occurred around them, to see if they were any different from those observed in a particular period. I had also gained the nurses' perspectives of everyday worlds that they put effort into, to confirm my observations. Therefore, not much was happening that was new. Because my qualitative study had exceeded the anticipated participant response rate, I had more than enough stories to think about and analyse. I was leaving their worlds to make their stories mine and share them with the outside world. For that to happen, I needed to continue with the journey of completing field notes, transcribing interviews, managing vast amounts of data, analysing them and writing up an ethnographic report. I reflected on my fieldwork and how nurses reacted to my presence in their world as an insider in one moment and as a 'spying agent' in another, and how their differences intersected to accomplish the care of sick new-borns and make their workplace as vivid as a showcase. I also recalled how many of them were concerned about the privacy of their interactions and responses, and the possible effect on their work lives.

The change in relations between the participants and me, as a researcher, was remarkable. Some lost their trust of me in my transition from a colleague to a researcher and were suspicious of my role, but, in the end, they enclosed me in their worlds and forgot about noticing me. Some even regarded my new role as that of an advocate and put all their troubles and concerns on a shoulder to lean on. Inevitably, some nurses casually scrutinised each other's whereabouts. At times, this resulted in valuable information for me.

The underpinning ideas of ethnography are worthwhile. A well-known organisational ethnographer, John Van Maanen, acknowledged the potential for learning and wondering by just hanging out with people. How do people work together and to what do they respond? I learned that those who were observed put the observer where they were comfortable with. In sound ethnographic practice, the participants position the researcher. Questions come from curiosity, and willingness to learn about, their work.

My project was well accepted in the research setting, and people were ready for it to be there. Having said that, I waited a considerable time to win their trust, which lengthened my time in the field. But it was worth it. I realised that the participants were comfortable, at last, when they were ready for me to ask questions about their work, and they even gave their time for in-depth interviews about the value of this work, for them, and for others. I gave a presentation at the end of my fieldwork, as the unit was curious about my work. I described how I conducted my fieldwork, how it went, what I experienced and what I gained. This presentation not only updated the unit on the project, but it also fostered an understanding of what ethnography involves and how it accommodates the different traits, cultures and views of people in an organisation. I felt pleased that those who practised trials in clinical areas, and asked a lot of questions at the beginning, came to understand how ethnographic research works. Finally, I felt thankful to all the nurses who participated in the study and the people in the unit who facilitated my study, so I organised a fast-food lunch to say thank you.

Transcription of Interviews

I wanted to transcribe the interviews myself, to gain a deeper understanding of participants' perspectives of their everyday activities and relations in their workplace. It would also immerse me in my data and help me to reflect on, analyse and interpret them. However, as transcribing takes at least five times more time than recorded time (Hammersley & Atkinson, 2007), and my typing was well below the level of a professional typist, and I had a huge number of interviews to transcribe, I considered using transcription services. I sought quotes from services recommended by the university and some from friends' contacts at the nursing school. However, they had extra fees for accents, on top of their already expensive rates. I compared the time and monetary matters and decided that familiarising myself with the data would outweigh the time I would save by having them transcribed. Moreover, I had a test transcription with one of the services. When I went through their work, I noticed considerable number of mistakes in spelling and words, which altered the meaning of sentences. I could

not trust their precision. Even if I had the interviews transcribed, I would have to go through the transcript to check the accuracy. This made me strongly opt for transcribing the interviews myself. The decision proved to be not only a good use of my time to get to know the data, but also a saver of money and an improved typing efficiency.

Despite my slow rate, I was satisfied with the quality of the transcripts I produced. Although it was a tedious job, my hard work and familiarity with the participants, subject matter and technical terms assured the accuracy of my work. With the recommendation of a fellow PhD candidate, I purchased Express Scribe Transcription Software, with which I went back and forth, between the audio recordings and the texts I typed, with ‘rewind’, ‘play’ and ‘forward’ functions on the foot pedal connected to my computer. As I had conducted the interviews and knew the individual participants, it was easy to recall their non-verbal cues such as significant emotions and body language, when I transcribed their responses. I transcribed verbatim—although this is not as important in ethnography as in discourse analysis (Hammersley & Atkinson, 2007). I was examining interactions and relations among nurses, which involved both overt and subtle ways of acting, interacting, communicating and relating.

Data Analysis and Interpretation

Data analysis was a process of reducing data into pieces of information, generating themes and interpreting them in terms of the research questions, aims, theoretical framework and contemporary literature. Although it was purely an ethnographic analysis—in which the ethnographer’s senses and thought processes perform the analysis and interpretation—I used technology to sort the data and combined my ideas and experiences with various other methods, to facilitate the analysis. This sub-section describes how I managed the huge amount of data generated from my fieldnotes and interview transcripts and how I pursued an ethnographic analysis of those data.

To generate initial codes, I uploaded my data into Quirkos, a qualitative data management software that helps researchers sort and manage text-based data (Quirkos, 2017). In this software, I read data, selected those relevant to the research questions, or related to nursing workplace relations, and coded as I went. The software facilitated and simplified the coding and categorising process, as it allowed for the managing and grouping of themes or quirks that emerged. This way, the themes were categorised in levels, namely ‘child’, ‘parent’ and ‘grand-parent’—where the child was the main theme. Quirkos (see Appendix 8) enabled me

to pick relevant data sets and subsets for coding, as described by Hsieh and Shannon (2005), and arrange them into categories and sub-categories. The coding process was both inductive, or data-derived, and deductive, or theory-driven (Braun & Clarke, 2006; Elo & Kyngäs, 2008). However, I faced the practical difficulties of not being able to stick notes on each code and the crowded Quirkos canvas rendering the sub-themes invisible. The big amount of data was hard to manage in Quirkos. Therefore, I used in-text coding (see Appendix 9), which allowed me to jot down my ideas regarding the text, code or theme, beside the object in question, as a point of reference for comparing and relating it to other data items. The text-based manual coding broke up and segmented the vast amount of data into simple categories and themes, which opened them up for interpretation and conceptualisation (Coffey & Atkinson, 1996).

When I was halfway through the coding, I mind mapped the ideas to organise the codes and generate themes with iMindMap software (see Appendix 10). The program creates a central idea as the main theme, adds branches to it as key themes, puts keywords on the branches, colour codes the branches and includes images. The initial three steps were principally practised in academic mind mapping, which I adopted to organise my ideas, while, the latter two were for the additional benefit of creating mental shortcuts for easy recall and making the map appealing and engaging (iMindMap, 2018). As I prepared a picture of the whole thesis, with themes and sub-themes, I put the rest of the data into the respective themes and sub-themes, which simplified and shortened the analysis process. I found mind mapping similar to Quirkos' grouping of the quirks and formation of key themes. The difference was that Quirkos mostly aided inductive data analysis, while iMindMap was deductive. I used both methods, with a view to include both what the data said and what my research questions, aims of the study and the relevant theories and concepts produced.

The next step for me was to critically analyse the themes and sub-themes I discovered from the data sorting. It was time to tell the story of my data by presenting them in a clear, concise, coherent and interesting way. This was an ethnographic writing process (Hammersley & Atkinson, 2007), wherein the data were translated into arguments and supported by evidence in the form of excerpts from the fieldnotes and interview transcripts. The findings were then conceptualised thematically and discussed in relation to the theory of intersectionality. The resulting ethnographic text demonstrated how the theory of intersectionality could be used to describe nurses' daily personal and work spheres and implications for their social relations.

Further, the findings were contextualised within the current literature, theories and concepts including diversity and cultural safety, and informed by my reflective remarks as a researcher. From this process emerged a new notion of the things that matter for nurses working in a NICU. This notion went on to lead this thesis. The supporting ideas formed subsequent chapters that were developed as concepts useful for the betterment of nurses' social relations of work. The thesis now has implications for workplace practice and recommendations for future research on matters related to workplace relations.

Rigour in My Research Practice

Ethnography itself is considered a rigorous research process. My actions, as a researcher in the field, were guided by the principles of trustworthiness—that is, credibility, transferability and reflexivity (Baillie, 2015; Finlay, 2006). The methodologically pluralistic characteristics of ethnography, triangulation (Reeves et al., 2008), guided me to check the accuracy and integrity of data. I showed pieces of fieldnote recordings to the observed nurses in the initial stage and checked with them randomly throughout the fieldwork period to ensure accuracy. The act of checking not only reassured the nurses about their participation in the study and secured their trust, but also ensured the quality of data and transparency of the research activity. As Hammersley and Atkinson (2007) suggested, the accuracy was maintained in producing the true accounts of social phenomena that happened in the nursing workplace. I had recorded the occurrences immediately after the observations in a rough notebook clearly and thoroughly for later expansion. Moreover, my extensive fieldwork, covering every month in a year, every day in a week, and every hour in a day, is a testament to the credibility of the study. The data from the large sample size ($n = 76$) including 65 interviews also substantiate the trustworthiness of the results.

Transferability is the potentiality of findings to be applicable in another setting or context (Baillie, 2015; Finlay, 2006). I ensured the transferability of this study by producing a detailed description of the research setting. I painted a comprehensive picture of the NICU where this study was conducted and followed the same process with the research participants, while protecting their identity and confidentiality. As ethnographic research values the events and phenomena that occur in the research setting (Atkinson, 2015, 2017), I captured these as completely as possible to ensure that they were trustworthy accounts. I also clearly accounted for my role as a researcher during the fieldwork, as described in various places throughout the chapter. I separated personal feelings and experiences from the data by limiting them to the

initial context to the thesis and the reflection in the concluding chapter. I thus identified my own strengths and limitations through reflective journals. To avoid possible conflicts of interest, I resigned from my position in the unit before commencing the fieldwork. This separation contributed to the change of my role to a sole researcher, which believed to act on minimising possible bias and judgement of the organisation and participants. I also adopted a non-violent approach in my interviews with participants (Bourdieu, 1996). These processes allowed me to practise reflexivity (Hammersley & Atkinson, 2007) and contributed to the trustworthiness of the research practice.

CONCLUSION

This section summarises the design of the research project and conduct of fieldwork based on the principles and techniques provided by ethnography as a methodology. My design involved planning of how to conduct an ethnographic research including selecting the field in which to carry out research and the target group of people to include in the study. Since gaining access to the field was interlinked with the ethics process, it was a matter of careful coordination. My strategies for data gathering, management, analysis and interpretation also concerned how to ensure a rigorous research process. The fieldwork was an implementation of this design in my ethnographic practice, which involved how I approached the field, how I entered the everyday worlds of nurses, and how I produced records of what I observed and heard about their social relations of work. The practice of ethnography also involved the work after the fieldwork that included how I managed and analysed data, and how I maintained integrity in the research act.

The field recordings also included my learning experiences in every stage of the fieldwork. I found accessing the field the most challenging aspect of the process. It was like the games of Snake and Ladders or Hide and Seek due to the complexity of the processes and outcomes. It proved that the ethics approval and access to the research site were dependent on each other. Securing an alternate location also posed challenges, which concerned my ability to handle the bias and relationships in the field. However, the findings from the field, including the topography and demography, the policies in place to guide the support and management of nurses and my own experience of fieldwork have strengthened the data quality and supported their analysis and interpretation. The completion of fieldwork leads to the next stage of the ethnographic work, that is, writing an ethnography.

CHAPTER FIVE: TRUST AND RECIPROCITY

The idea of trust and reciprocity is based on social exchange theory (Budd, 2019; Emerson, 1976), as exchanges are undertaken in terms of the return of goods and services if social relations continue. Budd (2019) considers social exchanges as interpersonal relations that are open and ongoing having unspecified obligations of trust and reciprocity along with varied intents of status, respect, care or money. Trust and reciprocity thus enable nurses to constitute mutual respect and recognition, reliance and assistance, and pleasure and benefits among them. Moreover, as trust and reciprocity are relational, they go beyond the accomplishment of work to help team members feel included, share ownership of work and have a sense of belonging. This kind of sensibility contributes to sound teamwork and a collaborative process of accomplishing care of patients with optimum cooperation, voluntary skill use and constructive feedback, but it also appreciates the differences between the team members (Riches & O'Brien, 2017).

Since nurses working together are diverse in social and racial background, culture, ethnicity and expertise, these categories shape their way of thinking, working or doing things. The challenges of these diversities can range from misunderstandings, conflicts and disagreements to systemic and structural inequalities and injustice. The organisational challenge may involve how to make everyone feel that their values, beliefs and identities are respected, and how to create and maintain unity in diversity. This is because nurses as employees have expectations of being taken care of by their workplace for their service: the norm of reciprocity (Budd, 2019; Emerson, 1976). However, the organisational norm may not always be practised and with all categories of nurses. This chapter demonstrates how nurses experienced trust and reciprocity between them and with their workplace that involves meshing of interactions to and from nurses and what impact these interrelations had in their social relations of work. The chapter began by introducing the concepts of trust and reciprocity, and now continues to explaining how in building trust and reciprocity, nurses need to get to know each other, get along together, help and support each other and mutually navigate breaks so as to feel a sense of belonging at work. It will also show that while these aspects help achieve togetherness and cooperation among nurses, the consequences of their dearth are distrust and disagreement.

KNOWING EACH OTHER

Knowing each other involves nurses getting to know their colleagues from a personal perspective and making an effort to recognise their identities, cultures and backgrounds, as well as their skills, expertise and experience in social and professional spheres. Knowing each other also supports social relations between nurses of different social positions. For example, senior nurses are expected to identify the learning needs of new bedside nurses, acknowledge their prior skills and offer support where required. Similarly, new nurses are expected to seek advice and guidance from senior nurses, clearly communicate their needs and expectations and follow the policies provided to them at the commencement of their employment and thereafter. Some new bedside nurses are astute enough to know that the quality of supervision and guidance varies between senior nurses. Although most immigrant nurses are not regarded as educators and mentors, some are selected to learn from. The following note demonstrates how nurses mutually constitute each other's identities, how they accept each other's differences and how they recognise and value each other's expertise.

Chara was standing in the middle on Side A of IMU close to the second computer desk, while, Jeana was sitting in the chair entering patient updates in the electronic patient database. Chara laughed; Jeana asked in a firm voice looking at her, 'Why are you laughing?' Chara stopped immediately shrinking her lips to resume the original unsmiling position. She turned into a statue staring at the computer screen aimlessly. (Fieldnote 20, p. 1)

Jeana was an experienced nurse with strong personality and Chara had just joined the unit. As a new employee, Chara was getting to know the nurses working around her. She had laughed to start a conversation, as she had heard that Jeana had a good sense of humour. However, her intention was interpreted differently by Jeana, which made her feel intimidated. This is a difference in how people communicate and how styles of interaction are interpreted. People also arrive at different conclusions when they make presumptions about one another. Chara could have explained why she laughed to Jeana, but she seemed to have been made nervous by Jeana's way of questioning her. When I discussed the incident with Chara, she said, 'I was like mute'. However, Jeana had different view. She said, with a smile, 'Look, you know me, I don't know how to be nice in front and bite behind the back (made her mouth to smile). She laughed suddenly, that's why I asked'. Although both were white Australians, their styles of interaction differed, which influenced their ability to relate. As they were unfamiliar to each other, they lacked trust, and Chara's laugh was interpreted suspiciously by her colleague.

Junior nurses are allocated to experienced ones for teaching and learning purposes, namely training and education in clinical practice. It is also to mix skill levels and balance expertise. Chara, as a junior nurse, seemed to be trying to get to know Jeana. However, Jeana, as an experienced nurse, was not reciprocating an interest in Chara. Further, Jeana expected co-workers including Chara, to know her personality and nature. Jeana came across as a bully and Chara looked like a victim in this encounter. However, she taught Chara how to handle the breastmilk later in the shift without her asking. This demonstrates that some people may seem harsh in their actions and reactions but are supportive in deeds. Being helpful later but acting aggressively at first can mean that she is ‘all bark and no bite.’ It might be about the difference in personality and ways of responding but she certainly was not generous in her response. It might also mean that she would help but not engage in more casual joking with the new people. Hence, knowing each other well helps recognise co-workers and has the potential to promote positive social relations among colleagues at work. However, it is clear that knowing each other works better when it is trustful and reciprocal.

How ‘knowing each other’ works is demonstrated by another example, which talks about how young nurses recognise who they can relate to and what they can learn from certain people.

I really enjoy working with Carmel . . . she did a lot of training in [country name], she worked in [country name], she worked in [country name] you know she is really great to work with ‘cause [sic] she’s got experience from all these other countries and she can tell you how other places in the world do things. . . . Carmel is so calm, and people don’t realise how skilled she is, she is [a] CNS and she is not actually recognised as a CNS here because her qualification is from [country name] and so, it didn’t transfer across. But she is actually a CNS and comes from the hospital that does neonatal transplants and things you know; we don’t do that. (Alice, Interview, p. 8)

Alice, as a young nurse, recognised that one of the immigrant nurses had extensive experience in neonatal intensive care in various countries. Alice liked to connect with her and learn about, and from, her experiences and knowledge, including how nurses work in very specialised workplaces around the world. Alice’s respect for Carmel helped them accept and recognise each other’s identities and build trust and relate to each other as colleagues. This recognition occurred at the bedside as they worked closely together. I noted that when practising alongside one another, as in direct care, nurses frequently had the opportunity to get to know one another. In contrast, the senior nurses responsible for the workplace enacted their roles at arm’s length and thus failed to create the same opportunities. In this case, it meant that they failed to identify Carmel’s expertise. They even seemed to restrict her work, as

Carmel herself explained, *'I mean small handful sort of senior nurses, who, you know, if I would do something like they kind of looked at me like what [are] you doing? Without kind of realising [how skilled I am]'* (Carmel, Interview 1, p. 6). This statement substantiates Alice's thoughts about Carmel's skill use. While Alice had the opportunity to appreciate Carmel's expertise by getting to know her, there was little effort from the organisation to know who she was and the details of her expertise. Had management shown interest, this could have been a social exchange between the unit and Carmel, where her skills and efforts would be recognised and used for the benefit of patients and the unit, and in turn, Carmel would feel trusted and valued at work and more energised to contribute her knowledge and skills. However, the nurses in senior roles seemed to overlook her expertise, which were potential resources for the unit. This oversight shows how the workplace failed to know the nurse at an individual level and recognise her skills and experience, just because she was an immigrant and her expertise had been developed outside the unit, and outside Australia. Such a lack of recognition could have impact on Carmel's self-esteem, confidence and social positioning at work, as well as the social relations between her and the senior colleagues. While Carmel might lose her skills and expertise, by not being supported to practise to her full scope in the workplace, there was also the possibility for the NICU to waste this human resource.

In this unit, the senior nurses were perceived as inaccessible and were observed to keep their distance from bedside nurses. This inaccessibility made it difficult for them to know nurses on an individual level, or what was going on with them in the workplace. A young nurse of colour found herself unable to relate to them, *'I don't have a real relationship, I don't think with the [senior nurse], just with holiday leave and that kind of thing I talk [to her about]'* (Crissy, Interview, p. 2). Crissy did not feel affiliated with the senior nurses, and she predominantly consulted them about administrative and clinical purposes. Another young nurses of white Australian background echoes Crissy's experience:

Oh, I need to see the nurse manager today or I need to see the educators today, but once you get on to the ward, you get busy and if, not necessarily forget, it's there in the back of your mind you need to do it; but you get busy so you don't have time to leave the ward, because you have to go off the ward out into the offices and then you leaving someone behind who doesn't work here, you don't wanna leave them. So that's been hard, because like I said, you know, they always here but you never see them. (Bree, Interview, p. 5)

The social and spatial distance between the two categories of nurses is evident in Bree's feelings. Lack of social interaction and shared social spaces were, in part, because of the

structure of the unit and the nature of nursing work. However, it was also a product of how senior nurses enacted their roles. The seniors focused on the issues related to bureaucracy and did not seem to make efforts to get to know their staff personally or build social relations with them. At the same time, the bedside nurses were focused on patient care and were less able to seek out the senior nurses, due to their workload and clinical responsibilities. As Bree mentioned, she did not feel comfortable leaving her patients with casual nurses to go to the office and see the senior nurses. Casuals might not know the routines and emergencies and yet, Bree is a new nurse as well. This instance highlights an issue with skill mix as it was not safe for both patients and nurses when a new graduate and an inexperienced casual nurse were allocated to work together. However, this allocation might not be noticed by the senior nurses, which was another indication that they were sometimes unaware of what goes on in the clinical side of the unit and with the bedside nurses themselves as Crissy describes:

One time I was like really busy with a patient and he was deteriorating and I was like I didn't have time to document everything and my senior came up to me and just like didn't take me aside or anything like that but kind of was 'why aren't you doing this' kind of thing which made me very upset and I ended up crying, but like, I don't get upset very like you know in front of people very often but yeah I ended up having to go into the doctor's office and like you know just get out of the unit for a bit and like you know the doctors would come up to me and say 'are you okay' like you know and I told them what happened and they are like 'oh she shouldn't have done that, you've been doing like you know everything well like you know you've been busy and surely somebody else can like you know do the obs'¹² [observations/vital signs] for you while you're actually by the patient's bedside'. (Crissy, Interview, p. 3)

Senior nurses in this unit did not seem to know the staff, try to see their circumstances or comply with their responsibility to support them accordingly. As a result, there was a lack of trust and reciprocity between them. Nurses kept struggling with what they were going through in the unit and senior nurses—instead of providing close supervision, guidance and support—were described as intimidating, adding to the stress and undermining the bedside nurses' confidence. The senior nurse, as another paid worker, was given authority (i.e. status and power) by the workplace, to which the worker nurse did not have access. Crissy's background and skin colour might also have played a role in her receiving this kind of treatment. Thus, the wide hierarchical and racial differences between Crissy and her senior could have played a role in the social relations between the two. The senior nurse seemed to fail to recognise what

¹² Obs is a short form of observations that NICU nurses use to denote vital signs and general condition of the baby they care for (see Glossary).

Crissy had done for the patient, which was the priority for her, but not for the senior nurse. When the senior nurse questioned Crissy about recording and reporting, it demonstrated that the senior nurse had differing priorities, which were not about patient care but about the safety of herself and the organisation rather than the nurse working hard to accomplish patient safety.

Crissy had healthier social relations with medical professionals than she did with her senior, which is indicative of favourable interprofessional relations, in contrast with hierarchical intraprofessional relations. This also means the other team members know Crissy better how she works than her nursing senior and thus have trust and reciprocity between them. Hence, knowing each other is important for better social relations among colleagues at work. While bedside nurses appeared to be more interested in knowing colleagues and seniors, senior nurses seemed indifferent. However, knowing and caring about each other promotes trust and reciprocity among colleagues, and can improve cultural safety for nurses. This matters at work for nurses.

GETTING ALONG

Getting along is a state of relating with colleagues in a positive way in the workplace. It happens between like-minded colleagues and depends on who engages in friendship and with whom. However, an individual's willingness to engage in conversation with everyone bears greater weight in today's health care workplaces, where myriads of workers interact to accomplish care of patients (Borger, 2017). Just as people differ in background, culture, ethnicity, age, experience and ability, some people can get along with everyone and work in any team environment and others seek to work with their friends or people with whom they feel comfortable. Since getting along enhances trust among colleagues and promotes reciprocal assistance, the ability to get along with many people may create ease with work accomplishment, even in difficult situations bringing about positive social relations in the workplace. Whereas the development of a friendship circle to work within can form cliques that exclude other colleagues, which may cause feelings of isolation and alienation for them and negatively impact their social relations. Getting along also applies to relations between the senior nurse in place of employer, and bedside nurses positioned as workers. When the senior nurse does not consider and maintain equality, justice and inclusivity with the bedside nurses, the cultural safety of immigrant and coloured nurses can be jeopardised, and impaired social relations between the two groups may result. In this section, I discuss how nurses do, or

do not, get along with their colleagues, which groups experience privileges or disadvantages in the workplace and how getting along effects trust and reciprocity at work.

The first example of how nurses get along at work is a fieldnote excerpt. Camisa and Josie were working together in ICU Side A. Josie had a baby at Bed 1 and Camisa had two babies at Bed 2 and 3. Charlie was also working on that side, caring for a baby at Bed 4. However, Camisa and Josie were working together, from time to time, by going to each other's bed spaces to chat.

At Bed 1 Josie was sitting in the corner close to the bedside desktop computer. Camisa came in and stood at her side leaning on the edge of the wall that opened towards the corridor. Josie turned to her with smiles, Camisa started the conversation, 'I like the kurta that you wore last Friday'. Josie appeared brighter with the compliment, 'Did you? Yes, I like it too, it has all the embroidery'. Camisa agreed, 'yeah'. 'I liked your sari', said Josie, 'the colour was so sweet'. Camisa smiled with pride and was about to respond to Josie, [when] the ventilator alarmed at her bed space, [and] she hurried towards that. After a while, Josie went to Bed 2 where Camisa was entering the observations in the computer. Josie rested her right hand on the chair top and the left hand on Camisa's left shoulder. Camisa stroked Josie's wrist gently and held her hand with her left hand in comfort. Camisa spoke, 'You should teach me how to do proper make up'. Josie said with proud smile, 'I bought a make-up set last year, it's a good one'. 'What brand is it? Can you show me?' Camisa got curious. [A] Monitor alarmed at Josie's side, she silenced it from where she was, looked at the parameter in the monitor and observed the baby. The oxygen saturation was going downwards to 92%. She quickly asked Camisa to come to her bed space and went to the other side grabbing the stethoscope hanging on the IV stand¹³ on that side to listen to the baby's chest. Camisa stayed on her baby's side and Josie to the baby's left side suctioned the baby's endo-tracheal tube. It was a closed suction so Camisa was there to support the nurse and baby. Josie listened to the baby's chest again and asked Camisa, 'It is clear now, do you wanna listen?' Camisa did and said, 'Yeah it's clear, look the saturation came up'. It was 98%. (Fieldnote 6, p. 1)

Camisa and Josie's interactions went beyond just work and the babies they were caring for. They talked about their personal and intimate affairs, which can happen only with those who get along. At the same time, they kept their patients at the centre. They not only shared personal, social choices, but also patient care, which they attended to as a priority as evidenced by their thinking and working together for each other's patients. Camisa was an immigrant nurse born and educated overseas, with 15 years of experience in this NICU. Josie

¹³ A metal stand, with two hooks on the top and four wheels on the bottom, carrying an infusion pump and/or syringe pump in the middle part and bag of parenteral fluid in the hooks for intravenous infusion/transfusion.

was also from an immigrant background, but she studied nursing in Australia and had ten years of nursing experience, of which, seven were in this unit. As they were of the same nationality, they shared the culture and customs, including costume. Race, culture and nationality were the intersecting factors that facilitated their getting along. Moreover, since Camisa was more experienced, Josie consulted her when her patient required more assessment. These two nurses not only excelled in clinical practice, but they also enjoyed each other's company at work and supported each other's practice.

However, Camisa and Josie seemed to exclude Charlie, who was also from an immigrant background but did not belong to the same nationality. She was brought up and educated in Australia and had a total of six years of nursing experience, with three years in the neonatal field. While Camisa and Josie frequently met and chatted, it did not include Charlie. However, she did not seem to mind their togetherness as she said with ease, 'They are from the same country, they speak the same language. I have Milly to chat with, so it's alright'. (Fieldnote 6, p. 2). While Charlie respected and naturalised their identities, this kind of grouping can carry the risk of clique formation within the workplace, which can result in the exclusion and othering of some nurses. Charlie was, indeed, assisted by Milly, a senior bedside nurse, who was the team leader of the shift. Since Milly was born and educated in Australia, Charlie, schooled similarly, seemed to better relate to her than to Camisa and Josie. Milly's role and position and Charlie's solitary state in the shift contributed to constructing their social relations. Moreover, Milly was observed to be hands-on and got along with everyone in the unit. Her sociable nature and helpful attitude identified where the help was needed, and so had helped Charlie. It is worth noting that, although Charlie did not seem to consult Camisa as she did Milly, when Charlie's baby lost intravenous access, Camisa readily came in to perform the cannulation¹⁴. This shows that, while nurses sharing national, cultural and linguistic backgrounds relate more readily to one another, like Camisa and Josie, they also help other colleagues in need.

While the above example indicates that nurses from similar backgrounds and cultures get along better at work, an instance below shows how age group can play a role in getting along.

The ICU Side A was full and busy, experienced nurses were working there. Side B was quieter and had young and less-experienced nurses: Kaz was at Bed 6, Ella at 7, Clara had 8 and 10 and Cody had 9; all were on 12-hour shift[s] finishing at 20:00. Kaz went

¹⁴ Camisa, an immigrant and coloured nurse, had almost two decades of NICU experience, which was mostly in this unit. She had skills of IV cannulation from previous workplace but was accredited in this unit only recently.

to Ella and said, 'I am going out to the storeroom'. Ella standing on the left of her baby approved with a smile, 'Sure'. Chloe came in from IMU and stopped with Cody who was wearing sky blue scrub as she had returned from the operation theatre and [was] standing on the right [side] of her baby at Bed 9 to check vital signs. Chloe, smiling, pulled the drawstring of the scrub that was showing down. Cody appeared frightened, 'Aahhh!' Chloe laughed loudly; Cody also laughed, 'Oh my gosh! You scared me'. Chloe spoke after the laughter, 'Oh I have to get ready for my travels'. Cody asked, 'When are you going away?' Chloe replied, 'Friday, next Friday'. 'Going to Japan is hard, do you like snowboarding?' Cody asked. Chloe nodded, 'No'. Cody continued, 'I go every second day coz it's tiring. My body doesn't cope so I go today, tomorrow off, Sunday then Monday off, Tuesday then Wednesday off and the week gone!' Chloe switched the subject swiftly, 'Hey, is that shift swapped?' Cody replied, 'Yeah, yeah'. Chloe added with swinging hands, 'I'm working on days so then I have time in the night, thanks so much'. Cody said, 'No worries.' (Fieldnote 18, p. 2)

These nurses were all young, less experienced in this NICU and educated in Australia, but they had some differences. For example, Kaz, Ella and Clara were from immigrant backgrounds, but shared a similar skin colour with their Australian-born colleagues, Choe and Cody. As they were acculturated to Australia at a young age, the way they talked and behaved facilitated their social relations. Four of them were assigned to the same bay in ICU and appeared to be happy to be working together, but Chloe was separated from the group. She was allocated to IMU Side B but appeared to find opportunities to escape from there to catch up with her age group working in the ICU. Chloe's teasing with Cody implied that they had intimacy in their collegiality. In addition to chatting about personal affairs, Chloe asked Cody for a favour—to shift swap—using informal language and gestures, which was also a sign of close companionship. interacted mostly with Cody, she also went to other girls in the bay to touch base. Kaz and Ella also seemed to consult with, and back up, each other. They were all similar in age, race and experience, which appeared to contribute to getting along and their close social relations.

In IMU, Chloe was working with Barbie, a senior bedside nurse. She was obviously working as part of a team to accomplish tasks in providing care required by the patients, but she was not interacting much with her team partner, Barbie. Rather, as demonstrated above, she was going to ICU to chat with her companions, indicating she got along better with her own age group. The following fieldnote reinforces her preference and how her open and chatty approach became quiet and functional in the team.

Chloe was sitting in the chair at the first computer and Barbie was on the second. They were quietly looking at the computer screen. Chloe went to the desk at nursing station; [then a] baby at Bed 23 cried so Barbie went to attend him. Chloe came back and looked at the shift plan lying on the computer desk that was developed at the beginning of the shift. She then walked to Bed 24, where parents were cuddling the baby. There she set up the trolley for care and assisted the mum while dad was holding the baby. After the care, mum cuddled the baby and started breastfeeding; Chloe came to the computer, sat in the chair and started entering observations of the baby. A doctor (Jose) came to Barbie at Bed 23 and said, 'The baby needs an x-ray'. Barbie responded, 'Oh OK' and walked to Bed 26 that was just opposite to 23. She unplugged the small monitor and put it into the baby's cot, picked the cords from the floor and arranged them, and pulled the cot and drove it to the treatment room for an x-ray. The doctor had already left; Chloe was still entering the details on the computer. (Fieldnote 18, p. 1)

While Chloe was seen talking and making fun with nurses in the ICU, it was surprising to see her quiet in IMU. When I checked with her, she appeared to hesitate, 'Ah, I don't know [laughed]. Maybe [looking down and thinking] I don't know, probably...' (Fieldnote 18, p. 1). Chloe's hesitation invites various assumptions: whether she really did not know what to say, did not want to share the reason, or something else. However, the observation of her behaviour indicated that she seemed more comfortable with her young colleagues rather than Barbie, a senior bedside nurse, with whom she could not be open and playful and relate warmly. When asked about Chloe, Barbie appeared defensive, saying 'She is alright, she's doing her work' (Fieldnote 18, p. 1). She might have felt that it was okay, as long as they worked together and accomplished patient care. Chloe and Barbie were both white Australians, but they differed in age, experience and their positions in the unit, which may have been affecting the social relations between them.

The other example of who relates with whom involves Adler, who appeared to be getting along with Kitty, a young nurse from an immigrant background but had been brought up and schooled in Australia. Adler did not seem to share his private time with other colleagues in the NICU. He said, *I don't socialise with anyone here* (Adler, Interview, p. 7). However, the interview excerpt below describes how his social relations with Kitty cropped up outside work.

I did catch up with Kitty recently helping her with her assignment, yeah. She is doing [thinks] I don't know how many people know she's just doing like a Fashion, she's doing TAFE, she's doing a Diploma in Fashion Design and for her final assignment she needs to build this timber rack for her clothing, so I said I'd help her build, yeah so. So, I had to go to Bunnings together and we got timber, yeah, it's quite fun so we're doing

that again on Thursday. (Adler, Interview, p. 7)

Being an Australian-born and educated male nurse with more than a decade of experience in nursing, Adler joined this unit two years ago. Kitty seemed to trust him enough to ask him for help. He sounded helpful and understanding to Kitty, as he supported her in tasks that required workmanship to fulfil her passion and hobby outside nursing, and possible future career. Kitty benefitted from his assistance, whereas he took pleasure in the work they were doing together and the satisfaction of helping a colleague. This kind of trust and reciprocity constructed their social relationship, where their backgrounds, experience, age and genders intersected. This social relationship was unique, and did not compare with the relations discussed above, nor did it occupy a specific analytical category. It had, indeed, crossed the borders of categories such as age, race, gender and experience at work. Although it may not be necessary or possible for everyone to relate outside work, this can be considered an ideal social relation between the colleagues, where all differences are respected and accommodated.

HELPING EACH OTHER

Drawing on the notion of social exchange, this section explains how helping each other matters at work for neonatal nurses. The form of social exchange observed requires reciprocal assistance among nurses, which means identifying when colleagues are struggling with not knowing something, need an extra hand to finish their tasks, or are feeling isolated, and giving assistance or speaking to them. This approach not only assists in accomplishing the work, but also boosts confidence in team members and promotes positive social relations. The acuity of NICU, as a workplace, demands mutual assistance and togetherness among nurses. It also makes social relations harder because of busy routines, emergencies and rushes to finish tasks that result in less opportunities for nurses to socially interact and relate with each other. For example, if someone asks for help with suction or check medications, it will take time to finish the task that a nurse has at hand and come to help the colleague, which can cause stress. It is also possible that a nurse who is asked for help may not take these occasions as opportunities for interaction and socialisation with their colleagues. Helping others may be time and labour-intensive (Sanders, 2009), but the feeling of being supported at work and the satisfaction of being of assistance, or being appreciated for help, outweighs the time and effort taken. The help, in turn, will come their way when needed. This reciprocity matters at work.

Pearlie was clearing the rubbish of the care from the trolley, Neva called her, ‘Pearlie, could you do me a favour?’ Pearlie wrapping the waste in the plastic sheet turned to her,

‘Yeah’. Neva asked her, ‘Can you bring milk for me?’ Pearlie responded while putting the rubbish into the plastic bag attached to the side of trolley, ‘It’s Monogen, isn’t it?’ ‘Yes’, Neva confirmed. Pearlie washed her hands in the sink close to her bed space and walked to the feed room. She brought a bottle with her and gave it to Neva who was talking to parents of her baby. She acknowledged, ‘Thank you’ and Pearlie replied, ‘No worries, do you need a hand with anything else?’ Neva said with smiles, ‘No, thanks.’ (Fieldnote 45, p. 4)

The extract above demonstrates how nurses help their colleagues in a clinical setting. Neva was a young white Australian nurse and Pearlie was an experienced immigrant. This interaction was set within the context of different social positions, with the intersections of age, race, culture and professional experience. Neva sounded polite and hesitant to ask for help, as Pearlie was also busy doing the cares¹⁵ on her baby. However, Pearlie seemed ready to help. She also seemed to know the milk type to bring for Neva’s baby, which means she also knew the baby. Neva’s acknowledgement of Pearlie’s help offers reciprocity, that is, reciprocal relation between them. Pearlie seemed to be supportive of Neva, despite her difference in background and experience. Similarly, Neva seemed to trust Pearlie more than Eli, the other neighbour who was on her right side at Bed 8 and shared her race and ethnicity but was more experienced. When asked about this interaction, Neva said, ‘I feel more comfortable with Pearlie’ (Fieldnote 45, p. 4). Some young nurses choose whom to consult and relate to, even though it might not be the expected, or formalised, support. Personal characteristics and social dealings might also influence this. Pearlie said, ‘You know, I don’t care about work, but about people’ (Fieldnote 45, p. 4): a remark that related to both patient and nurse safety. The social relations between Pearlie and Neva showed that they respected their differences and exchanged their assistance and appreciation as reciprocity.

Another fieldnote example demonstrates how nurses study a colleague’s situation and offer help readily.

It was 19:30, 12-hour night shift people were at hand over. Luna was minding a crying baby at Bed 7 as the nurse Cody, looking after that baby, was busy taking care of a newly admitted baby at Bed 9. A dressing pack was ready for insertion of PIVC (peripheral intravenous cannula) on the baby’s bedside trolley. After a few minutes, Adele approached the bed space with her eyes fixed at Luna with bright face, ‘How have you been dear?’ ‘Good, good, long time no see, how are you, lady?’ Luna replied with wide smile. Adele looked around quickly and asked Luna, ‘Do you want me to do this cannulation?’ ‘Yes please, I was waiting for some spare hands.’ Adele started

¹⁵ Cares is a term used by NICU nurses to mean basic hygiene care to the baby (see Glossary for full meaning).

looking for the vein to insert the cannula on the baby's right hand from the bottom of the bed. Luna squeezed a drop of sucrose on the dummy that was in the baby's mouth and held it with her left hand; the baby stopped crying as he instantly started sucking on the dummy. (Fieldnote 5, p. 2)

This fieldnote extract gives a snapshot of nurses' work and how they help each other. The three nurses in this scenario were of different backgrounds, nationalities, experience and social position. Luna was a senior bedside nurse with immigrant background and skin colour, Cody was a young white Australian nurse with little experience and Adele was an immigrant experienced nurse coming onto night shift. Luna in a support role helped Cody by taking over her baby and relieving her to receive a new patient at Bed 9 and carryout care work. As Cody's patient at Bed 7 had lost intravenous access, Luna had prepared for the cannulation, but she needed someone to help her to hold the baby and settle him. Therefore, when Adele came in and offered her assistance, she looked pleased. Adele had come to catch up with Luna but on the way helped based on necessity. Luna and Adele seemed not only helpful to each other but also looked trusting and were clearly getting along. Thus, the pleasure and satisfaction of helping colleagues in need and receiving their support to accomplish tasks led to positive social relations of work. Such relations were reciprocal and contributed to a healthy environment in the workplace. From an intersectional angle, the categories that these nurses belonged to intersected to construct their work and social relations.

Contrast to this observation, Adler, a male nurse with many years of experience, had different experience of working in the unit. The following interview excerpt explains how he found his colleague unhelpful at work.

I was given the odd placements of babies; I ended up doubling up Bed 3 and Bed 5 and Bed 5 I, I basically got hand over for Bed 5 in a rush, the baby was just extubated and then quick, very quickly lost all IV access that was still on Prostine so I ended up spending you know good hour and a half sorting the baby out. In the meantime I had another baby ready for theatre I think that's, yeah another yeah and it was very much looking like to me from communications I had with the anaesthetist 'cause I was the only one communicating with anaesthetist that I only got to speak to them early in the morning that the theatre might not even happen so I, and if, would be in the afternoon so I wasn't too worried about spending too much time there but when I came back the senior staff, I don't know what the senior means I don't know there's, there was very stable babies each with the nurse so there was no reason I think she probably needs one set of obs [observations/vital signs] I don't know why I remember this. I suppose it got me really annoyed and I was gonna say something to her, but I don't know why I didn't. I was very late that day as a result because I like to finish the job, so I ended up getting

that baby ready for theatre, I ended up sorting that baby out and getting all my notes and things done. I handed over to another CNS who was very understanding, and she helped me get, get the last few jobs done and, so I ended up getting out of here after 5 o'clock. (Adler, Interview, p. 5)

Adler had two babies in separate bays assigned to his care: Bed 3 on ICU side A and Bed 5 on side B. These babies required significant care and attention, as one was going to the operation theatre for surgery and the other needed intravenous access established for continuation of medication. First, the patient allocation was impractical for him, as it was difficult to know what was happening on the other side while he was busy with the baby on the other. Second, the uncertainty of the baby's surgery made more work for him. The third, and key stress factor was unhelpful colleagues, and he was frustrated that they were called senior. They had lighter patient load but did not even try to help him with the baby's vital signs when he was attending the baby on the other side. Adler felt excluded by his female colleagues and lacked interactions in both the work and social spheres. Although he felt that the treatment from his colleagues was unfair, he did not speak up. It is clear from the above interview excerpt that Adler expected assistance from his colleagues, but he was unsupported. This lack of social exchange was affecting the social relations between Adler and his 'senior' colleagues.

Fiona, an immigrant nurse with almost two decades of total experience, and nine years in a NICU, had a similar experience to Adler.

[C]hecking drugs, you have to beg a lot of times, ask a lot of times, or when they know that you [are] going to check something, they just walk away, but they know that, they can see that you brought the drug chart. Some people offer you like 'oh, do you want to check something?' They do, but sometimes, someone will, you know just walk away. So, you are like, 'oh, I thought we were going to do this together', but you know someone actually takes their time to do anything for you. But, if it were someone, they are friends with . . ., they readily offer to do things for them. (Fiona, Interview, p. 3)

Fiona described not receiving help from her colleagues, even when she asked. Medication was a double-check procedure in the NICU, and everyone needed support to ensure timely medication administration. The offer to check was expected to come spontaneously from colleagues. However, the assistance she should have received was not forthcoming, which required her to wait and struggle, making her feel left out. She watches on as a lack of assistance was not experienced by other colleagues in the unit, and assistance was not withheld between companions. Fiona felt ignored and noted that there was a 'them', of which she was not part and was aware she was positioned on the outside, or 'othered'. From this

position, Fiona noted how, despite policy support for diversity and a workplace that was proud of its racial diversity in the workforce, in everyday practice and basic requirements of help, she felt left out. 'Walking away' from a medication check with an immigrant nurse might indicate discrimination. Fiona, as an experienced nurse, should have been recognised for her expertise, her identity and culture should have been respected and she should have been valued and helped in return. Such discrimination by white colleagues does not build trust and reciprocity that matters at work for healthy collegial relations, instead, the situation for Fiona is made culturally unsafe.

Crissy, a younger nurse of colour, had a more intense experience regarding getting help.

Because you don't wanna seem like you're incompetent and I have been told before by senior nurses that I'm incompetent; they have told me, they've explicitly said that word, and it's really, really like shattering to your confidence to have that said and it's very discouraging and therefore you don't wanna ask for help because you don't wanna ever feel that way again, so [laughs sadly]. (Crissy, Interview, p. 5)

In this interview excerpt Crissy described feeling judged when asking for help, so even when she struggled to accomplish tasks, she did not want to ask for help. This feeling was described by nurses of colour but was not identified among any of the white Australian nurses who were interviewed. If the latter ask for help, it is readily provided without judgement, but when the former ask for help, they feel judged and considered incompetent. Why they were judged, and not white nurses, was an issue of concern. In observations, nurses of immigrant background such as Pearlie and Adele helped their colleagues regardless of their background or experience level. However, when it came to their turn, it seemed to become problematic. In trust and reciprocity everyone is known, valued and respected for their contributions and supported to grow at work, equitably. An access to assistance is not something owned by one category of person at work. Where assistance is not easily and equally available for everyone working together as required, means there is discrimination in the workplace, which leads to impaired social relations between nurses. A diverse workforce is required to meet the health care needs of the diverse patient population that has occurred through migration policies but when it comes to nurses, they are not supported enough. Such lack of support, on one hand, threatens patient safety clinically, and on the other hand, clearly jeopardises the cultural safety of racialized nurses.

NAVIGATING BREAKS

Getting out of a busy and stressful routine for a scheduled break in a workplace like a NICU is a challenge. How nurses navigate through to breaks without compromising the care of their vulnerable patient population is discussed in this section. Having a break for a coffee or meal not only recharges the body and mind but may also be an opportunity to interact and socialise with colleagues, which matters at work. Breaks are also one of the rights afforded to workers by labour agreements. However, the intensity of nurses' work in a NICU means that taking breaks is often logistically challenging. The diversity of the nurse population also presents a challenge, as individuals have various values, beliefs and attitudes, which translate to different routines, both personally and at work. Some may want their breaks to align with their personal routine of tea and meals, while some may be flexible and take their breaks according to the flow of work. Similarly, some may rely on bodily signals, while some may take breaks as an opportunity to spend time with their preferred colleagues. However, individual and group purposes may not always be fulfilled, which can affect the negotiation process and create conflict among colleagues, which is indicative of negative social relations.

Access to timely breaks also means that employees are looked after at work, which is an indicator that the workplace attends to staff health and wellness. The workplace can also play a role in the negotiation process, where team leaders may plan breaks, or the CRN facilitates. This not only eases the work schedule but also makes nurses feel that they are looked after and treated equally at work. However, it is also possible that some groups will manage to take more breaks than others, and some may struggle to be relieved for their breaks. This can depend on the background and characteristics of an individual nurse or the category to which they belong. The power relations between senior and bedside nurses play a vital role in these kinds of inequality and injustice. This section reveals how breaks are shared and reciprocated among nurses.

[A] clinical support nurse [CRN] came to Clara's bedside and asked in a loud voice, 'Anyone need hand with anything?' 'No', Ella, Clara and Cody spoke together; Kaz remained quiet. She asked again, 'What about breaks? Can anyone go for early dinner?' Ella spoke, 'I can go now actually' and started handing over her patient, 'She is on SIMV [synchronized intermittent mandatory ventilation] 16 on 5, rate of 25 in 23% of FiO₂, Morphine turned down to 0.4 [microgram per kilo per hour], arterial line in'. (Fieldnote 18, p. 2)

The CRN is also known as the clinical support nurse, as this role has evolved with time. The primary purpose of the role is to assess the situation around the clinical area and provide help where needed. This includes facilitating breaks and relieving staff, as nurses are busy and find it hard to get away from their work. In this scenario, the CRN appeared to fulfil her role and met the workplace expectations for employee health and wellbeing. However, this role is not always available due to shortage of nurses allocated per shift. Negotiation in the above fieldnote seemed smooth and the management of breaks sounded acceptable to everyone in the team. Nurses took the opportunity, as per the nature of their work, and handed over their patients in critical conditions to their colleagues, in the absence of an assigned nurse. As there was a possibility of a delayed break, or even no break, nurses agreed to go for an early break, regardless of their bodily needs. This demonstrates trust and support among colleagues, which contributes to positive social relations of work.

While this break was supported by providing an extra hand, the following fieldnote excerpt details a scenario where the nurses negotiated among themselves.

Pearlie checked the baby and tidied up the wrap and looked at her plan. Nothing was due for the moment so [she] went to Kalyn and asked from the bottom of her baby's bed, 'Do you mind if I go to tea now? If you need hands, I'm free'. Kalyn said, 'No, I'm alright, go to tea, take the opportunity'. She replied, 'Thanks, I check with Neva too if she needs hands' and asked her from the other side of her own bed space, which was close to Bed 7, 'Neva, do you need help otherwise I go for my break?' Neva replied, 'Not at the moment, yeah, you go'. Pearlie had not asked Eli in Bed 8, but she also suggested, 'You better go Pearlie, then we can go too'. (Fieldnote 45, p. 2)

This shows that the nurses adjusted their personal and physical needs according to the flow of work. They had plans for patient care at hand, which were prepared at the commencement of shift according to the needs of the patient and the treatment routine. However, they did not have a plan in place for their tea and meal breaks and other needs. They seemed to negotiate their breaks during their shifts, when they had time amid the care of patients. Pearlie, an experienced nurse among those on the shift, started negotiating with her colleagues when she found free time on her shift plan. Although she prioritised her intention when speaking, she did not forget to check if any of her colleagues needed help before she went on her break. She went to Kalyn at Bed 5 first, with whom she seemed to work closely. Both had an immigrant background and they shared a similar skin colour—but differed in nationality and experience. Pearlie also asked Neva, who had a contrasting background and experience level to her own. With approval from both Kalyn and Neva, as well as volunteered approval from Eli at Bed 8,

she took the opportunity because she may not have otherwise had a break. The following extract demonstrates Pearlie's values.

It was half-past eight when Pearlie took her break. Since it was early morning, there was nobody in the tearoom to interact with. 'I was not so hungry, but...' She wanted to make sure all her colleagues could have a break, 'You know you have to escape when you have time, otherwise, we never know what happens'. (Fieldnote 45, p. 3)

This reveals the intense, taxing and unpredictable nature of nurses' work in the NICU, as well as Pearlie's feeling of responsibility for patients, the workplace and care for her colleagues, which matters a lot at work. Moreover, Pearlie's decision to have early break is also linked to her identity and recognition:

'I don't want to miss Noelle's round. She remembers my name, she doesn't have to ask me all these, "Pearlie, I haven't seen you for ages, where have you been? Are you all right? How are your kids?" She is really nice. To parents she introduces like, "Hello I'm Noelle, one of the doctors here", oh my God! She is so down to the earth.' (Fieldnote 45, p. 3)

Pearlie admires the doctor's approach to nurses and patients' families, and thus adjusts her break times to attend the morning round so that she gets to see Noelle. While Pearlie was recognised and respected by one of the senior doctors in the unit, she remained unrecognised and unacknowledged by senior nurses. This reveals her desire for identity, which she does not receive from her line of authority. Immigrant nurses struggle in this way for their identities to be recognised, which senior nurses could remedy by speaking to them—a small job compared with facilitating breaks.

While Pearlie compromised her bodily needs for her colleagues' convenience and her own desire for recognition, Addie struggled to take her break until late afternoon.

There's no support, I had no one here to help me, and they just left me. So that's the primary example that I hated, I hated that horrible (lightly laughs), like there's just no communication and they just come back because they all gone for lunch, I didn't get lunch until three thirty/quarter to four that day. (Addie, Interview 1, p. 2)

Addie was an experienced young nurse but relatively new to this NICU. This excerpt details how she ended up missing her break time. Everyone else took their own lunch breaks without making her aware. She was, in fact, forgotten at work with nobody to help or support her. If not facilitated by the workplace, breaks were supposed to be negotiated among colleagues, but Addie seemed to be left out. In this study this form of exclusion was experienced mostly

by immigrant groups. However, it also seemed to apply to junior nurses of local backgrounds, who were also not looked after at work. Moreover, in an intensive care unit (where the nurse–patient ratio is usually one-to-one and even two-to-one in some cases), the safety implications of leaving a full bay of patients with one nurse are of serious concern. It was unsafe for both patients and nurses—that includes both nurses at work and on those on break. Even more dangerous was that the senior nurses responsible for the workplace did not seem to be involved in the decision, nor did they take it seriously. Thus, it is evident from Addie’s statement that breaks are associated not only with personal suffering, such as workload, stress and hunger, but also with clinical safety issues, and require careful attention of management.

Taking breaks became more complicated when nurses were allocated to the side room, or to care for isolated patients in a separate room.

It was Friday morning; Carey, a casual nurse, was in the side room caring for a baby infected with VRE (Vancomycin Resistant Enterococcus). She sounded excited to see me [the researcher], ‘Ohhhh you came to see me! I had nobody to talk, you know!’ After all the background chats I asked about her break. She replied, ‘Yeah, Yeah. Judy relieved me. This room is very difficult; you cannot even go to loo; you know? Judy is nice; she said she would come to relieve me for lunch. [Lowering the volume] you know some in Charges are not considerate; they see from the window but do not pop in to ask how I am or offer relief. Sometimes I want to go to loo urgently but cannot find anyone to relieve me. Sometimes I want hot coffee but cannot. You know I don’t mind being here, but this is the hard part’. (Fieldnote 3, p. 2)

Carey was an experienced immigrant nurse working in a casual role. As there was only, she and a baby in the room, I was the only adult she could interact with. She looked enlivened to see people coming to her and appreciated the relief offered by Judy, the team leader. At the same time, she expressed the difficulty of being confined, which meant she had been there multiple times. While she admires the relief offered by the shift in Charge, she points out how some team leaders can be uncaring to the staff working in the isolation room. Although the other nurses in the unit were busy, they got to interact with their colleagues every now and then. However, in the isolation room, nurses were isolated with the patient; they could not leave the room, and it was not often that anyone went in to chat or offer help. This situation not only cut off the interaction and reciprocity practised between nurses, but it also affected breaks, including short bathroom breaks. Such a compromise of nurses’ basic physical needs is unsafe to themselves and the patients they are caring for. Lack of support and timely relief

for casual and racialised nurses, who are frequently allocated to isolation rooms are also culturally unsafe.

It is interesting to note that Carey, a casual nurse in the above fieldnote excerpt and Fiona, an immigrant nurse of colour in the interview transcript below appeared to be the ones allocated to the isolation room, who were often left unsupported for breaks in this unit.

Even if you organise your things and prioritise and do whatever time management, if someone doesn't come in to stay with the babies, you actually have to stand there in the corridor, and they will say, 'oh, I will come' but you never see them. You can't walk away to go and find them. So, you just wait there until you know a good Samaritan comes to offer. But they know it's their responsibility that they supposed to relieve you for your break. They know you can't leave babies alone to go for your break, even to the toilet. . . . I worked in another NICU before, if you are in a side room, people come left, right and centre to help you, to offer you even an extra break. This is why things like that surprise me here. . . . Because you are on your own and like you've got to change gown and gloves and things like that, and you can't leave your patient, sometimes they are very sick, they are intubated. . . . They know that this is medication time. Someone will actually come in and helps you with the drugs and someone will actually start doing them for you before you even ask for help. (Fiona, Interview, p. 5)

In this interview, Fiona not only described how the nature of nurses' work in the NICU did not allow them to leave the babies, but she also compared the two places in which she had worked. She described how nurses allocated to isolation rooms were better supported in her previous workplace, especially in taking breaks and doing medications. From Fiona's experience, this unit did not seem to comply with the responsibilities of a workplace. The lack of support was exacerbated when the team leader of the shift was inconsiderate or when the unit got out of control. It also depended on the kind of colleagues on a shift. The senior bedside nurses knew who was where and who needed to be relieved for breaks, assisted to check medications and helped with patient care, such as endotracheal tube suction. However, they did not seem to offer their support. As Fiona stated, it might be the case that nurses of her group were not supported because they were of visibly different race and ethnicity. If this were the case, it would suggest the presence of racism, bias and inequality in the workplace, which influence the social relations between senior and bedside nurses. Breaks were supposed to be supported by the senior nurses responsible for the shift, but they were often organised by the nurses themselves, like Pearlie and Kalyn. In particular, newly recruited or immigrant nurses, such as Fiona, were not supported, which is clinically and culturally unsafe. Although breaks are entitlements and linked with nurses' wellbeing in the workplace, these nurses did

not feel looked after at work. Taking breaks should be a two-way process of negotiation between bedside nurses and the workplace, which brings about a sense of belonging between these two parties.

SENSE OF BELONGING

The workplace is believed to be better when the environment fosters a sense of belonging. With a feeling of belonging, the workers trust each other, are supportive and inclusive. Colleagues, and the tenor of workplaces, play an important role in creating a sense of belonging among workers. Colleagues support each other by helping their co-workers accomplish tasks and by sharing their knowledge and skills, while the workplace can encourage the personal and professional development of its employees in an inclusive way. This involves respecting their identities, cultural differences and ethnicities, as well as recognising their prior knowledge, skills and expertise: essentially creating a culturally safe workplace (Ramsden, 2002), so that they can feel they belong. A sense of belonging is relational; it promotes confidence and togetherness, fosters friendship and helpfulness, and brings about health benefits and social wellbeing among colleagues. Workplaces are expected to create healthy work environments, where every worker is respectful, helpful and caring to others, but some employees feel othered in their workplace. This section presents empirical data and describes which nurses felt a sense of belonging, who was othered in the workplace, the power relations that played out in the including and othering of nurses and what effect this had on social relations in the workplace.

The following conversation is an example of a sense of belonging in the workplace, wherein nurses talk about their personal affairs with their colleagues.

Anita: [To Milly from the hand-washing sink in the corner] are you pregnant?

Researcher: [Standing between beds 26 and 27 close to Milly] are you?

Milly: Shhh... [Gave a smiley look and confirmed with nodding].

Anita: [Was still at the tap, did not see or hear the confirmation] sorry, I was joking.

Debbie: [Went close to Milly at bed 26 as she was at bed 23 then, which is just opposite to it] oh nice, congratulations, how exciting! [hugged Milly].

Milly: [In soft low-pitched voice with smiles] but I have kept it secret.

Anita: [Drying her hands looked towards Milly and Debbie] is it real? Oh my God! I was just joking, and it is true [laughed loudly].

Milly: Shhh.... [Supporting the baby with her left hand put her right forefinger in front of her closed mouth] I haven't told anyone.

Debbie: [Standing in front of Milly, with smiley face] how far now?

Milly: 13 weeks [baby still on lap, hands busy, talking with head and face movements].
Anita: [Sitting in the back-computer chair as Debbie left it] a lot of work for your mum.
Milly: [With smiles and sense of pride about her mother] she doesn't mind.
Debbie: [Sitting on the front computer chair] she is a machine.
Milly: [Laughing and agreeing with Debbie] yes, she is a machine.
Anita: Little friend for your daughter.
Milly: Yes [laughs], she kicks my tummy and I tell her not to, but she keeps on.
Anita: My son always kept his feet on my tummy. They know their siblings are coming.
Debbie: I think they protect; they want to play with their siblings from the beginning.
It's like Dolphins, they surround the pregnant one.
Milly: They protect as well, yes.
Anita: It's amazing, nature!
(Fieldnote 1, p. 2)

This was during the time when morning hand over was finished and the night staff had gone, but Milly was still cuddling the baby at Bed 26 in IMU Side B. Anita, one of the morning shift staff, was checking the bedside equipment such as oxygen, air and the suction in all beds. Debbie was at the back computer checking the records and reports to see if anything had been missed by the night staff, such as hourly observations or entries of feeds/IV fluids, and to establish an idea of the vital signs and general condition of the babies overnight. This conversation was an intersection of three nurses and their differing identities, roles and statuses. Milly was a white Australian senior bedside nurse, Debbie was a bedside nurse from the same background and they both shared a similar level of experience with Anita, who was an immigrant nurse in a casual role.

In this example, three nurses of different social and employment status engaged in a conversation where they showed interest in their colleagues and shared personal news while carrying on with their individual work. Milly's overtime stay to settle the baby, Anita's check of the bedside emergency equipment and Debbie's examination of the computer recordings were all nursing work, during which they were interacting. This spontaneity of work and interaction illustrates that nursing work is full of social exchanges. Moreover, nurses' values, attitudes and beliefs were evident in their relations. Anita apologised, thinking that she was wrong about Milly's pregnancy, Debbie expressed her affection for Milly by hugging her and Milly told her colleagues not to disclose the information to others in the unit. This was an example of intimacy among colleagues, wherein one shared her private good news and the others celebrated it with pleasure and goodwill. Milly even shared other family information and everyone in the team appeared to welcome it. This is indicative of them not only getting along and caring about each other, but also respecting and recognising each other's identities

and social positioning. Importantly, a casual staff member with an immigrant background, who may otherwise feel othered at work, was part of the interaction and valued like a regular staff member. This kind of close social relation among nurses encourages a sense of belonging, which is necessary for trust and reciprocity at work.

While the above scenario was a social relation observed in the workplace at a certain point in time, a similar experience of working in the unit was also reported by an individual nurse.

I think we've got a wonderful culture here and that everybody's very much a family; and I think family in the unit recognised that we're all quite close, we get along, everyone chips in and helps like you look tonight Jeff's baby is incredibly sick and just got back from theatre at seven o'clock and Kirby got to go home at eight o'clock, which is really good; everyone made sure she got out of the door on time and then there was about six of us helping Jeff get his baby stabilised and it's, you know everyone just chips in and it's all okay. People just grab things; you just ask for something and people would do it you know it's wonderful. (Alice, Interview, p. 4)

Alice was a young white Australian nurse, with a year of experience, all of which was in this NICU. Jeff was a white male nurse, born and educated locally, with six years of experience and Kirby was also a young nurse of similar background, with three years' work experience. This group seemed to be relatively homogenous in terms of race, ethnicity, nationality and language but varied in experience level and gender. Alice appeared to be satisfied with her colleagues and workplace, as she referred to them as helpful and the workplace as having a positive culture and 'family' environment. She also described how nurses help each other accomplish tasks and finish work on time, which is indicative of knowing each other, getting along and helping each other at work. This kind of cooperation brings about a sense of belonging, which leads to trust and reciprocity—all of which result in positive social relations among colleagues at work.

However, while the support and cooperation seemed to take place within this homogenous group, it is not clear from this interview with Alice whether this kind of help and support transcended categories such as immigrant status and casual employment. For instance, Fiona, one of the immigrant nurses of colour, did not feel helped. She said, '*You know that you are on your own, so you have to figure out what things are, how to cope with your workload*' (Fiona, Interview, p. 8). It was evident that Fiona did not receive assistance from her colleagues, as she appeared to be struggling to find a second checker for medication to her patient in earlier section. She was obliged to manage her own workload, which could mean

that she did not feel like part of the team, that is, she did not experience a sense of belonging in her workplace. The following statement illuminates how she struggled to carry out her work without help.

You know in IMU there are so many babies, and they can start crying at the same time. They can start screaming at the same time, if you are stuck doing cares you know you are glad you are changing someone's nappy and that one starts screaming, you can't leave this nappy to run to that baby. So, you've got to finish what you are doing, while that one is screaming and all the alarms are going off, someone who is, just stand[ing] there and watch[ing] you and see[ing] what you are going to do, just as if they are assessing you. (Fiona, Interview, p. 8)

Fiona's nursing work seemed chaotic and intense. She sounded stressed but had no support from her colleagues. Instead, she felt judged and left to struggle, which was not fair or safe when others were supported in the workplace. Nurses like Alice saw support everywhere but, for Fiona, even though she had colleagues around her, she did not seem to receive assistance when she was in need. Her race, ethnicity, social position and nationality intersected in this suffering. Although she was an experienced nurse, she was alienated and disadvantaged. Because of discrimination she was not supported at work. Thus, trust and reciprocity were deficient, and her social relations were affected, resulting in a lack of a sense of belonging.

Another message that Fiona communicated in this transcript was her feelings of being watched, observed or judged, which is similar to what Crissy described in the previous section. Fiona also felt that she was judged in the workplace and put in a separate space, where she was considered as if her existence and work did not have meaning. She said,

People in this unit are so judgmental, they don't know your experience, don't know your background, but they just you know look at you and judge you, and think, 'OK she doesn't know anything. She just belongs to the camp (giggles); she just belongs to the masses' (laughs). (Fiona, Interview, p. 17)

From Fiona's perceptions, it can be argued that the immigrant nurses were not valued for their contributions to the workplace. They perceived themselves to be ignored, their identities disrespected, and their knowledge and skills undermined. They did not also feel included, consulted for their expertise or empowered. White Australian nurses could confidently describe the support and resources available in the workplace and report that they were satisfied with their social relations with their colleagues and seniors. In contrast, the immigrant and coloured nurses described the workplace as deficient in a sense of belonging.

The worst case appeared to concern Moira, another immigrant nurse of colour. She was trained and had experience in a country with an equivalent level of health care, and a similar culture, to Australia. However, her experiences in Australia sounded adverse and non-constructive to the extent that she ended up questioning her own clinical competence, professional abilities and even her mental state. She sounded like she was trying to forget a bad dream,

Hope was an experience. I had never been on a ward that resisted me so much. All the other wards like me. Even here at Wave, they like me, 'Hi Moira where've you been?' You know when I went on leave, so nice, just have to be nice. But Hope! My God! I always thought there's something wrong with me. (Moira, Interview, p. 7)

She was telling it as a story, in an emotional tone. 'Hope' was the setting of this study and her previous workplace at the time of the interview. At Hope, she was perceived as problematic, whereas at Wave—her subsequent workplace—she was respected as a colleague and seemed to feel satisfied. She was comparing the two contrasting work environments—one where she felt rejected and the other where she felt welcome. One made her feel othered and the other gave her a sense of belonging. Prior to Hope, she worked in various other workplaces and was accepted as a qualified nurse and colleague. But, when she came to Hope, the distrust and mistreatment from (senior) colleagues made her question her own competence and lose confidence in her work. She saw a vast difference between this unit and other workplaces and realised that there was something wrong, not with her, but with Hope—it could not respect and accommodate diversity in practice. Why she found herself relating to colleagues and confidently doing her job in the other workplaces and not in this one remains a subject for discussion for nurses and the workplace. Moira's experience in this workplace was however, clearly shaped by an intersection of her race, ethnicity and nationality that has affected her sense of belonging and the social relations of work.

CONCLUSION

This chapter described how nurses in the NICU exchange trust and reciprocity. Knowing each other's identities, values, perspectives and expertise was shown to improve their social relations. Knowledge of one another enabled them to get along and contributed to trust and reciprocity between them. Getting along was shown to influence who gets helped or not, and therefore, how nurses helped those colleagues with whom they did and did not get along affected how they related at work. Similarly, negotiations about matters such as meal breaks

were associated with how helpful nurses were to their colleagues. All these practices taking place around nurses' work demonstrated how nurses feel the sense of belonging to each other and the workplace, which constructed their social relations of work.

The interactions between Anita, Milly and Debbie are examples of positive social relations. The qualities of collegial relation and intimate social exchanges between them constructed the ideal, emphasised by Harris (2017), where value and respect for diversity established inclusivity. Whereas, nurses such as Adler, Crissy and Fiona felt unnoticed, othered and unsupported. Adler was not helped by his colleagues when he had two patients in two different bays, each requiring urgent attention. Crissy felt a loss of confidence when she was called incompetent for asking clinical questions of senior nurses. Fiona experienced lack of support in many aspects of her work, including medications, questions and receiving relief when in the isolation room. While the social relations of work between Anita, Milly and Debbie count towards the expectations between nurses in a workplace, what Adler, Crissy and Fiona experienced clearly demonstrates how social exclusion influences fair social exchanges in the workplace. The disparity in support and recognition between the homogenous and heterogenous groups of nurses clearly demonstrates how culturally unsafe the workplace is. Hence, relating positively and caring about each other promotes trust and reciprocity among nurses, which is what matters at work for them. However, the intersection of the multiple social categories involved makes this a very complex set of social relations.

CHAPTER SIX: SUPPORT IN THE WORKPLACE

Personal, professional, collegial and social relations of work require examination for the assumptions around the support that nurses receive at work. Support in the workplace is conceptualised here as understanding of the workplace practices that assist professional growth, fair access to opportunities, and caring treatment. Senior nurses in the context of this workplace, are responsible for providing support to the nurses who work as care providers in the unit. Data collected in the unit are used here to examine whether nurses felt supported in the workplace, and the extent of the assistance or resistance, inclusion or exclusion and encouragement or discouragement nurses experience. The concepts of intersectionality and cultural safety help to identify inequality and injustice experienced by immigrant nurses in the workplace as intersectionality works as a tool to see those inequities and cultural safety helps addressing the issues of inequities in the workplace practice to bring about justice.

Nurses must receive support in the workplace to accomplish their everyday caring work, as well as to achieve personal, social and professional growth. The support in the workplace is expected to be inclusive for all nurses. The senior nurses are expected to help nurses acquire skills, offer constructive feedback and opportunities, and supervise in an unbiased manner. When successful this has a positive effect on social relations, which, will contribute to high morale, job satisfaction and enthusiasm towards work, in addition to augmenting employee health and the quality of patient care (Boorman, 2008; Burchell & Robin, 2011). In contrast, when these expectations are not met, the outcome can be a high level of frustration and lack of motivation towards work, developing problematic social relations (Fritz & Omdahl, 2006). Inequity and injustice are not limited to unequal distribution of resources and opportunities, but often include bullying, oppression and unreasonable performance management, leading to termination of employment and serious socio-economic and mental health consequences. This chapter explains how a support system worked among various categories of nurses within the NICU and how power relations were involved in its distribution.

LEARNING FROM SENIORS

Learning from seniors involves observing how the senior bedside nurses work and how they handle situations, while acquiring those skills in the clinical context. Some nurses in the study thought that seniors were the ‘think tanks’ and that they had a solution to every problem. They also felt that they had much to learn from them, and so they stuck to them at work.

However, others felt that ‘biggies are no better’ (Cody, Interview, p. 5), and instead found friends with whom to work with. The individual traits and attitudes of nurses also played a role, as some of the seniors—although they knew more than others—lacked skills in teaching, some were not interested in teaching, some were biased in teaching certain people, and others were intimidating to juniors. Some were good at teaching and had the knowledge, skills and interest but were not given that opportunity. Moreover, how nurses related to each other mattered to a greater extent. Some nurses simply liked to make the most out of the wisdom and skills of their colleagues, regardless of their background, while some may have judged by appearance and skin colour while consulting. This section reveals how nurses interacted with, and related to, senior nurses while learning from them, how senior nurses accommodated their approach and which groups of nurses were more supported.

I enjoy working shifts with the nurses who are incredibly experienced, so Rhona and Bobbie, I love shifts with them because you can learn so much in just one shift and you just gotta make the most of it ‘cause you know I think well they might not keep much longer because you know give them another 10 years they might wanna retire (smiles) that’s why I wanna make the most of my shifts with them and they’ve got so many skills you know compared to me. (Alice, Interview, p. 7)

Alice was young and inexperienced, while Rhona and Bobbie were experienced senior nurses. Bobbie was even more senior in role than Rhona. Alice, unlike her young workmates, such as Chloe (see Chapter Five, pp. 104-106), seemed to be interested in working with the senior nurses—despite the difference in age and experience. The pressing reason for this was her desire to learn from them, which benefitted her in developing her knowledge and skills in the clinical area. Alice was able to recognise who to learn with and what to learn, as discussed in Chapter Five. Regardless of any background or ethnic difference, she seemed to consult expert nurses for her learning. This kind of attitude not only received support from seniors, but it also nurtured social relations between the seniors and juniors in the workplace. Equally, Bobbie and Rhona also seemed to trust people regardless of age, experience, background and culture. They appeared to be supporting immigrant nurses at work and socialising with them outside work often. An example was their presence in Camisa’s house when immigrant nurses organised an informal get-together program (Fieldnote 46, p. 1). This kind of inclusive and non-discriminatory approach from senior and senior bedside nurses supported junior nurses, like Alice, and nurses from immigrant groups in their learning and development within the workplace. It also nurtured positive social relations between various categories of nurses.

However, these kinds of social relations did not seem to happen with other nurses in the unit. Kalyn, an experienced immigrant nurse, felt disregarded in terms of her opportunity to learn from seniors, *'No one has ever really given me feedback about what and how I do at work'* (Kalyn, Interview, p. 2). Kalyn revealed that, even though she approached the senior nurse—who was in a key role to support nurses' professional development—she did not receive information on the status of her clinical knowledge and skills. *'I spoke to Narelle, just to see how I was going, and she said everything was fine like she hadn't received like anything negative about me'* (Kalyn, Interview, p. 3). The feedback seemed generic and merely answered her question, rather than providing a detailed and specific critique on her strengths and limitations, encouraging her to learn more and helping her plan for the clinical progress ladder in the unit. Further, her initiation of appraisal was dismissed, which halted her path to learning and achieving the career goals in her progress plan.

I did, like a few months ago, I was supposed to do an appraisal like after I'd been in ICU for one year; but, no, they just hadn't gone back to me when I'm supposed to do it, like I got an email to say oh like we'll do it soon, and they're just busy, because they had to do other people as well. (Kalyn, Interview, p. 3)

In the interview transcript, Kalyn seemed to be aware of the professional development policies available for nurses within the workplace. However, although she started the process and followed up, it was delayed. It was not treated as a priority from those in the workplace responsible for staff development and progression. This was a form of exclusion—stagnating Kalyn from accomplishing her learning progression. She was overlooked in the workplace. Despite this, she sounded hopeful and understanding of her seniors.

Moira, another immigrant nurse with many years of experience overseas and in Australia had a more intense experience of learning with seniors in this unit.

On the day of my assessment she just gave up, she didn't assess me at all. Yeah so in the interview I said to the [senior nurse], Kasey didn't assess me, she gave up assessment before she could assess me. She says, "Oh yes because you failed". Oh my God, what? Kasey didn't even tell me what happened. She goes on, "oh because you did something wrong early in the assessment, so she just stopped assessing you." I just said, "you know Annie, I knew she was gonna fail me from the beginning. I've never worked with Kasey, she never trained me, all the time she was on maternity leave. Why didn't I have somebody who was here?" [She replied], "Oh, so what you wanna do, we can retrain you again, we gonna give another chance for another assessment." I said, "you know it's quite straight forward, I'll be failed again, so I don't think it's worth me going through another assessment. I don't wanna be traumatised again because I'm upset."

She is like, “why are you upset, what you think? I said, “because I, I don’t operate any differently from all the other girls; I have been working in ICU, I have been looking after ventilated babies. And now three and a half years later, you’re saying I can’t work with the ventilated patient! So, you mean all these babies have been risking their lives with me?” She says, “oh no no no, of course you know; I suppose, this is what we do, we have an assessment.” I said, “I like to actually leave, if you can have me here till December January, then I’ll be leaving, can you do me a favour?” And she says [tries to copy the senior nurse’s panicky voice], “oh OK, I don’t think anybody ever asked for that.” (Moira, Interview, p. 3)

This assessment was not supportive. Conducting it was, in fact, contrary to the unit’s staff support policy, which stated that as this was a supportive workplace, training and education are continuous processes. A support shift with a senior bedside nurse would be given prior to the formal assessment to identify learning needs and provide an opportunity to fill in gaps in clinical practice, and to prepare the staff for formal assessment, mentally and clinically. The assessment would be carried out three to six months from commencement of employment, before transitioning to ICU from IMU, or after a few months to a year of practising in ICU and for going into a higher role within the unit¹⁶. However, this did not seem to happen in Moira’s case. Instead, it felt like performance management for unsatisfactory practice and made her feel insecure that she was going to be terminated. Even so, according to staff assessment guidelines, the senior management is supposed to give enough information before, during and after the assessment. However, there was no effort made by the assessor to interact with Moira. She was called by the senior nurse directly to discuss the outcome. Moreover, the assessor, as a senior bedside nurse, did not precept or educate Moira, which can affect methods of work in clinical settings. Moira and the assessor did not work together, which indicates that they did not have established trust and rapport. Further, the staff assessment practice guidelines were not followed, the required feedback was not given, and Moira was not informed in a productive manner.

In addition, Moira had been in the unit for a few years and no such learning opportunity had previously been made available to her. She recalled her initial days, ‘*Lucy is the one who taught me for the two days Thursday, Friday. She was so good, you know she was so gentle and nice; she has just sort of gentle nature*’ (Moira, Interview, p. 4). While she appreciated Lucy (a white Australian senior bedside nurse) and her approach, Moira as an experienced immigrant nurse of colour was insulted by the senior nurse’s decision to retrain her and saw

¹⁶ Unit Policy of Assessment: not identified in references for privacy of the research setting

the re-assessment as a way to traumatise her more, paralyse her knowledge and skills and prove that she was 'incompetent'. She added, '*I don't impose my own ways, I follow the clinical guidelines, everybody should. I don't think I'm out of standards. I thought they didn't want me anyway*' (Moira, Interview, p. 4). She also gave an example of a colleague having the same experience, '*They did that not only to me but to others as well. You know Jeri, I heard they did the same to her as well*' (Moira, Interview, p. 5). The senior nurse did not seem to deny the fact that she was skilled but reinforced the unit protocol and the decision that the assessor made. A senior bedside nurse in the same role as the assessor had a different view, '*There's a way you can give negative feedback that people will want to improve upon what they did. And I don't think most people are good at that part*' (Cady, Interview, p. 6). This indicates that the assessor should have this kind of competence in her job. Perhaps the way of delivering the feedback was the reason that Moira opted to leave. She did express that sentiment in her interview, saying, 'Better to leave the place, where you are not respected' and it is certainly likely that. She might have taken the treatment she received as a sign that the senior nurses saw her as disposable. In this scenario, the assessor did not relate to Moira, nor did she speak with her during the assessment, clearly indicating that she did not have supportive intentions.

Hence, immigrant and coloured nurses were not supported by seniors in their learning and development. Instead, they were considered incompetent and disposed of, like Moira even though there were good policies in place to support them. The seniors were expected to support the learning needs of all bedside nurses equally regardless of their race, class, ethnicity or background. They have responsibility to provide mentorship equitably and act as a safety net for them, which was to utilise their expertise appropriately.

SENIORS AS SAFETY NET

The knowledge and skills of senior nurses meant that working with them was considered safe and secure. They worked smoothly and knew how to handle the problems and emergencies, so the junior and less experienced nurses, in particular, liked to work with them. This was not only for safe practice at work but also to learn from them. They believed that the senior nurses would prevent them from making mistakes and, in case of mistakes, they would have a chance to be corrected. They also felt that they had someone to ask questions and consult when they were stuck. However, only some nurses had access to that safety net, while others did not. This section discusses how support from seniors matters to juniors in their clinical

practice, how this kind of support effected the social exchanges between them, and why some nurses were supported and protected more than others.

I like the safety umbrella of senior person above me [laughs] 'cause it's, like I'm back from holidays this week; I've been away for nine weeks and they're very mean to like this morning and I was like 'are you kidding me?' [Giggles] like I had a ventilated baby for the first three nights and I was like 'Aghhh!' and she was day 1, but this one is completely different, she's so complex and there everything is going on, like I'm glad that there's a manual for everything just like I'm going constantly over it and I'm going through everything; this is a good thing, you should be checking what you doing and then they, they're all reassuring 'you be fine, you be fine' I'm like 'that's good for you to say guys but [laughs] I'm freaking out', so yeah. No, it's good to have, have the seniors as well as juniors, like I also enjoy teaching them; I like showing them things and how I did things ... I like a mix, but I like the idea that there's someone [laughs], someone senior above me, yeah. It's a safety net [continues laughing], you know what I mean, so yeah. (Addie, Interview 1, p. 3)

Addie was an experienced white Australian nurse but young and relatively new to this NICU. She had a short (holiday) break from practice, and therefore, wanted extra supervision. The reason for seeking this clinical safety was the mental state in which she returned from the break, the complexity of the patient she was allocated and the lack of support around her. She tried to find the resources to be able to operate and check things on the machines but felt that support in the manuals was not enough and too difficult to access, as she already had an intense workload. Therefore, she felt that the presence and assistance of an experienced or senior person would ease her work. While she accepted the need of a skill mix, that is, working with nurses that are junior to her and teaching them, she personally preferred working with seniors so she could feel safe, socially and clinically. Nurses' work is thus full of risks and demands support from the workplace in the form of senior bedside nurses as safety nets. Ensuring nurses' safety is thus directly related to patient safety, and support at work constructs social relations between senior and junior bedside nurses. This is also evident in another instance.

I guess specific time is when usually I'm with maybe a more senior nurse and we have a resource. That is a good day. Because I damn care all when Ava is working, they're usually good days, because I can ask her questions. Because I'm a new grad, I find that I have questions and it's good when I am working with senior staff because I can ask them questions. (Bree, Interview, p. 2)

Bree's statement indicates that she felt safe and had a good shift when she got to work with experienced and senior nurses. The nurse she mentioned was a senior bedside nurse and was,

as Bree described, resourceful. Working and relating well with a supportive senior nurse made a pleasant shift for Bree. Having extra help from a CRN and nurses like Ava thus proved to be a great support and safety net for nurses, especially those who were inexperienced, like Bree, or did not feel confident, like Addie. In fact, this kind of resourceful work environment not only boosted confidence in nurses, but it also ensured patient and nurse safety, which, as a result, nurtured social relations among nurses and allowed their differences to be co-constituted.

However, Crissy—another young nurse in the unit—seemed to have different power relations with seniors, in terms of her safety as a nurse.

You do get quite difficult families that come through and I mean it's fair enough, it's a stressful situation [for patient's family] but you don't have to put that stress on the people that are trying to help you, trying to look after you. And like management before, I don't know if that happens now but they would still always focus on that family and so the family got everything that they wanted and the staff member who had the problem got neglected from the management staff and so that staff member feels undervalued, even though they're working just as hard as the other person that's in their place now. And there was no, it's not faults like you know the family stressed blah blah blah. It made them feel like it was their fault, but the family felt like that, which should never ever be the case. And that's like nowhere a family centred organisation but when that is actually affecting the care of the baby that you're actually trying to care for then what's the point of being family-centred [laughs sadly]. I just don't get it sometimes like sometimes putting the family before the worker, before the baby, it can be more detrimental than actually focusing on most, really important, which is the baby and the baby's health. (Crissy, Interview, p. 9)

It is obvious from Crissy's views that she had not received support from the workplace. The patient's family was given priority and were heard, to the extent that their request for a different nurse was fulfilled. Crissy seemed to respect the parents' right to be supported with their sick baby in the hospital. She understood the fact that they were worried and stressed about the hospitalisation of their new-born baby, the strange medical procedures and the unknown outcomes. She was also aware of the family-centred care policy of the organisation and had been practising it in her daily routine. Her concern was why parents became difficult for nurses who were there to help them, and why their troublesome behaviour was paid more attention than the care provider. She meant that nurses needed support from management when dealing with difficult parents. However, the management seemed to problematise and demean the nurses as a way to appease parents. The consequences of which might have been

frustration, feeling undervalued and feeling unsafe and insecure at work, which would affect patient safety. Moreover, the seniors were not acting as safety nets for Crissy, but instead replaced her to meet the demands of the parents. More importantly, they did not have any conversation with Crissy before or after replacing her from the care of her patient to support her. The unspoken assumption here, is that the patient's family did not want a dark-skinned nurse and the workplace complied with their racist request. This was double jeopardy—she was victimised by both the patient's family and the workplace.

Adler questioned some of the senior bedside nurses' knowledge and expertise and challenged their status as safety nets.

I've gone over some advanced ventilation topics with some senior staff and I've got some interesting answers. . . . Pressure curves on the vent [ventilation] so the staff member couldn't make . . . because you guys haven't had those curves to look at before but it was basic mode of volume/ mode of ventilation so I think it's SIMV with volume guarantee and they couldn't . . . they couldn't clearly connect what that was saying in the settings to what was going on with the flow pressure curves. . . . We're talking about triggering and where's the infant's breath, where's the vent breath things like that, I just found a bit perplexing for someone to be CNS and have a bit of knowledge deficit you know but like they just pretend to know everything that I've got bulk of my time as an RN has been in intensive cares so I picked up a couple of things. (Adler, Interview, p. 4)

Adler was an experienced male nurse. He noticed some discrepancies in ventilation use in the unit and discussed these with the senior bedside nurses. However, he not only found them lacking in knowledge, but also reported their pretence of knowing everything and pride in their ways of working, despite the reality of their knowledge. He expressed doubts about their ability and eligibility to be senior nurses and, consequently, their value as safety nets was also questionable. How senior nurses could have come to be lacking in knowledge is addressed in the next section.

OPPORTUNITY TO GROW

Opportunity to grow involves the provision of learning and development framework in the workplace (Putnam, 2015) that develops the knowledge and skills to qualify for the clinical and career progress ladder and consequently advance in a position or role. These opportunities include online and practical training, in-service education, short courses and advanced clinical skills program, as well as encouragement and moral support, information, career advancement

guidance, constructive feedback and rewards. Importantly, a clinical progress ladder (see Appendix 11) is in place to lead nurses, step-by-step, to develop skills and advance. The workplace is supposed to assess individual circumstances and facilitate everyone equitably. However, some nurses in the study were encouraged to follow this ladder, while others were not. Obviously, there were nurses who wanted to progress faster and focused on ‘ticking the boxes.’ However, this does not mean that others did not have career goals, or the knowledge, skills, diligence and quality of work required for progression. As Ahmed (2012) argued, such plans and policies show the inclusiveness of the workplace, but they are not implemented—especially in the case of people of colour. This section uncovers the inequities that negatively affected the social relations and job satisfaction of nurses.

I just finished my grad cert in NICU, like I got my results on Friday, so I just am going to Uni. I think like maybe in a year's time I like start working towards getting or half of through next year, I can start working towards my CNS, I like to get one eventually but I went to the conference, the ACNN [Australian College of Neonatal Nurses] conference a couple of month ago, and I was sitting next to Erica with Alice; and Erica was saying like 'oh yeah like next year, we gonna get you girls doing T/L'ship'¹⁷, and I was like oh I don't think I can ever [giggles]. So, I like a little scared, I don't feel like I have the knowledge, nowhere near what other people do, so. (Cody, Interview, p. 4)

This shows that some nurses, despite having little experience in the field, were encouraged by the senior nurses to make plans for progression towards career objectives and did not have to initiate the process themselves. Cody is an example of such encouragement in the young group, who was informed about a career path and how to achieve her goals. This was an opportunity to grow and receive the support of the workplace. In other words, Cody was on track to progress in the unit and she was provided with a ‘staircase’ to climb. She seemed to be constantly in touch with her senior colleagues so that she could receive constructive feedback and be updated about the next steps to take. This kind of encouragement presumably made her feel enthusiastic about her progress, as she had completed the courses required for progression. Although she seemed to be surprised by her senior’s encouragement and was aware of her own inadequacy of knowledge, she seemed confident about her professional goals and progress within the workplace. This means that a close social relationship existed between Cody and her seniors, and the favouritism was working to construct this kind of opportunity for her. Hence, her Australian background, whiteness and social position in the core group intersected to produce opportunities for growth and fast-tracked career progress.

¹⁷ T/L’ship is a speech shorthand that the nurse used to mean team leadership or in-Charge ship

However, as Adler argued in the earlier section, these were the categories that seemed to matter when getting senior positions, but these may be the people with less clinical expertise.

A similar opportunity was offered to Margot, an Australian nurse who was older than Cody and had more experience. The following interview excerpt explains how she felt about the encouragement.

They wanted me to do my CNS and I didn't, I don't wanna do that. Because I still don't feel that I have enough knowledge to do that. I just don't think that I am in myself I don't feel that I am ready to be in charge of a ward at night with a junior registrar and no other CNS because you don't have a CNS either, and if they are just relying on my knowledge I just don't feel [pauses] it could go really well, but it could go pear shaped as well. And I think it could go horribly wrong and I don't wanna be responsible for causing a baby any harm because I didn't know something so. So, I don't wanna do, I really don't wanna do my CNS and I feel that because in a way I feel like because I won't do that, I am not sure where I fit in now, because I am not sure whether they only want me here because I could have been a CNS, and so I am not sure what the future holds for me, because that's what they saw for me, but it's not what I saw for me. So, I am not sure, whether there is a spot for me here because I won't do that. So, I am just hanging in there. (Margot, Interview, p. 6)

Margot seemed to have different views about fast progression. She appeared sincere, true to her capabilities and able to estimate the safety of patients, as well as the nurse. While it could be interpreted as the lack of confidence to take on more responsibility and accountability at work, she did not believe in progression without the required knowledge and skills. However, she seemed to feel pressured, and that made her concerned about the outcome if she did not go with the flow. Margot did not seem career-oriented, like Cody, but she was supported and encouraged by senior management. She was expected to rise, but she did not want to take up the opportunity because she was mindful of the risks. She was honest and felt accountable for her actions, and the possible consequences weighed heavily on her at this stage. Despite her skills and experience, she was hesitant, and the pressure made her worried about future power relations with her senior colleagues at work. While her background, nationality and race intersected to produce the opportunity to grow, her work values, honesty and wider job experience governed her decision to not seize that opportunity.

While Cody was enthusiastic and willing to be encouraged and Margot was not, immigrant and coloured nurses did not have mentors to support their learning in the unit. Fiona was one of the nurses who struggled to access a mentor, even though she made multiple requests.

You supposed to have a mentor who supposed to, you know, help you with your progress, but then, you know, people went on maternity leave, people got promoted, and then, you are just, you know, left without anybody. When one of them went to maternity leave, I was assigned to somebody else, then she got a promotion, and then, nothing happened after that. (Fiona, Interview, p. 1)

Like everyone, Fiona was entitled to the support of a mentor for her learning and progress in the workplace. She seemed to get one replacement and none after that, which is a form of bias and discrimination in the workplace wherein nurses perceived to be of 'other' categories are ignored or neglected. Fiona's immigrant background, quiet nature and brown skin intersected in the construction of this injustice. It was unusual that her mentor, upon progressing within the unit, abandoned her. The mentor should have continued to support her, as senior people are more responsible for staff's wellbeing. However, there was a big gap in actual relations between the mentor and the mentee. It was up to Fiona to enquire from her side, but she seemed unsure about the process, '*You don't know who to ask, because, like, they are supposed to allocate you somebody, but no one says anything about it*' (Fiona, Interview, p. 1). This means that there was a clear lack of information and communication between the senior and bedside nurses, who were particularly different in background and race. Fiona did not have anyone to guide her, provide information on avenues of progression or give feedback on her clinical performance.

A similar case concerned Crissy, who, despite her childhood and education in Australia, experienced discrimination in her clinical progression because of her race.

When I was transitioning up to the ICU, I was the last one in my batch to go through; and I was doing the post-grad certificate via the college so it was done through the unit, but I was the last one to get into ICU. So, like people who I did my new grad placement with, who [weren't] doing the post-grad certificate, got transitioned up to ICU before me. Not gonna mention any names [laughs]. And it made me feel like you know 'how am I supposed to do this course when I don't even have experience to do it'. I mean I got through it and I got good grades but like you know I could've done so much better if I had that [pause] opportunity. (Crissy, Interview, p. 6)

The ICU transition was the progression of nurses from IMU. It could be done one-by-one, or in a group of two or three at a time. Thus, Crissy could have transitioned with her batch mate, with whom she commenced employment in the unit. However, she did not get her turn, despite her enrolment in the graduate certificate in neonatal intensive care, which requires ICU experience during clinical placement. Nurses who were not doing the course, and could

wait their turn, were transitioned before Crissy and she was left to wait till last. It does not seem to be a coincidence that she was the last as she could have been transitioned in a duo or trio, so that she would not have felt that she was the last in her group. What seems important to be considered was her course, which was facilitated by the unit, directly relevant to her work and required practice in real situations to learn, write assignments and sit exams. All of those involved in designing this transition process did not seem to support for her, care about her feelings and needs or see the need to provide learning opportunities for her. This has implications for understanding the way immigrant and coloured nurses are side-lined from opportunities to grow.

Further, Crissy spoke not only about the discrimination against herself, but she also revealed that she witnessed some of her other colleagues being targeted for discouragement.

They like you know it was very 'I'm gonna pick on you' that kind of mentality like you know I mean we had a few male nurses who got picked on and ultimately left because they couldn't deal with it anymore. I don't think that's a healthy situation and like you know there's been a few people that [have] been handpicked like you know targeted; and instead of giving positive feedback like you know telling that where they can improve, they would just say exactly where they did go wrong but never gave suggestions [of] how to fix that and therefore it kept on happening; [their] confidence was lacking, and ultimately [there was] no learning, no progress, they were stagnant in their positions, they remained in IMU for ages. (Crissy, Interview, p. 6)

Crissy pointed to the negative workplace practice of blaming and discouragement of the nurses of 'other' categories. Instead of supporting them to grow at work, the senior nurses seemed to be driven in the opposite direction. 'Picking on' seemed to occur with nurses who were new, quiet and judged as 'different' by those who were experienced and in senior roles. This was not only an inability to co-constitute the identities of others and share workplace opportunities, but also intimidation and bullying that was discouraging and destructive to those who were othered. As Crissy stated, their confidence became lower, and their learning progress stopped—creating an impasse in their development. The nurses suffering this kind of harassment and stagnation were most commonly those with immigrant attributes related to race, class, gender and skin colour. Although all units of the hospital had equal opportunity policies in place to support all staff equitably—regardless of any diverse characteristics—these policies were contained within their files and folders. In practice, they were not used, and nurses of diverse backgrounds were victimised either directly and obviously or indirectly and subtly. This kind of injustice has a negative effect on social relations between nurses.

CONSTRUCTIVE CHALLENGES

Constructive challenges provide ways that workers can advance their learning and development within a workplace. Examples include encouraging nurses to take patients with more complex health conditions, giving them extra responsibilities and teaching them how to deal with unique and difficult events in the clinical context, while supporting them from outside. These positive challenges develop skills and experience among nurses so that they can handle complex clinical situations. However, in the study location, there was huge variation in the nurses giving and receiving these challenges. Some seniors liked to challenge, and some did not want to take the risk of allocating complex patients to junior nurses. Similarly, some juniors were given challenges and support, while others were not. Local nurses in particular were favoured, and immigrant nurses were discriminated against. Even though many immigrant nurses had previous experience, they were not given the opportunity to practise their skills, which resulted in deskilling. This section uncovers how a positive challenge at work proved to be helpful in developing nurses' confidence in problem solving and how it nurtured one intersectional group over others.

I find some of the educators might recognise certain work that you wanna shift and then like I had one that said, 'oh put you onto the study the advanced neonatal concepts study day'. I was like 'oh okay!' I just said, 'I think I'm ready for it'. So, it was just different things they see I've had like when worked with one of the NUMIs . . . she was doing some clinical shifts; she was our resource person; she said, 'you take the baby on nitric oxide'. I said, 'Oh, I haven't had nitric yet', 'you take it', she said, 'and I'll help you'. So, it seems like that they move you forward a bit and you take on the more challenging patients. I think also I had to do my like annual plan and everything to yourself so I did my forms, development plan and they'd just like I've been encouraged by person with me, she said, 'you need to take more challenging patients', she said, 'that's the only way you[re] gonna learn' because [it's] so [much] easier just to take the ones that you know you[re] gonna be OK with and I don't have other people to help but it was probably [the] best advice I've been given to take the complex patients. Because you just learn so much and people are encouraging you to learn so. (Alice, Interview, p. 1)

This is an example of how nurses were given useful challenges to tackle and from which to learn. The senior nurses were responsible for providing these kinds of supportive challenges to nurses working in the unit, to develop clinical knowledge and skills required to care for patients with different complexities of health conditions. This kind of support from the workplace empowers nurses clinically, to be able to maintain safety for patients as well as

themselves, as health care providers. The senior nurses seemed to provide that, in the case of Alice—a young and minimally-experienced local nurse—who sounded enthusiastic about learning and ready to take what was offered. However, these kinds of positive challenges were expected to be equally provided to all nurses working in the unit. The equal distribution of such opportunities would enable everyone to develop skills and contribute to quality patient care. It would also make everyone feel valued and looked after and foster positive social relations among the diverse group of nurses. The following interview excerpt is another example of how constructive challenges were distributed among the nurses.

I had several occasions I had a baby with nitric and like it was really complex unstable baby and a bit sick baby you know and several senior staff [were] on it and she's like 'Addie I've given this to you, I think you need, I think you can have a challenge'. I'm like 'Yes, brilliant!' [Excited] I've got to say that. And she backed me up saying 'you've got Judy as a support so you can ask her if you need'. And like, yeah, Judy is another good one, she puts me in the situation like that. But Chiara is very much like that, she's like I think you need a challenge. (Addie, Interview 2, p. 4)

As Addie was experienced in caring for complex patients, she looked pleased to have had such a baby and she appreciated the trust and generosity from Chiara—one of the senior nurses in the unit. Addie also felt gratified when Chiara allocated a senior bedside nurse who she admired for her support and back up. As mentioned earlier, the challenges and learning prospects were expected to be equitably distributed among nurses to ensure fair and just opportunities. However, it seemed to be influenced by personal choice and the social relations between the senior and bedside nurses. Fiona, for example, appeared to be a victim of this inequality.

They don't give you the opportunity to learn and they still expect you to know, so, that's big challenge for me. You know you try to learn as much as possible and you try to push yourself which is why I try to do a post graduate studies so that you improve your confidence levels. But even doing this, if you are not put in a situation where you can actually learn something new, you don't get to an advanced level. You know you are in IMU most of the time, it's like changing nappies and feeding those babies, you don't get [the same] learning opportunities as everybody else at your level (Fiona, p. 19).

Here, Fiona described how she experienced a lack of opportunities to learn, which is unlike what Alice and Addie reported. While Alice and Addie were naturally offered challenges to learn, even with extra support to ensure safety, it did not seem to happen in Fiona's case,

despite the fact that she was an experienced nurse trying to advance her expertise in the field. Alice and Addie's needs were assessed without their awareness. They were given study days, information about performance development and learning opportunities without asking, and were supported with extra hands and expertise from all sides. However, for nurses like Fiona, nothing seemed to be available from the workplace. The senior nurses were responsible for this disparity in learning and the development of nurses. Since the immigrant and coloured nurses, such as Fiona did not receive support in the workplace, they looked for avenues of learning and advancement themselves, either within or outside the workplace, such as through a university degree. Even though they sought out and studied degrees, they were not supported. Crissy was another nurse who was victimised by the disproportional distribution of opportunities.

...you know how the college course, you have to do three competencies, two days each and like you know how can you do those and pass them with no experience in ICU? Like basically my first competency was done like my second week into ICU. Yeah it was with ventilated patient as well like I was supposed to just be with a like, I mean I was with an educator for the competency but I was supposed to be with the non-vent patient but I was with the vent patient and then my second competency was supposed to be with the ventilated patient; however, I got a really, really unstable vent for that competency and then my last competency was with like an unstable vent and they gave me high-frequency, which I'd never ever looked after before, and so I had to do competency based on that. (Crissy, Interview, p. 6)

Crissy was transitioned to the ICU with the last of her batch mates even though she was required to be there first for her clinical knowledge to be synchronised with the theory she was studying. Consequently, she had to do the competency assessments required by the course, when she had only just transitioned to ICU, which affected her ability to face the assessment. Support for undertaking her course was already out of her reach. Worse, she was given patients more complex than her capability. Although this section argues for an equal distribution of constructive challenges, this challenge was not constructive for Crissy, who had just transitioned to ICU. Instead of supporting her with more time to learn complex cases and prepare for the assessment, her seniors gave her unfamiliar challenges that seemed to be intentionally counterproductive. This is typical of the disadvantages and injustices that nurses like Crissy experience in the workplace. Nurses of colour were either not given opportunities for learning and development or were given unreasonable challenges, which made them feel intimidated and harassed or caused them to struggle and eventually collapse. These

discriminatory practices also affect autonomy in practice, which some nurses get to enjoy, while others do not.

AUTONOMY IN PRACTICE

In a clinical setting, autonomy is the authority to work independently and the freedom to make decisions based on clinical circumstances, using professional knowledge and expertise. While nurses in this unit seem to be respected and listened to medical professionals, the hierarchy and power relations within nursing, appears to complicate the dynamics of social relations of work. This seemed to be more problematic in the case of nurses from immigrant and coloured groups. While many nurses enjoyed the freedom to make clinical judgements regarding patient care, and their judgement was respected by their seniors and doctors, some nurses were frustrated because they could not practise their skills. Another facet was that some nurses were trusted, and some were not. Regardless of their experience level, the nurses from local backgrounds were trusted and allowed to make decisions, while the nurses from other backgrounds, even if they were experienced, were not. Therefore, autonomy in practice was associated with support at work, which was not always fair and free of prejudice. This section unveils the dealings relating to autonomy in the unit, how it was practised, and which groups of nurses were more supported to practise autonomously. The fieldnote excerpt below provides an example of autonomy in practice.

The team was now at Bed 19. Chanel, the nurse working on that side mixed up with the team members in line to the left of the baby. Reena briefed the feeding plan and Ash added details on [the] general condition and the progress that the baby was making. The mother sitting in the chair cuddling the baby agreed to the conversation, 'Yeah, he sucks [on the bottle] for 20 minutes and falls asleep but he will get there'. Bishop looked to Chanel and asked, 'Any other issues?' She just shook her head with smiles. Lulu spoke instead, 'Try breastfeeding twice a day'. 'OK', the mother agreed. Bishop also agreed, 'Yeap'. Rosie noted it on the plan sheet. (Fieldnote 8, p. 4)

Chanel, a young nurse, was teamed up with a male nurse, Jeff, in IMU Side A. From left to right, Ash (one of the neonatal fellows), Bishop (one of the neonatal consultants), Reena (AHCP), Sona (AHCP) and Rosie (CRN) were surrounding the baby and the mother at Bed 19. Jeff had just finished the stoma bag change on the baby at Bed 17 and was entering the details in the computer. Chanel was fixing the infusion pump for that baby and Lulu (one of the experienced RNs on a specific role) was talking to mother of the baby at Bed 20, before she also joined the round. Reena was concerned about the feeding capability of the baby at

Bed 17 and Ash was concerned about his clinical condition. The mother was hopeful about the baby's progress on sucking. Bishop was collecting more details from the nurse directly involved in the care of the baby. He also sought to address her concerns about the baby's care. Lulu advised the mother to breastfeed twice a day, which everyone agreed with, as limiting the feeding to two sessions was expected to decrease his tiredness. They also acknowledged that a switch to breastfeeding had benefits, including the control of milk flow and the promotion of bonding between the mother and baby.

The consultant's round looked like democratic practice, where everyone's views were respected. Nurses were asked for their concerns and opinions, as primary care providers and advocates for the patients, and their suggestions were taken up. This shows that nurses had significant interprofessional autonomy in this unit and the usual power imbalance between the doctors and nurses was lessened in daily practice. Here, the intersecting categories were various professions and nurse positions. The above scenario corresponds with Crissy's experience of autonomy in the unit.

[I]n regard to advocating for patients I find that I can do that with doctors, with senior nursing staff and I feel comfortable in suggesting at ways of doing things to a junior person as well. If a senior person hasn't thought of that way, I will step up and, I feel comfortable in that [laughs] like I don't feel like people are judging me for actually coming up with an idea. (Crissy, Interview, p. 2)

Crissy seemed to enjoy the freedom of advocating for her patients as their direct, continuous care provider. She did not seem to hesitate in suggesting ideas for the benefit of the patients, despite her junior status, and her ideas were respected. Although the final decision rested on doctors and senior nurses, the nurses working on the floor were able to influence decision-making. However, Crissy also pointed out the fact that social relations augmented the power of autonomy.

It's nice when they actually listen to you and everything aim for the most part they will do but you know you've got the special doctors who you have a little bit more rapport with so that makes thing like you know suggesting things a little bit more easier as well. Like the other day I went up to a doctor and I was like 'this baby needs to be extubated now' [laughs]. (Crissy, Interview, p. 3)

This demonstrates that nurses felt valued when they were listened to. Because they were at the bedside with the babies, they knew the cues for the progress, stability or deterioration of their conditions. They also knew the manoeuvres that were used, or were to be adopted, in case of a

change in a baby's condition. It was expected that this professional expertise and knowledge of patient health would be respected, and that the nurses would feel recognised and supported at work. Importantly, this appeared to give them a feeling of autonomy in practice, which came from good social relations with doctors. Nurses felt free to say what they saw in the patient's condition and suggest the action to be taken. For example, Crissy's proposal to the doctor illustrated how nurses judged the patient's clinical progress in a high-tech care environment and communicated with their colleagues. Crissy demonstrated appreciation of the process of influencing decision-making indicates that nurses in this unit had a substantial degree of autonomy. However, some nurses (especially those who had worked in other facilities) felt that there was a lack of autonomy. Addie, for example, felt restrained from using her skills in practice.

I've come from the background of adult intensive care for I think two and a half years and then came here, I needed to change. I just felt like I wasn't growing, I was going backwards in my skills 'cause in adult ICU you [are] pretty much forced to do your own decisions and changes and stuff and then go to the doctors and [say] 'this is what I've done and this is how it's improved'. Here you can't do that, you gotta consult the team leader and the doctor and go 'ok what you want to do?' Do you know what I mean? (Addie, Interview 2, p. 3)

Addie was a young nurse with ICU experience who came to the unit over a year ago. It is evident from her statement in the interview that what she had practised in her previous workplace was restricted in this one. The skills she had acquired could not be practised, which resulted in deskilling and stagnation. She felt a lack of autonomy in decision-making, as she had to consult the nurse in charge, as well as the doctor, and ask for their decision regarding any changes in patient care. She was frustrated by not being able to make suggestions or decisions on interventions based on her judgement of clinical situations. This means there was interprofessional autonomy but not intraprofessional autonomy—perhaps because of the hierarchy and power distribution in nursing—that was affecting the social relations between Addie and the senior nurses.

Adler's experiences in the unit were similar to Addie's, in terms of restrictions, but also slightly different as to the ways of doing things.

I [would] much rather adhere to the protocol but make [it] patient specific as well because I've done a lot of different jobs in critical care that, I think that's what Annie is trying to encourage but there's a way that the unit runs at the moment with the senior staff is that they're encouraging very blanket . . . generic 'you must do the way we do' .

. . . without stopping and thinking about things. I think that's nothing that she wants to address but it's very difficult when you've got staff, you've got lots of staff here that have been here for more than 15 years. And it's very hard to change that culture but yeah so if I do work with the junior staff member[s], I like to encourage them to try thinking a little bit laterally, yeah. (Adler, Interview, p. 3)

Adler was a male nurse who had a decade of experience in adult ICU before coming to this unit. He believed that nurses should be allowed to make practical judgements in patient care, directed by clinical guidelines. While the senior nurse seemed to be open to, and supportive of, his ideas, they were restricted by senior and experienced bedside nurses. This indicates that the power relations between hierarchies and categories were imbalanced. Moreover, Adler saw the attitudes of these senior bedside nurses as problematic to the nurses who liked to practise in an innovative and creative way. This could be regarded as a lack of autonomy and an unconstructive culture in the unit, which discouraged novelty and originality. Adler also found that it was hard to change this kind of culture because of the large number of nurses in the unit who were hindrances to the change. Therefore, he was inclined to encourage new and young nurses to think and use their senses in assessing a patient's condition and evaluating nursing interventions. However, he seemed equally careful not to go away from the clinical guidelines and policies while making patient-specific, condition-based and individualistic care plans to care for patients.

Senior nurses were also identified as problematic in an interview with Rosie, a young nurse with some prior experience, who joined the unit almost two years ago.

Yeah with Chiara I think some days I found . . . [thinks] I felt like there was, had to be a lot of control on her part and I can understand that because you're responsible for everyone but sometimes I felt a little bit [of a] lack of autonomy I don't know how to explain it like there's so much control, you have to feedback so constantly that you didn't feel like you had any autonomy yourself. (Rosie, Interview, p. 6)

Chiara was one of the senior nurses in the unit and was experienced in neonatal nursing. While it is understandable that she had fixed ways of doing things that she developed over decades of working in the same field, it was equally important for her to trust and respect others' expertise and ways of working. However, she seemed to exert her power over nurses by making them constantly consult her for permission to do procedures and constantly report information about what was going on in a clinical scenario. This made the nurses working with her feel controlled and suffered a loss of autonomy in practice, which has implications

on social relations between senior and bedside nurses. This also relates to what Addie and Adler experienced and is indicative of a lack of autonomy.

CONCLUSION

This chapter analysed how support at work affected nurses' social relations of work. Bedside nurses viewed the expertise of, and support from, senior nurses as clinical resources available to them, to facilitate their accomplishment of work. Nurses mobilised these resources in the workplace to provide opportunities to learn, practise and grow in their clinical practice. As experienced and senior bedside nurses had more knowledge and skills, they were considered clinical role models and they provided guidance and mentorship to the junior bedside nurses. They were also viewed as safety nets when they readily answered the questions of junior bedside nurses. Hence, support at work was instrumental in providing opportunities for nurses to grow professionally within the workplace. The provision of constructive challenges for learning complex problem solving developed the clinical skills of bedside nurses. This kind of professional development was also linked to the development of autonomy in practice, which determined feelings of social worth at work.

Support in the workplace enabled nurses to acquire more skills and gain the expertise to provide quality care to their patients, assisted their personal and professional growth within the workplace, which led to opportunities for promotion, and gave them confidence and the feeling of being safe and cared for in the workplace. Some nurses, such as Alice and Cody, experienced these elements of support at work. However, nurses of colour, such as Kalyn and Fiona, were excluded. Disproportionate access to resources and opportunities made a difference to how these nurses achieved through their social relations of work. Importantly, this kind of inequality demonstrated how immigrant status, as an intersectional category, was a major disadvantage among nurses, wherein immigrant nurses were rendered clinically and culturally vulnerable. This vulnerability constructed the workplace as uninhabitable for some nurses of different ethnicities and races, resulting in lower job satisfaction and high turnover of staff in the NICU. This defeats the reasons for encouraging skilled migration of nurses.

CHAPTER SEVEN: HAVING A GOOD SHIFT

[Having a good shift is] knowing that you are working with someone who you can laugh with, you can share a joke with, you know you can negotiate your breaks, negotiate your work plan and you know, just get along. Because, you know, everybody at the end of the day goes to their house, and then you know you just have to cope with me for a few hours [laughs].

(Fiona, Interview, p. 15)

NICU work can be demanding and stressful. However, as Fiona expressed, if we have good co-workers, with whom we get along, relate socially and emotionally and share hardships and mutual support, and we get to our breaks on time and, most importantly, feel satisfied with the care we provide to patients and their families, it is still possible to have a good shift. The social, emotional and cultural aspects of having a good shift are related to nurses' experiences in their workplace. These include feeling supported and looked after at work; encouraged to take on challenges and mentored in educational opportunities; recognised for skills, identities, strengths and contributions; and trusted, helped and included in the workplace. Hence, what matters at work for nurses is the quality of collaboration amongst colleagues within the work environment, the support received in the workplace and the people nurses care for, which are all related to the social relations that characterise their work.

Having a good shift is difficult when the social relations of work are challenging. The effects of white privilege can pose such challenges that include inequitable distribution of resources, unequal opportunities, exclusion and alienation, and discrimination and disadvantage between nurses working in the unit. This has the potential to cause impaired social relations between the bedside and senior nurses responsible for managing the workforce. While inequity is a common concern in workplaces, the effects of heterogeneity, brought on by global migration have increased the complexity of these challenges. Global migration and the shortage of skilled human resource has made Australia's health care workforce multiracial, multi-ethnic and multicultural (Kingma, 2001, 2008). In this context, local nurses are expected to value the work of immigrant nurses and ensure they feel welcome in, and belong to, their new workplace. However, instead of enriching the workforce with diversity, immigrant nurses are subject to the colonial and imperial logic that produces inequity and injustice (Said, 1993; Young, 2016), that are seen in many places, including this NICU.

Underpinned by the theoretical and conceptual understandings discussed in Chapter Two, this chapter unpacks the interlocking and overarching issues of diversity, safety, and social justice that emerged out of the synthesis of ethnographic data analysis reported in chapters five and six. The first half of the chapter discusses how nurses experienced the effects of whiteness of the unit on their everyday social relations of work that influenced whether they had a good shift. These everyday issues include whether nurses were included or excluded, recognised or ignored, encouraged or curbed and looked after or neglected in the workplace. The last half considers the implications of the disparities in how nurses were treated in the unit. These implications involve a reduction of diversity to mere numbers, rather than capitalising on it as an available resource; poor use of human resources, rather than recognizing and utilising skills to prevent wastage and deskilling; patient safety as rhetoric, rather than reality; and attrition among nurses, rather than them feeling supported and looked after in the workplace so as to prevent turnover.

WHITENESS AND WHITE PRIVILEGE

Australia has three broad layers of cultural population: Indigenous Australians (Aboriginal and Torres Strait Islander people), white settlers, and international immigrants arriving after the initial colonial settlement. Although white settlers were immigrants to Australia, they occupied the country, established imperial power and dominated social and cultural practices, language and customs. The system of whiteness ensued and governed Australia by colonising the established structures and institutions with British traditions. Colonial power usurped Aboriginal and Torres Strait Islander peoples' sovereignty over their lands, languages and knowledge as well as their own traditional health care system. The white-constructed health care system that was imposed disregarded Indigenous knowledges and therefore, did not train or employ Indigenous peoples (Best, 2015; Usher & Best, 2010). Instead, the race laws and acts of Protectionism and Segregation between 1890s and 1950s imposed on Indigenous peoples restricted their rights of movement and employment opportunities (Best & Bunda, 2020). Racial superiority was established, and Aboriginal Australians, Torres Strait Islanders along with various waves of immigrant people of colour were discriminated against (see, for instance, the White Australia Policy that was about Chinese immigration specifically at Federation). Australian Human Rights Commission (2017) refers to these discriminations and prejudices based on skin colour as racism that creates privileges for those identified as white and disadvantages others. While racism is an injustice that comes out of whiteness (Bhopal,

2018; McGibbon et al., 2014), whiteness is the system that dominates Australian organisations including health care services, and the experiences of immigrant and coloured nurses offer a way of exploring the whiteness of the Australian health care system.

A key assumption of whiteness is that it is blind to racial differences in the workplace. The operations of whiteness interact primarily with the diversity of races, ethnicities and intersect with gender and expertise to increase the power of some categories over others. Another assumption of whiteness is that its effects occur knowingly or unknowingly, meaning senior nurses in the unit may or may not be aware of how whiteness influences their actions or those of the organisation, and hence remain unexamined in the social relations of work. McIntosh (1988) explains how whiteness of people and an organisation deliberately or unconsciously oppress the people of colour. Whiteness works in the form of racism in the health care of Aboriginal and Torres Strait Islander people in Australia, where their cultural needs are dismissed (Lavery, McDermott, & Calma, 2017). While the health care services are not fully able to achieve the culturally safe care for Aboriginal and Torres Strait Islander people, the cultural needs of immigrant patients are also challenging.

NMBA (2018) code of conduct outlines the expectations of nurses to practise in culturally safe ways that include: knowing one's own culture, values, beliefs and attitude and how it affects others; an interest in understanding others' culture, values and beliefs and respecting them; and supporting an inclusive work environment and role modelling. Such approach, however, requires an integration into workplace policies and implementation in day-to-day workplace practice. CATSINaM (2015) is a representative body tasked with developing and implementing cultural safety strategies in health care and education, and recruitment and retention of Aboriginal and Torres Strait Islander nurses and midwives. Nurses and Midwives Unions, the Fair Work Ombudsman (n.d.), and Australian Human Rights Commission (2019) are available to help immigrant nurses in interrupting unfair workplace situations. However, these organisations generally deal with workplace issues rather than cultural safety. Racism often operates in slippery ways and goes unacknowledged and unreported. Immigrant nurses of colour can thus be co-sufferers of racism and disadvantage from the system of whiteness and co-beneficiaries of the diversity support policies recently implemented to address discrimination against Australia's indigenous populations. Cultural safety, introduced by Ramsden (2002) in the bicultural context of New Zealand, does thus apply to Australia's contemporary multicultural context to address the cultural safety. Such application broadens

the scope of cultural safety in conjunction with diversity and multiculturalism of globalised health care workplaces including this NICU.

This section also illustrates how white privilege operates to support and nurture white nurses and exclude and marginalise the immigrant and coloured groups. As discussed above, due to the global exploration and subsequent colonisation, whiteness dominated and was privileged. According to McIntosh (1988), white privilege is an invisible bag of special advantage that white people enjoy as freedom, licence, favour or opportunity. While white people get privileged in a cumulative fashion, coloured people suffer disadvantage and exclusion in the same fashion (McIntosh, 1988; Moreton-Robinson, 2006), which widens the gap between the white and coloured people, and between the workers and their employers or managers. In the context of this NICU, white Australian nurses found to get all the attention of senior nurses and the opportunities to develop within the workplace, while in comparison, immigrant and coloured nurses are ignored and disadvantaged. Such discrimination not only proves this workplace as culturally unsafe, but also challenges the social relations between the diverse groups of nurses working together and their ability to have a good shift at work.

Social Inclusion and Justice

The concepts of social inclusion and justice help explain ‘matters of institutional inequality, welfare, human rights and social mobility in order to be an informed citizen and advocate for justice’ (Selvakumaran, 2016, p. 110). Social inclusion enables the full participation of all people in economic, social, cultural and political areas of the nation and society—making sure they have equal opportunities in every sphere of life, including education, income, work and advancement (Australian Human Rights Commission, 2013; Gillard & Wong, 2007). Social inclusion, in clinical settings, means socialising with colleagues, co-constituting, reinforcing and naturalising the cultural identities of the immigrant nurses, sharing privileges and equal opportunities to learning and progress (Samuels & Ross-Sheriff, 2008; Shields, 2008). In contrast, social exclusion and injustice concern social disadvantages, such as unequal access to education, health care and employment (Gillard & Wong, 2007; Steed, 2015). The ways in which social exclusion operated in this NICU included a lack of opportunities to learn, lack of feedback on performance progress and unequal access to in-service education and training (Gillard & Wong, 2007; Steed, 2015). Drawing from the findings of the study, this section discusses what kinds of inclusion and exclusion took place in the unit and what effect this had on nurses’ social relations and the quality of their shifts.

The social relations between Adler and Kitty (see p. 102 of this thesis); Adele and Luna (see p. 104); and Debbie, Anita and Milly (see p. 113), are examples of inclusion among nursing colleagues, who, despite being different in race, gender, background, culture and experience, respected each other's identities, assisted each other's work and cared about each other's wellbeing. Budd's (2019) notion of social exchange was illustrated by the situation where Adler, an experienced white male nurse, helped Kitty with an interest outside work. Kitty was a young and less experienced Australian coloured nurse, who sought Adler's help. Without relating well, this kind of help would not be offered, nor received. In this case, trust and reciprocity surfaced and nurtured respect and mutuality between the two co-workers.

Although Adler related to Kitty, as one of only two men (out of 88 nurses in the unit), he often felt excluded. While Adler's case differs from most discussions of gender-based exclusion due to his maleness, his disadvantage in the workplace, as a member of a minority group, relates to intersectionality literature including Crenshaw's (1991) writings. Crenshaw explored the structural, political and representational aspects of exclusion of, and violence against, women and minority groups and argued that discourses such as this should bring those issues to the fore. As a male, Adler found it hard to work with, and relate to, his female colleagues. Like other hospital wards, NICU was a gendered workplace. Nursing is female-dominated work, which the very low ratio of male nurses in this NICU substantiated. Adler (see p. 109) was allocated patients on two different sides of the unit, which was inconvenient. When both of his patients required urgent attention, his female colleagues did not help, and he struggled to keep the babies safe. This resulted in his suffering and further impairment of social relations, which ruined his shift. Another aspect of Adler's exclusion at work may relate to his work experience and expertise, which enabled him to identify and critique the senior bedside nurses' knowledge deficits and their attitude of 'you must do what we do'. This might have affected how he was received at work by the senior bedside nurses he worked with on that shift. This issue can be understood in terms of intersectionality because Adler's gender, minority status and expertise intersected in his exclusion and disadvantage (Crenshaw, 1991).

Like Adler and Kitty, Adele and Luna were examples of social and collegial inclusion in the workplace. They were both experienced immigrant nurses but migrated to Australia from different countries and differed in race and positions within the unit. Adele offered her help instantly and Luna indulged her, which built their acquaintance and social inclusion. A similar

collegial relation was observed among Anita, Debbie and Milly. While Debbie and Milly were local, white nurses, with a similar amount of work experience, they differed within the hierarchy of the unit. Anita was even more different because of her casual status, ethnicity and immigrant background. However, they felt like they had known each other for a long time and got along very well, as evidenced by their sharing personal matters with each other. This was social exchange as described by Budd (2019), as they had trust and reciprocal respect for each other, but very little power relations between them. These purely social and inclusive relations construct a positive workplace culture and enable nurses to have a good shift at work.

However, the ideal of inclusion might be illusory and unrealistic in institutional life, as many workplaces do not comply with their own policies for facilitating inclusion, but simply mask exclusion and racism under the veil of diversity policies (Ahmed, 2012). Despite the previous examples of social inclusion, exclusion was almost an everyday occurrence in this unit. As described by Steed (2015), exclusion takes place in many ways and for various reasons, is interpreted differently in different contexts over time and is relational, as it involves two parties: excluder and excluded, between whom power relations play out. Exclusion occurred in different contexts and affected Charlie (see p. 104), Barbie (see pp. 105-106), Adler (see p. 109), Fiona (see pp. 133, 136) and Kalyn (see p. 125). Charlie's exclusion by Camisa and Josie aligned with nationality, as Camisa and Josie were from the same country and Charlie belonged to another. Charlie was excluded when Camisa and Josie socialised at their patients' bedsides and shared their interests and personal matters during the shift. As members of the same nationality, Camisa and Josie shared language, culture and customs, and they often related to each other better than they did with others, which Charlie appeared to understand.

A severe form of exclusion was based on race, ethnicity and background. Fiona and Kalyn were immigrant nurses from two different national, racial and ethnic backgrounds, who experienced a lack of opportunities to learn and grow within the unit. Farmer (2004) explains how socio-economic systems are dominated by imperial power, playing out to cause structural violence. As being systematic in nature and exerted indirectly within the usual social order it is often experienced by minority-group and powerless people, who 'are marginalized by racism, gender inequality, or a noxious mix of all of the above' (Farmer, 2004, p. 308). Fiona's mentors repeatedly deserted her, while Kalyn did not receive feedback on her performance from the senior nurse responsible for staff clinical education, despite her requests. Instead, she was told that she had not yet been complained about, an irresponsible

approach to staff development. Crissy's assertion from Chapter Six (p. 130) is poignant in this context. She argued that some nurses were watched, rather than guided and were not provided with training, education and feedback. This withholding of guidance established a process where it was only a matter of time before an error was made, which could then be used to intimidate, bully and carry out official courses of punishment. These potentialities of making errors and getting intimidated or punished are associated with clinical safety of nurses, which not only led to the stagnation and deprivation of immigrant and coloured nurses, such as Fiona and Kalyn, but also rendered them vulnerable in the workplace jeopardising their job security. This insecurity, structured by unequal distribution of resources and opportunities in the unit, was an effect of whiteness in the system, an imperial power that dominated the rights and privileges (Nielsen, Stuart, & Gorman, 2014; Schooley, Lee, & Spanierman, 2019) of immigrant and coloured nurses.

The systematic and institutional exclusion marginalises and disadvantages immigrant and coloured nurses. Institutions adopt diversity in their policies but fail to exercise inclusion in everyday practice (Ahmed, 2012), which is not only unethical, but it is a misuse of diverse human capital. Moreover, social exclusion of immigrant and coloured nurses from the workplace goes against the nation's inclusion policy (Australian Government, 2009; Australian Human Rights Commission, 2013). What is ethical is that social inclusion should be practised in every workplace as a moral imperative (Thompson & Rowe, 2010) that support positive social relations of work. Such workplace relations are especially important in critical care settings, such as the NICU, as they are required to accomplish the safe delivery of care. Staff wellbeing is directly linked to the quality of patient care, which means social inclusion, job security and clinical safety of nurses determine the patient safety. However, social exclusion and its effects on the social relations of work affect nurses' abilities to have good shifts.

Recognition and Social Exchange

The nurses in this study identified being 'recognised' in the workplace as another aspect of a good shift. Being recognised means being respected for their identities and acknowledged for skills, strengths, and contributions in the workplace. Ideally, nurses contribute their knowledge and skills with diligence and dedication to their workplace, and in turn, they are recognised for their efforts and rewarded and taken care of. This social exchange, as described by Budd (2019), is based on trust and reciprocity between the workplace and workers.

However, in the workplaces such as this NICU, the social exchange did not seem to apply to all workers as nurses from diverse backgrounds were frequently ignored: a process that involved remaining unnoticed as a team member, being disregarded and having skills and expertise overlooked. This non-recognition might be the strategic veil to the unit's misuse of immigrant and coloured nurses' skills, which makes them feel ignored and invisible in the workplace. This strategic ignorance 'serves as a productive asset, helping individuals and institutions to command resources, deny liability in the aftermath of crises, and to assert expertise in the face of unpredictable outcomes' (McGoey, 2012, p. 553). Mapedzahama et al. (2012) view it as a neglect, which is a passive form of racism that carries a misguided idea of protection from claims of overt discrimination on the part of management or the organisation. The immigrant and coloured nurses do not have idea where this 'ignorance' comes from or believe that they would experience such discrimination in their workplace. When they experience the racialised behaviours and treatments, they internalise the effects of such racism, feel stuck or leave quietly. Whereas, cultural safety, works to appreciate and support productive social relations among colleagues and between bedside and senior nurses. A diverse workplace thus necessitates the cultural safety of nurses, wherein their cultural values and identities are respected and their expertise and contribution are recognised (Ramsden, 2002; Viken, Solum, & Lyberg, 2018).

Immigrants are required to work hard to meet the challenges of survival in a strange country and match their performance with their local counterparts. At first, they may not be familiar with the politics of the new society or the culture of the new workplace. However, once they have learned the culture of the workplace, immigrant nurses were likely to be loyal to their employer and tended to stay longer, which helped to decrease staff turnover (Smith, Crow, & Hartman, 2007). When asked and encouraged to take on extra responsibilities, they would also be pleased to contribute. An example from my general observation in the unit is breastfeeding, which might be a strong and effective skill in some cultures including mine. Nurses from such cultures might be helpful in supporting mothers to establish and sustain milk supply and facilitate mother–infant bonding. They might even volunteer in setting up breastfeeding interest group in the unit and assist in developing training module. However, very few immigrant nurses are recognised and consulted for their abilities and experience. Instead, local nurses who have had little exposure to breast feeding and require training in such practices to work in this area, are encouraged.

Trust and recognition issues appear to be mostly related to immigrant nurses, but this NICU also ignored the skills of nurses who were trained in another facility or were new to this unit. Although they were local experienced nurses, Addie and Adler (see p. 140) were not trusted and recognised for their previously earned experience and expertise. Adler thought that it was because a group of nurses—who considered themselves the core group—had developed certain ways of doing things within the unit and other nurses were compelled to do things their way or be deemed ‘incompetent’. Addie also did not seem to have special social exchanges with the nurses in senior roles. She too reported not being allowed to use her skills. This kind of unrecognition relates to Shields’ (2008) claim that one intersection may be more disadvantaged than another, within the same intersectional group. Both Addie and Adler were white Australian nurses. Addie was not trusted, and her skills were not used because of her new-comer status, while Adler, a male nurse, was ignored when he challenged female senior bedside nurses’ knowledge about ventilation. While Carmel (see pp. 99-100), an immigrant nurse with internationally acquired expertise, shared the same skin colour as Addie and Adler, yet was more disadvantaged. Therefore, the intersections of explicit categories attracted further disadvantages, which meant double or triple jeopardy for immigrant and coloured nurses (Aguilar, 2012; Beal, 2008).

Senior nurses in the unit questioned Carmel’s ways of working just as they did Adler’s. However, Alice, a young and enthusiastic colleague, respected and consulted Carmel. This recognition occurred informally, at the bedside when practising alongside one another. Alice had an opportunity to appreciate Carmel’s expertise because she got to know her, while the organisation did not. Instead, the organisational structure led the senior nurses to overlook Carmel’s expertise, so they failed to see them as potential resources (Higginbottom, 2011). Such culture of the workplace, as experienced by the workers, reveals that the behaviour of management was discriminatory and indifferent to some categories of nurses. This relates to the strategic use of bureaucratic ignorance (McGoey, 2007, 2012), where the unit might have deliberately ignored immigrant nurses’ talents so as to deny the liability of non-recognition.

In addition, the lack of recognition of Carmel’s expertise in the workplace, or lack of social exchanges between the management and the nurses of different categories, means that the cultural safety of immigrant nurses in this study was undermined. Culturally safe health care for patients and respect and recognition of the cultural identities of nurses is now both an expectation and a necessity in this context (Browne et al., 2009; Phiri et al., 2010). Cultural

safety also fosters equal social exchange between the senior nurses, who are positioned to oversee the nursing workforce, and the bedside nurses, who are in the position of providing health care. While the Australian health care system is beginning to acknowledge patient needs within shifting demographics (e.g. the introduction of Halal diet and the translation of some languages), the cultural needs, talents and identities of immigrant and coloured nurses are still ignored. Cultural inclusiveness continues to be limited except for Aboriginal culture training course to understand the cultural needs of Aboriginal populations. However, this training treats Aboriginal people as a culture to be learned about. Instead, the training needs to include understanding of whiteness and awareness of the privilege that such whiteness obtains. Further, the training needs to foster an appreciation of the issues of health inequity that results from dispossession and denial of sovereignty over their lands for Aboriginal and Torres Strait Islander peoples. The orientation programs are designed for immigrant nurses to learn about Australian life and culture, without regard for their potential contribution. The conversation is not mutual—white Australian nurses do not formally learn about immigrant nurses. This lack of mutuality persists between the workplace and immigrant nurses and impairs their social relations. This consequence denotes that because whiteness dominates the identities of others with its hegemonic power relations. These power relations hold these nurses back from having good shifts at work.

Encouragement and Patronage Relations

When nurses are encouraged or curbed at work it influences their ability to enjoy their shift. This is related to bedside nurses' social relations with senior nurses. These relations can be thought of as patronage systems, which often use familial tropes to cement the relationship, but are more about power relations, reward and punishment systems and the control of scarce resources (Eisenstadt & Roniger, 1980; Stein, 1984). In the NICU, the senior nurses were positioned as patrons and had the power to facilitate or stop the progress of bedside nurses, as defined by a set of opaque rules. The power relations between the senior and bedside nurses were socially constructed to benefit one category of nurse and marginalise the others (Budd, 2019). While some nurses were encouraged through the development of an explicit plan for advancement and targets for promotion, others were denied timely feedback on their performance progress and opportunities to take on challenges in increasingly complex clinical assignments and education and training for new procedures.

Both Australian (see, for example, Alice's interview excerpt, p. 99) and immigrant nurses described how encouragement was inequitably distributed and how opportunities for professional development were not staged in accordance with the nurses' experience but were uncomfortably associated with a patronage system under those in management roles. The workplace had a formal plan to upskill white Australian nurses, according to the clinical progress ladder in place (see Appendix 11). They were fed information about progression and supported accordingly. However, immigrant nurses were curbed from the opportunities, left unsupported at work and remained generally uninformed about the avenues for progression. This kind of relationship between senior and bedside nurses is comparable with patron–client relationships (Eisenstadt & Roniger, 1980), where the patron has the power to control progress and access to resources and decides who to push up. As Eisenstadt and Roniger (1980) and Stein (1984) described, patron–client systems are hierarchical and their power relations affect social relations. This is because patronage is biased towards people like the patron, which encourages individuals who are similar to one another to network and relate among themselves and to curb strangers who do not understand how the client–patron system works for their benefit. Senior nurses in this NICU have encouraged white Australian nurses regardless of their knowledge and experience level, to take up the challenges and grow within the unit. Patronage system is also a double-edged sword as the same structures are used to curb rather than support and encourage immigrant and coloured nurses equitably in the unit.

Alice (see p. 135) and Cody (see p. 131), despite being inexperienced, were encouraged to progress up the career ladder and were facilitated by their relations with the senior nurses. They were favoured by the senior nurses and offered opportunities to grow and advance. They shared expectations of 'each other to do what [was] necessary for the other's success' (Budd, 2019, p. 109). Margot (see p. 132) was another white Australian nurse, who was pushed to progress despite her hesitation. Although she had five years of experience, unlike Cody, she did not feel ready for the challenges and responsibilities of advanced roles. However, she was concerned about the repercussions of her refusal to upgrade because the ways in which nurses advanced in this NICU have similar characters of patronage relations. Using the favour of senior nurses to advance at work is akin to receiving assistance from the Mafia, which relates to the patron–client relationships described by Eisenstadt and Roniger (1980) and Stein (1984). These favours are characterised by the future benefit involving the favouring person and control of the beneficiary. Margot appeared to feel that she might pay for not having taken up the favour, that is, she might be curbed. These kinds of power relations are counter-

productive to the social relations between the senior and bedside nurses, as it can curb the nurses who do not accept the favour and those who are considered 'others' in the workplace.

Senior nurses followed the organisational norms when encouraging white Australian nurses, but they did not engage in the same OCB (Budd, 2019) with immigrant nurses in the unit. That is, they did not provide adequate guidance and supervision equitably to immigrant and coloured nurses. Fiona (see pp. 133, 136) and Kalyn (see p. 125), for example, were not given the opportunity to learn, despite their explicit requests. This lack of support in their growth and development meant that the senior nurses, as patrons, were withholding the opportunities from these nurses. The lack of support also shows that the social relations between the senior and immigrant nurses did not have social exchanges. Fiona and Kalyn were not trusted, and the expected reciprocity between them and senior nurses was also lacking. This lack of social exchange contrasts with the trust and reciprocity between the employer and workers (in the context of this NICU, between the senior nurses and immigrant nurses) could go beyond just monetary and power relations (Budd, 2019). There was also a mismatch between the interests of senior and immigrant nurses, as the former neither recognised the hard work, loyalty and dedication of the latter, nor made efforts to implement training and mentorship to keep up their skills and motivation. Instead of being treated with care, immigrant and coloured nurses were treated like stepchildren or second-class citizens, which made them powerless to the extent that they had no option to grow but to get stuck or leave the workplace. Conversely, the social relations between white Australian and senior nurses can be compared with maternal relations, as the favours seniors gave them were unconditional and ensured that they regularly enjoyed good shifts.

A striking example of the patronage system was seen in the case of Moira (see pp. 125-126), who was born and raised overseas, but trained and worked in the Global North before migrating to Australia. Moira was an experienced nurse working in various health care units in Australia prior to working in this NICU. Although she was encouraged to come to the unit initially, she faced problems in this workplace. She was not supported in her learning and development and did not receive a support shift, like other colleagues, prior to her formal assessment on which her career progression depended. She had an assessor who had never precepted or worked with her. Instead of having the assessment outcome discussed by the assessor, she was called to the senior nurse to be informed of the unexpected result. The assessor did not communicate with her before, during or after the assessment, nor was Moira

given any feedback on the assessment. She described feeling that she was not even allowed to have an opportunity to be assessed. This lack of interaction is the everyday racism that Essed (1991) conceptualised, which describes the subtleties of what immigrant and coloured nurses experienced at work. Such racism was culturalised in the veil of diversity and structuralised in problematising the competence and wisdom of immigrant and coloured nurses, which they experienced in their everyday work lives (Essed, 1991). However, this social reality is often denied or simply unseen by the dominant group as it is linked to their reputation (Ahmed, 2012; Essed, 1991). While the dominant group practise racism whether inadvertently or intentionally, this everyday phenomenon curbs and controls immigrant and coloured nurses. Yet, for senior nurses of the dominant group, to be described as racist, would hurt or offend (Ahmed, 2012).

Workplace Habitability

The habitability of a workplace is associated with moral habitability described by Peter et al. (2004), where nurses feel empowered, advantaged, respected, comfortable, trouble-free, cared for and listened to. It is about a work environment that is free of oppression—where nurses have a sense of belonging, and there are clear moral responsibilities and no moral suffering (Peter et al., 2004). As the authors have described moral habitability in terms of workplace, this concept is adopted in this thesis as an extension to moral habitability in order to analyse nurses' experiences of working in the NICU. Thus, workplace habitability, in this section, refers to being supported and looked after at work, which plays a vital role in nurturing productive social relations of work among nurses and influences their ability to have good shifts. Being looked after requires support from colleagues and seniors, including caring about personal, social and work matters and providing time for breaks. The high acuity of patients in the NICU required nurses to be responsible, accountable, alert and receptive. Workplace habitability matters a great deal for nurses' ability to think and judge efficiently to ensure quality care and patient safety. This section focuses on whether nurses received support or not from the workplace, and which groups consequently struggled more with their work.

In this NICU, there were disparities in support systems on both the individual and group level. The presence of the CRN, who relieved nurses for their breaks (see p. 112), was an example of support at the workplace/group level. This bestowed organisational care by allowing nurses to meet their physical needs. It also promoted quality patient care, through the continuation of nursing care when one nurse was on a break, and because that nurse then returned recharged

and satisfied. However, the CRN was not available on all shifts, so nurses negotiated their breaks among themselves. Pearlie, Neva, Kalyn and Eli (see p. 113) made such negotiations for their breaks—keeping the safety of their patients central by taking the opportunity to go early in the shift when they had lighter workload. Thus, nurses tried to adjust their needs and routines when support was not available, which was a contribution the nurses made to their workplace. This is a form of social exchange between nurses and their workplace described by Budd (2019) as one that goes beyond monetary and work matters, and helps improve nurses' social relations of work.

In contrast, Addie (see p. 114) could not take her break until late in the shift because there was a lack of support and relief from her workplace and colleagues. This meant that both Addie and her patients were in an unsafe situation because Addie was not cared for by her workplace and colleagues. This also shows that the possibility of taking breaks – a legally determined entitlement in the unit, depended on workload and the attitudes of colleagues and senior nurses. Taking a break at work is not only necessary but also meaningful, as it boosts productivity, morale, and satisfaction among employees and is beneficial for the workplace because it promotes motivation and retention (Crenshaw, 2017). It is also a time out to chat and socialise with colleagues. However, the workplace in this study was deficient in caring about these matters. As explained by Addie and the nurses who worked in the isolation room, such as Carey and Fiona (see, pp. 115-116), even attending to nurses' physical needs that should have been of prime importance were overlooked and this carelessness about the basic needs of some nurses made the workplace uninhabitable for them.

While Addie was deserted at work, nurses of immigrant background were more neglected. For example, Fiona's background, accented speech and brown skin intersected to result in multiple jeopardies (Aguilar, 2012; Beal, 2008). She reported being unsupported by her colleagues when she needed a second check to do medications (see p. 110), left in the isolation room with no relief for breaks (see p. 116), watched and judged while left to suffer and struggle with excessive workload (see p. 120) in the workplace. While white nurses were encouraged to ask questions, immigrant and coloured nurses with questions were judged and deemed incompetent. Dhamoon (2011) describes this type of situation as a 'crash' at the intersection of prominent social categories, resulting in multiple layers of disadvantage. In relation to Fiona's experiences, therefore, her immigrant background was navigating through the main intersection, her race crossed over with her ethnicity, culture and English accent to

cause the ‘crash’, which disadvantaged her in multiple layers: lack of help from colleagues, lack of support from workplace, being ignored, no relief for breaks, being observed and judged, and being left to struggle and suffer. A contradiction is evident between what the workplace said about diversity and what they did in practice (Ahmed, 2012), which meant the workplace was not habitable (Peter et al., 2004) for immigrant and coloured nurses.

The family-centred care is facilitated by the nurse caring for the patient for the establishment and maintenance of the baby–family relationship in the NICU (Trajkovski & Mannix, 2018). However, in the unit, the need to develop effective baby-family relationships was used to exclude, discriminate against and marginalise rather than support multiracial nurses. Crissy’s replacement as the primary nurse—at the racist request of the patient’s parents—was an assault on her cultural identity, which left her distressed and dissatisfied and with a loss of confidence. Despite being physically and legally Australian, she was treated like a foreigner. She was targeted because of her race and ethnicity, resulting in othering and dehumanisation (Rummens, 2003). Crissy’s replacement was also a systemic whiteness, which reproduced racial violence by patient’s parents through workplace’s actions on the coloured nurse (Mapedzahama et al., 2012). As described by Dalton, D’Netto, and Bhanugopan (2015), senior nurses in this unit appeared to be biased and indifferent in the management of racial and cultural diversity and support of nurses from diverse backgrounds, which can impair the social relation between these groups. Such impairment in social relation not only makes the workplace uninhabitable for them but also affects nurses’ ability to have a good shift at work.

WORKFORCE IMPLICATIONS

Social relations in the workplace have implications for the workforce, the workplace and the patients. Helpful workplace practices, such as inclusion, recognition, encouragement and looking after one another result in knowing each other, getting along, feeling a sense of belonging and having a charitable attitude. These practices nurture positive social relations. Conversely, workplace practices such as exclusion, ignoring, curbing and neglecting cause frustration, dissatisfaction, attrition and poor social relations among nurses. These practices are assumed to emerge from the whiteness of the workplace, which can contribute to the privilege of the white Australian nurses and the disadvantage of the immigrant and coloured. Thus, the implications of the way social relations are practised in the workplace affect all stakeholders: nurses, patients, and the unit itself. These implications include the way that diversity becomes rhetorical by counting the number of diverse staff rather than the benefits

of having them, wastage of human capital resulting in deskilling, patient safety as a catchphrase but not a practice, and dissatisfaction among nurses resulting in high turnover rate.

Diversity as Mere Numbers

The diversity seen in today's health care workforce is the result of global migration of nurses (International Council of Nurses, 2019). While the migration from the global south to the north has supported the development of a diverse, skilled workforce in affluent nations, such as Australia, this has created shortages of skilled workforces in less affluent nations (Kingma, 2008; World Health Organisation, 2006). This NICU, like many health workplaces, has depended on the immigrant nurses to meet its workforce shortages (Kingma, 2007), but at the same time, it is also facing an additional stressor of high staff turnover within the unit.

However, despite the wide recruitment of immigrant nurses, and their ongoing contribution to the Australian health care system, they are discriminated against and left unsupported, with few opportunities. While young white Australian nurses, such as Cody (see p. 131) were encouraged to advance their skills and position within the unit, nurses of colour, such as Crissy (see pp. 133-134, 137) were discouraged. Senior nurses planned to push Cody beyond her expectations and experience level to a team leadership role. Whereas Crissy was the last to transition to ICU from the IMU, despite undertaking post-graduate study related to her NICU practice and the advantage of the patients in the unit. The contrast between Crissy and Cody's stories calls into question the inequitable way in which the workplace valued the contributions of their nurses. While numerically, the unit appears multicultural, the nurses are stratified across dominant hierarchical positions.

Yet, when I asked interviewees about racism in the relations between staff, they were silent. Nurses and managers alike were hesitant to talk about racism. While diversity was considered positively, racism had negative connotations (Ahmed, 2012) like a black spot on a clean white shirt. As racism was linked with their reputations, it was always denied, hidden, silenced, and made illusory through a mask of diversity, despite its ongoing practice and institutionalisation (Ahmed, 2012; Mappedzahama et al., 2012). Organisations and responsible people commit to diversity through policies and proclaim that they value and comply with it, but it is limited to the speeches and documents; they do not feel it necessary to facilitate diversity in everyday situations (Ahmed, 2012). Institutions take pride in diversity while, at the same time, they

continue to discriminate against their own diverse workers. Diversity is reduced to numerical reporting systems; mere numbers used to show ‘the colours’ in the workforce.

A diverse nursing workforce is essential for meeting the cultural needs of a diverse population that seeks health care (Phillips & Malone, 2014). Nurses who share ethnicities with patient populations can help patients in cultural, linguistic and religious areas by understanding their cultural norms, speaking and translating their languages and recognising their religious practices. In order to provide culturally safe care to the patients, nurses need to feel culturally safe themselves, which can be provided in a culturally safe environment in the workplace. However, if diversity in the workforce is not valued in the workplace in meaningful ways, its associated benefits, including knowledge exchange, respectful disagreement and constructive criticism are missed. These benefits help nurses enhance productivity and innovation, nurture social relations in the workplace and have a good shift every day.

Poor Use of Human Resources–Deskilling

Recruiting countries, such as Australia, have frequently failed to utilise human resources to their full potential (Nichols, 2006). This NICU especially seemed not to value the existing skills of nurses from ‘elsewhere’. As described in the cases of Addie, Adler and Carmel, not only were the skills of immigrant nurses undermined but so were the skills of local nurses who were new to the unit. Failing to use nurses’ skills from previous learning and experience turns experts into novices in their new workplace, as described in an Australian study of non-English-speaking nurses (Deegan & Simkin, 2010). It also leads to deskilling (Alexis & Vydelingum, 2005a; Matiti & Taylor, 2005). As Lundy (1996) argued, ‘Deskilling is a step backward for the industry, and it has serious implications for patient care’ (p. 163). It is, in fact, a waste of expertise and human capital in the workplace that could otherwise contribute to the care of patients.

Many immigrant nurses enter the workplace with more qualifications and skills than the locals. This is because it is the most clever and capable who dare to migrate and work in a foreign country, and are selected by recruiting countries, like Australia (Hawthorne, 2005). Employers could draw on this expertise for the benefit of the organisation. Simply accrediting their existing skills saves on many of the resources used in training inexperienced nursing personnel. Unfortunately, technical skills such as peripheral intravenous catheter insertion and advanced new-born resuscitation are considered high level in the clinical progress ladder (see

Appendix 11), and opportunities for certification are rationed. Immigrant nurses consistently reported that they were not given the opportunity to be certified (O'Brien, 2007; Taylor, 2005). This means that the senior nurses are either participating in the deskilling of immigrant nurses or missing an opportunity to develop resources for patient care.

The unit policy that has to regulate safety issues does not trust the new and immigrant nurses' skills. Because the skills that immigrant nurses already practise in their respective countries of origin are the skills that senior bedside nurses get to learn in this unit, they would not certify them, and this means that immigrants have to go through the progress ladder to reach the point to get accredited. While the progress ladder is short and time sequenced from year one of registration for white Australian nurses, it is a slow and difficult process for immigrant and coloured. It is an effect of structural whiteness in the unit that marginalised nurses like Carmel (see pp. 99-100), whose skills were not recognised despite extensive work experience. This situation was also found in a study of immigrant nurses in the UK neonatal units, where immigrant nurses were deskilled and lacked autonomy in practice (Alexis & Shillingford, 2015). Lundy (1996) is right when stating that not using the expertise that staff already have, while simultaneously investing in and preparing new skills takes a toll on time and economy. It also has implications for patient care, as nurses cannot use their skills in circumstances where they otherwise would.

Patient Safety as a Rhetoric—not Reality

Much of the literature on safety focuses on patient safety (Aiken et al., 2011; Kamimura et al., 2012; Wong, Spence Laschinger, & Cummings, 2010), but very little is found arguing for the clinical or cultural safety of nurses in the clinical area. The component of nurse safety is equally important because, only when nurses feel safe in their workplace, can they ensure better and safer patient outcomes (Hall, 2005; Richardson & Storr, 2010). Adjusting organisational structures and nurturing the work environment, using a safe staff-patient ratio, technological abundance with adequate training, equitable distribution of resources and opportunities, and recognition and use of the existing skills of nurses construct clinical safety of nurses, which are linked to patient safety (Allan, 2007; Richardson & Storr, 2010). Nurses perform better and provide safe, high-quality patient care in conducive environments such as these (Reyes & Cohen, 2013). However, nurse safety is not limited to work environments but is also linked with cultural safety (Richardson, 2012a). Treating nurses of diverse background and intersectional categories as unique individuals, respecting their cultural norms, lessening

power differences and decolonising are ways of ensuring their cultural safety (Martin, n.d.; Molloy & Grootjans, 2014; Prior, 2007).

Also, as nursing work is focused on patient welfare and safety, patient safety is interrelated with the emotional, social and cultural safety of nurses in their workplace. Therefore, when nurses' safety is jeopardised, patient safety is also at risk. However, workplaces like this NICU use patient safety as a catchphrase and a weapon against the new and immigrant nurses. The victims of this weaponisation are nurses like Crissy (see p. 129), who was racialised and objectified with a choice made by the parents of a patient. Crissy's replacement without consultation with her by a senior nurse meant that the unit was practising erroneous family-centred care, which was, in fact, counterproductive to patient safety. Rather than respecting the nurses' identities and expertise (Ramsden, 2002; Wepa, 2005), this type of racist practice was condoned and promoted in this workplace, which is not only racial discrimination but also a lack of cultural safety that makes patient safety mere rhetoric.

Another example that challenges patient safety is Adler's knowledge of ventilation (see p. 124) and his discovery that some senior nurses lacked knowledge: a clear risk to patient safety. The limited knowledge and expertise of the senior bedside nurses—who were acting as educators, mentors and preceptors to the less experienced bedside nurses—not only put the patients at risk but also nurses who were learning from them. Adler's point can also relate to nurses who focused on seizing opportunities and were favoured by management to upskill quickly. Cody (see p. 131) was such an example, who had little experience, yet enjoyed a greater degree of autonomy at work because of patronage relations with the senior nurses (Eisenstadt & Roniger, 1980; Stein, 1984). However, due to the lack of experience, her upgrade had the potential to jeopardise patient safety, as well as the safety of nurses.

The other example that challenges the concept of patient safety is Bree's allocation with a casual nurse (see p. 100), who would not frequently work in the unit. Bree was a new graduate nurse assigned to care for five patients in the IMU side of the unit. While she felt confident working with Ava (see p. 128), a senior bedside nurse, she was stressed by having to work with a casual nurse. She feared that her own lack of skills and experience would jeopardise the safety of patients as well as her own safety. Although patient safety by skill mix is widely talked in the clinical literature and focused in the clinical practice areas, this situation failed to abide by the skill mix required by the policy to implement patient safety (Cunningham et al., 2019; International Council of Nurses, 2010).

Attrition: High Turn Over

This NICU had a very high turnover rate, as evidenced by the fact that 23 out of 76 research participants left during the study period of 18 months. The white Australian nurses were more mobile, perhaps because they would feel confident in their country of origin, know options to adopt when required and were trusted and hired more quickly than the immigrant and coloured nurses. Immigrant groups thus tended to stay in the workforce compared with their white counterparts (Smith et al., 2007), but the treatment they received from the workplace, such as being excluded, ignored, curbed and neglected, along with experiencing structural violence, was sometimes sufficient to make them leave as explained by several immigrant participants I interviewed after they left the unit. Such high turnover has serious workforce implications that need to be addressed thoughtfully.

The nature and culture of the workplace plays a vital role in turnover. While intensive nature of work, high acuity of setting, unique and tiny patient population, and high-tech and complex work environment might contribute to attrition in some nurses, these characteristics cannot be changed or improved as such. What can be adjusted and improved is culture of the workplace that practise exclusion, inequalities, disadvantages, and discrimination. These are forms of the systematic whiteness and structural violence, where the unequal social exchanges occur to exclude, ignore, curb and neglect immigrant and coloured nurses. Helms (2017) describes whiteness as ‘the overt and subliminal socialisation processes and practices, power structures, laws, privileges, and life experiences that favour the White racial group over all others’ (p. 718). This whiteness is not all about skin colour; rather, it is a marker of the whiteness in the system that dominates the Australian workplaces such as this NICU and uses racism as a form of structural violence. Galtung (2010a) describes structural violence using metaphors of top dogs and underdogs, where the top dogs were privileged and received the most resources, while the underdogs received the least or none. This leads the underdogs to be disadvantaged to the extent that they live with long-lasting suffering (Galtung, 2010a, 2010b). Immigrant and coloured nurses in the NICU are positioned as underdogs that are generally pushed away from the opportunities in the unit. Such systems of inequities contribute to attrition and turnover, which have detrimental effects on organisations or workplaces such as the NICU. The effects include the loss of employee skills, financial taxing, decreased productivity and low morale among remaining employees (Speer et al., 2019).

Moira's experience (see pp. 125-126) of being assessed without prior support and failing was an example of such disadvantage. Her immigrant background, race and ethnicity provided the axes of intersection that contributed to this discrimination (Crenshaw, 1991). Her prior experience was undermined, and the discrimination she experienced was not based on an assessment of her skills or abilities, but other factors that were well outside of any policy and indicative of structural violence (Galtung (2010a). Moira was informed of the result by the senior nurse instead of the assessor, which provided an opportunity to converse with her and when Moira made a counterpoint about her risking the patients' safety for years before the assessment, the senior nurse got back on track and put the unit policy forward. The senior nurse was alarmed when Moira talked about giving up and leaving, but for Moira, staying there and going through those assessments again and again was nothing more than directly suffering the effects of violence. Threatened by the possibility of being called racist, the senior nurse deferred to the policy-based procedures for conducting such assessments. This behaviour of the senior nurse describes how institutions fear how racism may injure their reputation and use policies to cover it up (Ahmed, 2012). Moreover, what Moira experienced was a violation of the *Racial Discrimination Act 1975* and the *Australian Human Rights Commission Act 1986* (Australian Human Rights Commission, 2014), wherein racial discrimination, such as this, is considered illegal. However, as identified by Ahmed (2012), in the experience of many, these policies are rhetorical, rather than implemented to support immigrant and coloured nurses in their workplaces. The result of this is the high turnover rate.

CONCLUSION

When equity and cultural safety is maintained in the workplace, nurses can have good shifts every day. A good shift includes equal opportunity to learn and grow, access to resources, trust and reciprocal support among colleagues and from senior nurses, respect for cultural and ethnic identities and acknowledgement of skills and contributions in the workplace. However, systemic whiteness and structural violence seem to dominate these constructive elements and contribute to the emergence of racism, exclusion, discrimination and deskilling leading to unsafe work environments, where some groups, such as white Australian nurses, are privileged—with access to all the resources to learn and opportunities to grow—while the other groups, such as immigrant and coloured nurses, do not have access, and experience hurdles, misery and deficits at work. This inequality causes imbalanced power relations between the senior nurses and underprivileged nurse groups, which can lead to frustration and

attrition. The inequality also impairs social relations of work with implications for clinical and cultural safety of nurses, patient safety, and staff turnover, all of which affect the prospect of having a good shift.

CHAPTER EIGHT: WHAT MATTERS AT WORK

If we are to achieve a richer culture, rich in contrasting values, we must recognize the whole gamut of human potentialities, and so weave a less arbitrary social fabric, on in which each diverse human gift will find a fitting place.

– Margaret Mead

REFLECTING ON THE JOURNEY

The search for what, why and how about my initial experience in the NICU led me to the literature about experiences of immigrant nurses. I learned about issues relating to cultural change, such as the difference in clinical language use and the inability of local nurses to accommodate and support nurses of varying race, class, ethnicity and expertise. This was not enough to address my deep feeling of being incapacitated, disregarded and deprived of opportunities. The instance of when NBM was not NBM, pushed me forward to learn what was happening to me at an individual level. At that stage, I did not have much depth of analytical understanding of workplace politics. Gradually, I learned that it was not really about the incident with the baby, rather, it was the tip of the iceberg—only a small taste of the widespread issue of systemic racism and whiteness of health care structures. The shorthand speech and subsequent aggression of the ultrasound technician, the lack of complete information and the inability of the CNE to speak up or be heard, and stereotyped blaming of me instead of constructive management of the incident by the senior nurses were found to relate with many studies on experiences of immigrant nurses (Deegan & Simkin, 2010; Turritin et al., 2002; Walker, 2010).

The commencement of this study gave me more exposure to various theories, concepts and methodologies that deepened and widened my understanding of the workplace, nurses' work and social relations. I learned how to rigorously analyse workplace issues and social relations of work and articulate a sophisticated discussion of them. My feelings of inadequacy that emerged from the initial experience in the workplace have started to fade away with my empowerment through knowledge and research practice. I had found my interactions with the stakeholders destabilizing as they interfered with my confidence, but the power of knowledge transitioned them from personal to political understandings. I had started with blaming myself and internalised feelings of disenfranchisement. However, bringing myself up into this thesis

through reflexivity, I learned that it was not about me; it was instead the underlying whiteness of the workplace.

Originally, I wanted to conduct my study in this NICU to understand my disquiet caused by that initial experience, but as working and studying in the same unit would have presented a conflict of interest, I looked for another NICU. The barriers I faced in trying to gain access to another NICU brought me back to the original site—this NICU. Thus, more than the loss of my employment, this was a valuable opportunity for me to understand the meaning of my experience—the mechanism of power relations. Conducting this study helped me develop an understanding of what was troubling me while I was practising on the unit. Although my original disquiet was what brought me to this study, doing it opened a new view of my experience. It helped me see how whiteness and dominant understandings operate in often subtle ways to render healthcare institutions unsafe for not only patients but professionals as well. Participants in this study from an immigrant background shared my experience of deskilling and silencing. The ethnographic approach to interviewing nurses I used reinforced what I saw during observation and what I read in the literature. My familiarity with the staff and insider status meant that eventually, during observation, I was less noticed, and I noted how they shifted my position from that of a possible ‘spy’ to an ‘advocate’ over time. This thesis has offered a platform for nurses who felt silenced to voice their concerns and experiences of working in the NICU. Thus, the research questions attended to the relational and cultural practices of the NICU; how nurses experience everyday work life in the NICU; and how are nurses’ social relations of work affected by the NICU.

Padgett’s (2013) findings of nurses’ tendency to avoid conflicts resonated in the actions of many of these silenced immigrant nurses, who learned to keep safe by keeping to themselves. They formed little cliques where they felt comfortable, avoiding the discussions of what was happening. If this was not safe enough, or if there was not a group to join (such as the male nurses), they left the unit and reported that they felt much happier where they are now (in the new workplace, for example, Moira’s experience). While an effective and honest feedback system on departure would help the unit know its flaws that could be addressed, nurses would not confront by saying anything critical about the unit even after they left (which I found when I came across or interviewed some of them). This culture of non-confrontation made me contemplate whether it is just about avoiding conflict or something much deeper—perhaps an awareness that the organisation beyond the unit might also be full of structural violence that is

frequently race-based so that silence is the only tool they have if they wish to maintain their own safety and likelihood of future employment.

For the progression of the thesis, I dug into more literature to explore the ways of conducting study and theories and concepts to underpin it. Ahmed (2012) gave me an insight into how diversity became a requirement and a matter of organisational pride, while, racism developed such a negative connotation in workplaces that it became untouchable: to be racist was now an insult instead of an opportunity to reflect on workplace practices and having a dialogue about change. While racism was often denied, it continued to be embedded in the workplace practice knowingly and ignorantly, subtly and explicitly. As a form of structural violence, racism affected the quality of social relations of work experienced by immigrant and coloured nurses and made the workplace unsafe, challenging their ability to practice. As race, class, gender and expertise of nurses intersected to shape these experiences, intersectionality was considered as a theoretical perspective to frame this thesis. This theory provided me with insights into how these social and structural inequities occurred in the NICU and how immigrant and coloured nurses became victims of these inequities. The inequities related to being known and trusted, utilising prior expertise and opportunities of learning to grow, where immigrant and coloured nurses were the most disadvantaged. Intersectionality helped me analyse and interpret the subtleties of social relations contextual to racial and cultural nature of injustice and disadvantage in the NICU.

Ethnography as a methodology guided me with principles on how to conduct the research study to examine how nurses made sense of their workplace, how they experienced working in a NICU and what mattered at work for them. The ethnographic approach provided a cultural lens to view and interpret the social interactions, behaviours, and perceptions that occurred within nursing groups in the NICU (Reeves et al., 2008). It showed me ways to capture how multiplicities within the nursing group constructed a workplace and how the culture of complex organisations, such as hospital wards, or units such as the NICU shaped social relations of work. It also guided me to explore the inequality, exclusion and other unfavourable workplace behaviours and to uncover the everyday politics of the NICU and nurses' lived experiences of work relations. Importantly, it gave me tools and techniques of data collection, including how to conduct fieldwork and strategies of facing challenges of ethnographic processes and methodological criticisms. The challenges included having to deal with personal, emotional and relational distress during observations and interviews, where I

felt painful to see some nurses bursting in tears while telling me their stories, and to hear their experiences that resonated to mine.

Experience of the Research Process

The ethnography with extended observation and interview, my insider status and the fact that I was an immigrant nurse augmented with my own feelings of disquiet, led to the original questions confirming the reflexive circle. Having to research my own workplace had a few issues. One of them was my insider status—although I had resigned from the workplace—because I was a nurse and former employee. Being an insider meant I helped nurses at times and started conversations when they were mute in my presence. However, as Rudge (1995) argued, it was crossing of the boundaries of the researcher and was ethically and methodologically problematic, I minimised my involvement in such activities. Since I was open to challenges and questioning of the researcher positions, the insider perspective instead helped me. As Bourdieu (1996) noted, the rapport and lessened power relations between the nurses in the NICU and me as a researcher meant that they confided some things that had previously been silenced or never been able to mention in previous discussions and shared their profound experiences of the complexities of working in the unit.

Another issue was the risk of bias in observation due to the offer from the unit to become the research setting for this study. This possibility of bias made me aware if I were missing or overlooking any events that occurred during my observation. This awareness, according to Berger (2015), was an agency of self-supervision and reflexivity that maintained rigour. At times, I also faced the dilemma of whether to record and use specific data. The research ethics, study aims, and the research questions led me to decide what was essential to the research study. Since I did not see any significant events during my observations, which was unlikely, compared with the time when I worked as an employee, I, modified my observation strategies from the scenes to the individual nurse and their periphery of interactions. I also extended my fieldwork beyond year-round and repeated interviews with some participants, as suggested by Berger (2015) to ensure rigour through reflexivity. However, incidents only emerged when I started interviewing, which not only gave me meaningful data but also strengthened my confidence in recording and using the data in my study. My perception of inadequacy in the unit also changed after hearing the experiences of other immigrant and coloured nurses during the interviews. Some of the white Australian nurses' experiences of 'patronage relations' also stood out to me as significant and the underside of white privilege.

What nurses talked about endorsed what I saw happening in the observations of nurses at work. Nurses created a different place for me to work as a researcher—as an insider but as observant of what mattered at work for them. Observations of the work could then be found that highlighted what mattered in what they were saying about the work.

Despite moving entirely outside of the unit and the field of neonatal nursing, I was still hesitant to share the findings of this thesis and my experiences in the workplace although these are relevant to strengthening the workplace and supporting nurses and anticipated to be welcomed. As Ahmed (2012) noted, I felt that the study findings might hurt the reputation of a ‘vibrant’ workplace, to which I feel considerable loyalty. Therefore, I have paid careful attention to protecting the identity and confidentiality of the workplace and the participants. I have identified how we are all enrolled in these processes that undermine social relations of work, from those who make assumptions about the difference to those who fail to interrupt these, instead, develop ‘safe’ cliques as coping strategies. Furthermore, the national principles of responsible research practice persuaded me to believe that with the power of knowledge, self-reflection and commitment to moving beyond dominant structural injustices, the organisation and the people in it are motivated for reform—for their own benefit and the others involved. I also believe, individuals and institutions would thrive when they find the paths to improve through an understanding of their weaknesses and openness to critiques. Allowing social research in their organisation can mean their receptivity of the study results and willingness to adopt the recommendations. Importantly, I must share the knowledge this thesis produced, as it is unethical to withhold the results of the research just because some of the stakeholders are uncomfortable. What this ethnographic study reported is valuable to nurses’ work-life in this NICU, in the other Australian health care workplaces and broader contexts.

CONTRIBUTION TO KNOWLEDGE

Since very few research studies carried out on the issues affecting immigrant nurses discussed the relevance of intersectionality as a theory in their analysis of findings (Seeberg, 2012)¹⁸, the knowledge this thesis produced stands alone. An understanding of how dominant relations of power structure social relations of nurses’ work, is constructed at the intersection of the strength of ethnography in observations and interviews, my insider status as a neonatal nurse,

¹⁸ I found only Seeberg (2012) using intersectionality in her study of Filipino migrant nurses in Norway.

my background as an immigrant nurse, and reflexive disquiet with the way the unit operated. While the knowledge from other research studies identified the immigrant and coloured nurses as problems, the synthesis of ethnography and intersectionality in this thesis opened the understanding of the workplace as the problem rather than the nurses. Hence, this section considers the knowledge produced by this thesis and its contribution to what matters at work for nurses.

The Fusion of Intersectionality and Ethnography

This thesis is a unique experiment in the use of intersectionality as a theoretical framework and ethnography as a methodological approach that inquired as to how nurses' social relations of work operate on a day to day basis in a NICU, where systematic whiteness dominates their work experiences. While intersectionality provided ways of seeing the problems of whiteness such as exclusion, discrimination and marginalisation happening in the NICU, ethnography provided principles, tools and techniques to examine the mechanisms of whiteness. Similarly, while intersectionality made visible the intersections of identities, social positions and power relations between the senior and bedside nurses, ethnography supported the critical analysis of how nurses practised or experienced power relations in the NICU every day. Moreover, while intersectionality embraces a qualitative approach (Syed, 2010), ethnography as one of the qualitative approach works with various theories (Atkinson, 2017; Hammersley & Atkinson, 2007) including intersectionality. In constructing this thesis, intersectionality, as a theory, explained what ethnography as a method did, that is, it helped interpret what was observed in the field. Hence, the method and the theory were not only compatible with one another but also made a unique fusion in exploring what matters at work for nurses.

Addition of Expertise in Intersectional Axes

This thesis identified nurses' expertise as an asset important for their clinical and cultural safety regardless of their social positions in the NICU. While bedside nurses valued the expertise of senior nurses as a resource of learning, the use and distribution of that expertise were inequitable in this unit—some received more support and guidance, and others did not. Senior nurses also failed to recognize and utilise the expertise of bedside nurses who came from other places, which raised a discussion around its use or disuse and the impact of that on nurses, patients and the NICU itself. Such inequity resulted in the expertise of senior nurses not being available to everyone in the unit, and the lack of recognition of the expertise of bedside nurses led to wastage of skills, deskilling and potential for an impact on patient

safety. Nurses' social positions differ in terms of their level of expertise ranging from the junior, inexperienced or new bedside nurses to experienced, senior, specialist, educator or consultant nurse. These are the hierarchies within nursing that differentiate nurses from each other and affect their social and power relations. Since expertise has many roles to play in nurses' social relations of work, it is counted as another category of intersectionality for an analysis of the workplace and is put forward as unique to this study. It is also offered as important for any analysis of the nursing workplace or other professional workplaces and their social relations of work. The addition of expertise demonstrates that intersectionality is an open theory that goes beyond the 'original' categories of race, class, gender. Thus, this addition makes a unique and vital contribution to knowledge produced in this thesis.

The Work of Cultural Safety

While intersectionality showed how and what inequities happen in the nursing workplace, the concept of cultural safety offered the ways of addressing those issues. Practices of cultural safety provide nurses with a way to understand the conflicts of the postcolonial world—the whiteness of the health care system. The framework is essential for Aboriginal and Torres Strait Islander peoples, but it also offers a model to explore whiteness of the institutions and thus support both for patients and nurses especially those who are invited to Australia under skilled migration policies. Given the diversity of the health care system, cultural safety is relevant to the cultural needs of both nurses and patients from Indigenous and immigrant backgrounds. More powerfully, therefore, cultural safety as applicable in the health care systems turns the object of study onto the dominant culture and its processes and assumptions.

Cultural safety offers an approach to consider and support social relations of work among nurses in today's diverse workplace by valuing the cultural identities of immigrant and coloured nurses. It enabled me to consider how nurses with cultural difference experienced their work-life in the NICU and how they could be better supported through their work of caring for patients. Importantly, this NICU and other health care units where patient safety was prioritised, nurses need to feel trusted, valued and recognised to ensure the delivery of quality care. Culturally safe care for patients from diverse backgrounds is enacted by nurses, and thus, as care providers, they also need to feel culturally safe to be able to provide such care. However, within the unit inequitable power relations and social exchanges between the immigrant nurses and the senior nurses responsible for the workplace were observed. As Ramsden (2002) emphasised, trust is a key for differences to be revealed, discussed and

negotiated constructively at work. This argument is relevant to the social relations between nurses, where respect, trust and reciprocity (Budd, 2019) have a role in achieving and maintaining cultural safety in the NICU. Within the increasing complexity of today's multicultural workplaces, therefore, cultural safety was adopted to consider issues and a way to guide support for immigrant and coloured nurses at work.

Awareness of White Privilege

How systemic whiteness operated in the NICU to marginalise the immigrant and coloured nurses came to be a key issue in this thesis. While a diverse workforce is a necessity, these nurses were excluded from the opportunity to grow within the workplace. The senior nurses responsible for the workplace and nursing workforce were operating within the institutional structure of whiteness. White Australian nurses had opportunities for learning through mentorship and constructive feedback, which resulted in career progression in a 'fast-track' fashion. Whereas immigrant and coloured nurses often did not get a mentor to monitor their progress, and their requests for feedback were ignored. According to McIntosh (1988), what white nurses got from the workplace was a privilege because of their whiteness. Immigrant nurses and Australian nurses of colour were systematically denied opportunities and status resulting from the intersection of their race, class and ethnic identities.

The white privilege applies to all white people, including the ones who are distressed to see the oppression and act as a voice or advocate for racially disadvantaged people. Peggy McIntosh (1988) was the one who pointed out the benefits, freedom and licence that a white person holds within the society. Since people either do not want to share the privilege or in many cases it is not shareable (e.g. skin colour as an asset), the effects of it can be minimised by being aware of one's own whiteness and the privilege associated with that asset. As McIntosh (1988) suggested, whiteness is not limited to an individual racial advantage but associated with institutions or systems where indigenous and immigrant people are affected. Moreover, the racial advantage seems to differ from advantages linked to other intersectional categories such as age, gender, ethnicity, nationality and physical ability, and therefore, they should not be considered as the same. The racial advantage is thus associated with white privilege that is both personal and organisational, which excludes immigrant and coloured nurses in the workplace impacting social relations between nurses. Hence, how whiteness dominated nurses' social relations of work and how its effects can be lessened to ensure equity of opportunities among all nurses is what this thesis constructed as knowledge.

Social Exchanges between Nurses

Social relations of work relied on how social exchanges operated between nurses within the workplace. Social exchanges were based on trust and reciprocity between nurses as colleagues and as employer and workers, where senior nurses were positioned as employer and bedside nurses as workers. While most of the bedside nurses observed to be knowing and helping each other as colleagues, the disparity in trust and reciprocity were found between the senior nurses and the immigrant and new nurses. White Australian nurses were trusted and supported, while others were ignored. Nurses such as Pearlie found challenges in negotiating their break times, yet she saw a senior medical professional who recognised and appreciated their identity and contributions to the workplace. However, senior nurses did not realise the benefits of knowing and caring about nurses, nor did they make an effort to know them. Alice's appreciation of Carmel's expertise and Neva's consultation of Pearlie are examples of how immigrant nurses demonstrated expertise in their work and how they supported their junior nursing colleagues. However, they did not get their due recognition or appreciation from senior nurses. The lack of trust and reciprocity not only affected the sense of belonging among nurses in the NICU but also rendered their social relations of work less productive and not as able to produce safe and high-quality care. Similarly, social exclusion and injustice, lack of recognition of skills and identities, and discrimination and subordination at work impaired the social exchanges and made the workplace uninhabitable for some categories of nurses. Such unbalanced social exchange between nurses is what this thesis explored in the NICU.

Patronage Relations in the Workplace

The challenges of how social relations operate are associated with the lack of respect and appreciation for difference, which contributes to patronage relations in this workplace. Senior nurses were compliant to organisational norms in the encouragement of white Australian nurses who were close to them, but in case of immigrant and coloured nurses, either they did not comply with those norms and organisational policies or oppressed them based on their interpretation. They not only refused to provide adequate guidance and supervision to immigrant and coloured nurses, but they also discriminated against them in opportunities of progression. Nurses' work is relational, and the social relations formed between those who were ignored appeared to be cliques of loyalty and intimacy, which kept these nurses in silos or bubbles away from the main social group. Within the dominant group, patronage relations were observed where the advancement of some nurses was prioritised. To achieve relations of

patronage, nurses must be on the same page as the person who is giving them the patronage so that rewards follow. Patronage relations thus develop dependencies that conflict with notions of autonomy and independent positions that are supposed to be part of nurses' developments. The encouragement in this NICU operated in terms of a patronage system, where senior nurses, as patrons, had all the power over opportunities and resources and decided who to facilitate or not facilitate, which saw bedside nurses, as clients, confused about how to maintain positive relations of work (Eisenstadt & Roniger, 1980; Stein, 1984). The effects of patronage system on immigrant and coloured nurses such as deskilling, attrition and feeling stuck were what this thesis contributes as new knowledge.

Habitability of the Workplace

The NICU was found to tolerate discrimination, patronage relations, lack of recognition and inequitable support systems, which contributed to uninhabitability of the workplace leading to powerlessness, marginalisation and lack of belonging among nurses. What Peter et al. (2004) found in their study was about moral uninhabitability of the workplace, where nurses felt unsure and overburdened about their moral responsibilities leading to vulnerability. While, this thesis talks about ethical habitability, which is structural in nature because what nurses in this NICU experienced are unethical workplace practices and against ethical recruitment of skilled immigrants (International Council of Nurses, 2019). While both moral and ethical issues are about workplace habitability, this thesis has adopted the concept as an addition.

Senior nurses in this workplace encouraged white Australian nurses through the clinical progress ladder (see Appendix 11) and did not offer immigrant and coloured nurses the same opportunities, support and information about the avenues of progression. Failure to create equitable futures for nurses working in the unit makes the workplace uninhabitable. Not only immigrant and coloured nurses but also some junior white Australian nurses were neglected in workload and work breaks, which carries a risk for both the nurses and patients. Nurses who worked in the isolation room were also not looked after well, and most often, it was casual, immigrant, coloured and junior nurses who were allocated to these rooms. These nurses were subjected to the questioning of their competence and were judged when they asked for assistance. Some nurses of colour were replaced from care on request of the patient's parents. Some white Australian nurses were encouraged to upskill, beyond their expectations or readiness. While support to personal and social needs such as meal breaks and professional support such as mentorship were seen to contribute to workplace habitability,

there were fewer efforts made by senior nurses responsible for the workplace towards these enterprises. Such lack of endeavours that use senior nurses' expertise and equitable opportunities to learn and upskill is what this thesis found to affect the habitability of the workplace for immigrant and coloured categories of nurses.

Having a Good Shift Matters at Work

Nurses 'have a good shift' when they feel being included, recognized, encouraged and looked after in the workplace. Feeling included is related to social inclusion and justice where nurses irrespective of races, classes, gender and ethnic backgrounds are equally trusted and helped; their cultural identities are respected and naturalised, and the privileges and opportunities to learn and progress are equally shared so that they feel they belong to the workplace. Being recognized means skills, strengths and contributions brought to a workplace by all nurses are identified, acknowledged and utilised to support patient care. This recognition is associated with the social exchange as nurses use their expertise with diligence and dedication in the workplace, which in turn, recognises their efforts and offers care and rewards to them. This develops trust and reciprocity between the workplace and nurses that benefits both parties (Budd, 2019). Being encouraged is where all nurses working in the unit are equally offered opportunities to learn and pushed up to advance their skills by giving challenging cases with constructive feedback as to the lessons learned in challenges. However, often, bureaucratic approaches to skill-building are seen not to include nurses who come to work in this NICU. The encouragement can also sometimes operate in a patronage system, where resources are controlled. Being looked after at work is about being supported, mentored and cared for in personal, social and work matters. This relates to the workplace habitability, where all nurses, regardless of their differing attributes, feel empowered, advantaged, cared for and listened to. This thesis located how a comfortable work environment free of unfavourable workplace practices contributes to 'having a good shift', which is what matters at work for nurses—a significant contribution to the knowledge.

LIMITATIONS OF THE STUDY

The NICU as a single-centred research site meant that it might be questionable for its ability to represent other NICUs around Australia and generalisability of results. However, it was a unit with a large number of nurses working together (n=88), and this study had a high rate of participation (n=76), which compares with survey studies that often claim to be generalisable.

The experiences shared by such a number of participants through observation and interviews ascertain the depth and richness of the issues researched (Hammersley & Atkinson, 2007).

Despite the depth and richness of the results, the findings from researching this NICU might be considered unique to the setting or questioned for exact applicability. However, these are the workplace issues that are broad and studied in many locations worldwide using a variety of approaches. I found similar issues to those raised in other studies of immigrant and diverse nurse groups such as workplace uninhabitability (Peter et al., 2004), wastage of nursing skills (Deegan & Simkin, 2010) or racism and discrimination (Mapedzahama et al., 2012). Cultural safety offers the opportunity to address these issues and is adopted in this thesis to challenge the whiteness of the nursing workplace. It is also used as a means to consider how to improve the work practices to be inhabitable for all categories of nurses who then can work together.

My ethnographic fieldwork went for an extended period with 24/7 mode of observations and interviews that included waiting and revisiting nurses at ghost-times of the night to capture the one-off events and interactions. This intensity and extensivity produced a vast amount of data that took longer and harder to manage. This has the potential to the method as time- and labour-intensive (Hammersley & Atkinson, 2007) and discourage the novice researcher from adopting ethnography. However, I am satisfied that these temporal and work demands have brought powerful stories to the study findings.

The unstructured nature of data collection, hitches and hindrances in accessing the research setting and my relations with the participants as an insider have made the research practice challenging. I believe that the knowledge of the ethnographic process, strong interest in the methodology and willingness to face such glitches enabled me to overcome these challenges and come up with rich and meaningful data (Atkinson et al., 2007; Hammersley & Atkinson, 2007), which contributed significantly to knowledge construction with a wide variety of issues that made visible from those data.

Referring to the unit, hospital, and state policies could add more sense to the interpretation of findings. However, the ethical responsibilities of maintaining privacy and confidentiality did not allow me to do that in view of protecting the identities and the location of the research setting. However, I have used the national organisational documents extensively to support analysis and where local materials were inevitable, I have footnoted the confidential statement regarding the reference. Also, while policy analysis is out of the scope of this thesis at this stage, I plan to carry it out in the future to examine what policies are in place to support new,

immigrant and coloured nurses, how effective they are in addressing the issues, and what others are required to be developed.

RECOMMENDATIONS

Since this thesis examined how nurses experienced the social relations of work in a NICU, the knowledge may be especially relevant information for those who are managing workplaces. As this thesis discussed the implications of workplace culture on nurses, the results make recommendations for shaping a workplace that will adopt positive practices for all nurses, including nurses from different cultural and ethnic backgrounds, and importantly, for senior nurses, the workplace and patient safety. As recommendations can be developed as policies and guidelines for future strategies of supporting nurses and the knowledge for future nursing scholars, they are offered for the workplace employing nurses and the scholarships on nursing and workplace issues.

For the Workplace

While diversity is a necessity and inevitability of Australian workplaces such as this NICU, they would be better places of work when they embrace differences from such variety, recognise the potentialities that the difference brings and weave the differing culture and contrasting ideas in one garland as Mead suggested. However, instead of valuing and including as resources, this NICU did not accommodate and support immigrant and coloured nurses equitably in the workplace. Instead, they were counted to make up the diversity of the NICU. Therefore, attention is required to support the development of these nurses through enacting equal opportunity policies.

Due to lack of opportunities, the expertise that the new and immigrant nurses brought with them remain unnoticed and unrecognized, which led to a waste of skills and deskilling that could otherwise serve the unit and the patients' needs (Deegan & Simkin, 2010). Accrediting the immigrant nurses' existing skills regardless of their social position in the unit would save the resources, benefit both the workplace and the patients and develop productive forms of social exchange beyond the patronage system. Therefore, a mechanism is required to identify and recognise the skills of newly recruited, experienced nurses.

White Australian nurses appeared more mobile than their immigrant counterparts in this NICU as evidenced by 17 of 51 white Australian, one of two indigenous and five of 25

immigrant nurses leaving the unit. It is notable that of the five immigrant nurses who left, two were white from Global North countries and two were coloured but received their education in Australia. This demonstrates that only one immigrant nurse of colour (who migrated for work) left the unit, which means they do not leave unless they experience something like Moira. Yet, the attention of the workplace focused on the white nurses who tend to leave rather than the nurse groups who were more loyal and stable. They were, instead, excluded, ignored, curbed and neglected, which can leave them stuck with no option to develop nor to leave the workplace. To prevent exhaustion and bring about enthusiasm among nurses, an individual approach of communication between the senior nurses and bedside nurses is recommended to know each other and establish equitable social exchanges.

Patient safety becomes a reality when nurses feel clinically and culturally safe. As skill mix is associated with clinical safety, a particular enactment of skill mixes is required while allocating nurses to team up. Patient safety would be mere rhetoric when the NICU confronted cultural safety with its whiteness that erased difference rather than value. Therefore, it is important to discuss the application of the principles of cultural safety to address the nurses' needs of being culturally safe at work. These may include developing policy on cultural safety to support nurses, designing self-awareness training on white privilege, and incorporating cultural safety in nurse orientation programs. An awareness of personal and organisational whiteness and its effects on culturally different nurses would be very useful in respecting diversity and protecting their identities.

Workplaces such as this NICU need to develop the mechanism of supporting nurses through ensuring social and job security through communication and sympathy to address social and emotional upheavals faced at work while caring for some patients and dealing with some parents. Nurses were found to be withdrawn from the patient care on parents' requests which should not be the case, yet they were not informed or counselled about prejudices that might underpin such changes. Also, the system of blaming needs to be deactivated entirely, and instead, training on how to have a constructive conversation is required to improve the culture of the NICU.

This thesis focused on how nurses construct and experience the social relations of work. This was a meaningful way to examine aspects of workplace relations. In the future, I would like to analyse how nurse leaders and managers operate and manage the workforce in general and specific to diversity. This will include how managers prepare themselves, what training are

available for workplace managers and what other programs can be incorporated to improve and broaden their knowledge and skills to manage workforce inclusivity and what matters at work for nurses.

For Research

A gap in the scholarship surrounding nurses' safety was identified in the nursing literature. Nurse safety involves clinical and cultural aspects that include personal, social, emotional and relational elements of nursing work. Feeling safe, secure and satisfied at work is important for the delivery of quality care. Therefore, more literature emphasizing nurse safety is required for workplaces to understand its relation to patient safety. Job security is another important facet of nurses' work life, which is threatened by not only a blaming culture rather than support at work, but also lack of cultural safety of nurses of diverse background. Therefore, studies designed to address nurses' cultural needs could provide the knowledge base to better support nurse safety that is needed for patient safety.

So far, a large part of research covers how immigrant nurses experience working in their exotic workplace, or how nurses get job satisfaction, motivation and retention. There is a lack of exploration on the work environment, how nurses can be empowered regardless of their differences and what efforts employers/managers/senior nurses make to know, recognise and care about these nurses. Therefore, this thesis recommends that more studies of this nature be carried out and more by coloured nurses to empower themselves through such knowledge.

CONCLUDING REMARKS

As this thesis examined how trust and reciprocity assisted nurses to work together to create a sense of belonging and how support at work counted for opportunities to learn and grow within the workplace, the findings of this thesis share understanding of what matters at work for nurses in an Australian NICU. Although the findings are specific to this NICU, they are in-depth—covering a significant number of participants, times and kinds of observations, to collectively make up the work-life of nurses in a closed unit in a large hospital. The findings contribute to how current social relations of work are practised in workplaces and how they can be better nurtured. The recommendations from this thesis can serve as a foundation for awareness and change activities in both senior and bedside nurses. The senior nurses can learn how white privilege operates and the need to attend to the cultural safety of immigrant nurses in order to authentically value diversity and challenge the whiteness of the unit or the entire

health care system. Bedside nurses understand how everyday work life can be affected by various power relations and how they can be turned into resources for having a good shift.

Despite the necessity of employing a diverse workforce, immigrant and coloured nurses became mere numbers to make up a diverse workplace and to fulfil workforce shortages rather than being recognized for their attributes and skills. Disproportionate access to resources developed patronage networks and made the workplace uninhabitable for some intersectional diverse categories. While most of the white nurses benefitted from inclusion and encouragement from the workplace, the immigrant and coloured nurses experienced exclusion, injustice and non-supportive patronage relations in the workplace. This inequality in access to resources and opportunities makes a difference in how these nurses experienced the social relations of work. This demonstrates how an immigrant status, as an intersectional category, was a major marker of disadvantage among nurses, where immigrant nurses were rendered clinically and culturally unsafe. Therefore, recommendations from this thesis can contribute to disseminating the importance of applying the concept of cultural safety as a key to better support culturally diverse nurses by respecting their identities and recognising their expertise. This is what matters at work for these nurses.

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APPENDIX 1 PARTICIPANT INFORMATION SHEET

PARTICIPANT INFORMATION SHEET

**Title: Building Social Relations within a Nursing Workplace:
An Ethnographic Study in a Neonatal Intensive Care Unit**

Investigator

Shobha Nepali, PhD Candidate, Sydney Nursing School, The University of Sydney.

This is an information sheet that has been put together to help you decide if you would like to take part in a research study about nurses' collegial relationships at workplace.

Who is doing the study?

The study is being conducted by Shobha Nepali, as part of her degree of Doctor of Philosophy at Sydney Nursing School, The University of Sydney. It is an academic institution for education and research in nursing.

-----, Clinical Nurse Consultant at ----- will be the on-site supervisor and Trudy Rudge, Professor from Sydney Nursing School, the University of Sydney, the primary supervisor.

What is the study about?

I am trying to find out about how collegial relationships are formed among nurses within your workplace. Specifically, I aim to examine how work culture is practiced in this unit, how you experience your everyday work life in your workplace, how you act and interact in providing care and how you relate to nursing colleagues and other members of the health care team. Finding out these things will help me develop strategies on how best to support nurses in the workplace.

What will I have to do if I take part?

If you agree to take part in the study you will sign the consent form. That means you are taking part in observations, casual conversations and possibly in-depth interviews. Observation will be carried out as you work together and will be focused on the events and interactions as they happen in the unit. The periods will be about 1-2 hours at a time and they may lead to short discussions. These short discussions will take about 5-10 minutes and may happen in your workspace if you are alone or in a separate private space when you are free. The observation and these informal discussions will not involve any recordings into digital media. You may be interviewed for longer periods depending on the observations and short conversations. These interviews will involve more in-depth discussions and will be audio-recorded. The formal interviews will take 30-90 minutes and are negotiated with you as to a time and place of your convenience.

Do I have to take part in the research?

You are not under any obligation to participation in this study. It is completely up to you whether or not to participate. If you decide not to participate it will not affect your dealings or relationships with the researcher, your workplace or the University of Sydney now or in the future.

Even if you take part at the beginning and change your mind later on and don't want to be a part of the study that is okay. All you need to do is tell the researcher that you don't want to take part anymore. You also don't need to answer any question that you don't want to.

Will anyone know that I am taking part or hear about what I tell you?

No-one will know what information you gave to the researcher. You can tell them whatever you want and no-one will know that it came from you. Any identifiable information that is collected about you

in connection with this study will be deidentifiable. No one will have access to your details in consent forms as well. Because the research setting will be anonymous in this study, you are requested not to tell other people that this study is being carried out in your workplace and that you are one of the participants.

Is there anything that might make me upset if I take part in the research?

It is possible that you may have minor feelings of oddness, nervousness, embarrassment and inconvenience caused from the observations. They will fade with time as you are more comfortable with researcher's presence and forget that you are being observed. However, if anything upset you during the research you can stop the observation and/or interview.

What will happen to the information I tell you?

The information you tell us will only be used by the researcher, her supervisors and the University of Sydney for research purposes of this study. No-one else will be allowed to use this information. The researcher will decode the identifiable material before consulting the supervisors for guidance. A thesis will be produced as part of the researcher's examination and the results of the study may be published in peer-reviewed journals and/or presented at conferences but no information about you will be used in any way that is identifiable.

The information you tell us will be stored in a password protected computer file. The computer itself is password-locked so no one can open it without researcher or the IT administrator at Sydney Nursing School. The laptop computer with the data will be locked in a cabinet when not in use. The information will be stored in the University of Sydney's special Research Data Storage System for 7 years of completion of the project and then if not needed anymore, it will be destroyed by irreversible formatting of the computer hard/external drives including back-ups with the help of professional IT staff at the university.

If you have any questions about this project or you want to talk about it, please contact me at -----, e-mail: snep3422@uni.sydney.edu.au.

You can also reach -----, on-site supervisor at -----, e-mail: ----- and/or Professor Trudy Rudge, research supervisor at ----- Email: trudy.rudge@sydney.edu.au.

This project has been approved by the ----- Human Research Ethics Committee. If you have any worries or questions about the study, please call the Research Ethics Manager, ----- who is the Secretary of the Ethics Committee and quote approval number HREC-----.

This booklet is for you to keep.

APPENDIX 2 CONSENT FORM

CONSENT TO PARTICIPATE IN RESEARCH

Title: *Building Social Relations within a Nursing Workplace:
An Ethnographic Study in a Neonatal Intensive Care Unit*

Investigators:

Shobha Nepali, PhD Candidate, Sydney Nursing School, The University of Sydney, Phone: +61 2 8810 2088

1. I acknowledge that I have read and understood the Participant Information Sheet relating to this study. I acknowledge that the general purposes, methods, demands and possible risks and inconveniences which may occur to me during the study have been explained to me by Shobha Nepali (the researcher) and I acknowledge that I understand the general purposes, methods, demands and possible risks and inconveniences which may occur during the study.
2. I acknowledge that I have been given time to read the information, seek other advice and consider whether to participate in the study.
3. I acknowledge that refusal to take part in this study will not affect my relationship with the researcher, my workplace and the University of Sydney.
4. I acknowledge that I am volunteering to take part in this study and I may withdraw at any time.
5. I acknowledge that this research has been approved by the ----- Human Research Ethics Committee and authorized by ----- Research Governance Office.
6. I acknowledge that I have received a copy of the Participant Information, and this form which I have signed.
7. I acknowledge that any regulatory authorities may have access to my records relevant to this study to monitor the research in which I am agreeing to participate. However, I understand my identity will not be disclosed to anyone else or in publications or presentations.

Name of participant _____

Address of participant _____

Signature of participant _____ Date: _____

Signature of researcher _____ Date: _____

APPENDIX 3 DATA COLLECTION FORM

DATA COLLECTION FORM

Title: *Building Social Relations within a Nursing Workplace:
An Ethnographic Study in a Neonatal Intensive Care Unit*

Investigators:

Shobha Nepali, PhD Candidate, Sydney Nursing School, The University of Sydney, Phone: +61 2 8810 2088

Demographic Information about Participants

- 1 Gender: Female Male
- 2 Age: 20-29 30-39 40-49 50-59 >60
- 3 Family status: Single Married De-facto Separated
- 4 Live with: Self Parents Partner Husband Wife Children
(Please tick two or more where applicable)
- 5 Position: RN CNS Others Please Specify.....
- 6 Qualifications: Please specify:
- 7 Country of birth: Please Specify.....
- 8 Country of nursing education: Please specify.....
- 9 First place/state/country of Employment: Please specify.....
- 10 Total Professional Experience: Please specify.....
- 11 Experience in this NICU: Please specify.....
- 12 Type of employment in this unit: Full Time Part Time If PT, hours of work PW:

APPENDIX 4 SAMPLE INTERVIEW QUESTIONS

Starting Questions

1. How did you come to work in this unit?
2. Could you tell me about your experience in this unit?
3. What do you think influences social relations between colleagues?
4. What keeps you working in this unit?
5. As a registered nurse/NUM/CNS what does a good shift feels like to you?
6. What makes the difference in the workplace do you think?
7. Are there other issues that you think are important about working in this unit?

Follow up Questions

8. How does your role impact on collegial relation?
9. What challenges and opportunities do you see in your role?
10. Do you have anything more you would like to share about your experience on relations?

APPENDIX 5 ETHICS APPROVAL AT SITE 1

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----- Hospital

Dear -----

LNR Research Project: 'Building Social Relationships within a Nursing Workplace: An Ethnographic Study in a Neonatal Intensive Care Unit'

Your request to undertake the above protocol as a Low and Negligible Risk (LNR) research project was reviewed by a subcommittee of members of the Scientific Advisory Committee and the Human Research Ethics Committee. We are satisfied that your protocol meets the criteria for an LNR research project and does not require review by the full HREC.

This HREC has been accredited by the NSW Department of Health as a lead HREC to provide the single ethical and scientific review of proposals to conduct research within the NSW public health system. This lead HREC is constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research* and the *CPMP/ICH Note for Guidance on Good Clinical Practice*.

I am pleased to advise that the HREC has granted ethical approval of this LNR research project to be conducted at:

- ----- Hospital, Chief Investigator, -----

The following documentation has been reviewed and approved by the HREC:

- LNR Application Form submission code
- Protocol, version 1, dated
- Participant Information and Consent Form, Nurses, version 1, dated
- Participant Information and Consent Form, Doctors, Allied Health, and Casual Staff, version 1, dated
- Participant Information and Consent Form, Parents of Babies, version 1, dated
- Data Collection Forms, Nurses version 1, dated

Please note the following conditions of approval:

- The coordinating investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including unforeseen events that might affect continued ethical acceptability of the project.

HUMAN RESEARCH ETHICS COMMITTEE

- The coordinating investigator will immediately report any protocol deviation / violation, together with details of the procedure put in place to ensure the deviation / violation does not recur.
- Proposed amendments to the protocol or conduct of the research which may affect the ethical acceptability of the project, must be provided to the HREC to review in the specific format. Copies of all proposed changes must also be provided to the research governance officer.
- The HREC must be notified, giving reasons, if the project is discontinued at a site before the expected date of completion.
- The coordinating investigator must provide an annual report to the HREC and a final report at completion of the study, in the specified format. HREC approval is valid for 12 months from the date of final approval and continuation of the HREC approval beyond the initial 12-month approval period is contingent upon submission of an annual report each year.
- It should be noted that compliance with the ethical guidelines is entirely the responsibility of the investigators.

You are reminded that this letter constitutes *ethical approval only*. You must not commence this research project until separate authorization from the Chief Executive or delegate has been obtained. Copies of this letter, together with any approved documents as enumerated above, must be forwarded to the Research Governance Officer.

In all future correspondence concerning this study, please quote approval number **HREC** []------. The HREC wishes you every success in your research.

Human Research Ethics Committee

cc -----, Research Governance Officer

**Please complete the boxes below and return a copy of this page to the -----
Research Office:**

_ I acknowledge and accept the conditions of ethical approval listed above

I will not commence this project at any site until separate written authorisation

from the Chief Executive or delegate of that site has been obtained

*Printed Name
Chief Investigator*

Signature

Date

APPENDIX 6 ETHICS TRANSFER APPROVAL TO SITE 2

Research and Development
 Ethics & Governance Administration Assistant
 Phone: -----
 Facsimile: -----
 Email: -----
Contact for this correspondence:

[Redacted]

 ----- Hospital

Dear -----,

HREC Reference: -----

Old Reference: -----

Project title: ***Building Social Relationships within a Nursing Workplace: An
 Ethnographic Study in a Neonatal Intensive Care Unit***

Reviewed for: ----- **Hospital**

Thank you for submitting the above project for transfer from ----- Hospital to the
 ----- Hospital.

This ----- HREC is constituted and operates in accordance with the National Health and Medical
 Research Council's *National Statement on Ethical Conduct in Human Research* and *CPMP/ICH
 Note for Guidance on Good Clinical Practice*.

I am pleased to advise that your application has been successfully transferred and the SCHN
 HREC has granted ethical approval of this research project.

Your approval is valid from the date of transfer. [Redacted]

The following documents have been approved for use:

Document	Version	Date
LNR, Submission Code [Redacted]		[Redacted]
Protocol	1	[Redacted]
Participant Information and Consent Form, Nurses, Doctors, Allied Health, New Graduates and Casual Staff	1	[Redacted]
Participant Information and Consent Form, Parents of Babies	1	[Redacted]
Data Collection Forms	1	[Redacted]

Please note the following conditions of approval:

1. The co-ordinating investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including:
 - Unforeseen events that might affect continued ethical acceptability of the project.
2. Proposed changes to the research protocol, conduct of the research, or length of HREC approval, will be provided to the HREC for review in the specified format.
3. The HREC will be notified, giving reasons, if the project is discontinued at a site before the expected date of completion.
4. The co-ordinating investigator will provide an annual report to the HREC and at completion of the study. The annual report form is available on the Hospital's intranet and internet or from the Secretary.
5. Your approval is valid for 5 years. If your project extends beyond five years then at the 5 year anniversary you are required to resubmit your protocol, according to the latest guidelines, seeking the renewal of your previous approval. In the event of a project **not having commenced** within 12 months of its approval, the approval will lapse and reapplication to the HREC will be required.

Should you have any queries about the HREC's consideration of your project please contact the Ethics Administration Assistant on -----.

You are reminded that this letter constitutes ethical approval only. You must not commence this research project at a site until separate authorisation from the Chief Executive or delegate of that site has been obtained. A copy of this letter must be forwarded to all site investigators for submission to the relevant Research Governance Officer.

The ----- HREC wishes you every success in your research.

Yours faithfully

Executive Officer
----- **Human Research Ethics Committee**

APPENDIX 7 RESEARCH GOVERNANCE APPROVAL

Contact for this correspondence:

Research and Development

Name: -----

Phone: -----

Facsimile: -----

Email: -----

Date:

Cc Shoba Nepali

Site Authorisation Letter

Dear -----

HREC reference number: -----

SSA reference number: -----

Project title: **Building Social Relations within a Nursing Workplace: An
Ethnographic Study in a Neonatal Intensive Care Unit**

Site: -----

Thank you for submitting an application for authorisation of this project. I am pleased to inform you that authorisation has been granted for this study to take place at the above site.

The following conditions apply to this research project. These are additional to those conditions imposed by the Human Research Ethics Committee that granted ethical approval:

1. Please advise us of the date when the project starts at this site.
2. Proposed amendments to the research protocol or conduct of the research which may affect the ethical acceptability of the project, and which are submitted to the lead HREC for review, are copied to the research governance officer.
3. Proposed amendments to the research protocol or conduct of the research which may affect the ongoing site acceptability of the project are to be submitted to the research governance officer.

Yours sincerely,

Research Governance Officer

APPENDIX 8 QUIRKOS DATA CODING SAMPLE

The screenshot displays the Quirkos 1.5.2 software interface. On the left is a vertical toolbar with icons for Home, Project, Undo, Redo, View, Query, Report, and Help. The main workspace contains a mind map with several nodes:

- Top-left cluster:** Support Working in a Team, Togetherness and Teamwork, Helping Each Other, and Along.
- Top-right cluster:** Patient/Parent Predictable Day, Having a Good Day, Productivity, and breaks.
- Center node:** Coping Strategies.
- Bottom-left cluster:** Auto Career Goal, Attraction/Motivation/Satisfaction, Opportunity to Grow, and Mentor.
- Bottom-right cluster:** Generations as Safety Net, Support from Seniors, Good Colleagues from Seniors, and Getting Trusted.
- Bottom node:** What Matters at Work.

On the right side, a chat window is open, showing a question and an answer:

Q: How are you going to do it then
Are you going to the manager directly or

A: Like when we first started, it was supposed to be a transitional program, and apparently you supposed to have a mentor who supposed to help you with your progress, but then, you know people went on maternity leave, people got promoted, and then, you are just, you know, left without anybody. But, when one of them went to maternity leave, I was assigned to somebody else, then she got a promotion, and then, nothing happened after that.

At the bottom of the interface, there is a status bar with 'Zoom: [slider]', 'Source Text Coverage: 14% (14% total)', and the user name 'Fiona'. The Windows taskbar at the very bottom shows the search bar, system tray, and the date/time '6:11 PM 22/06/2020'.

APPENDIX 9 SAMPLE OF IN-TEXT CODING

Analysis_Narelle_Revised.docx

File Home Insert Design Layout References Mailings Review View Help EndNote X8 Grammarly ACROBAT

Editor Thesaurus Word Count Read Aloud Check Accessibility Translate Language New Comment Delete Previous Next Show Comments Track Changes Reviewing Pane Accept Reject Compare Block Authors Restrict Editing Hide Ink Resume Assistant

AutoSave Off

197 about this is the right job, this is the right time, do you have too much in your plate because to
198 me you are burnt out so. And certainly I've spoken to Annie about it as well. I think the
199 challenge is staff ... if obviously to me the (pauses) staff needs to speak to Annie but if it's
200 not me then ah I would hope the staff would feel that they can come and talk to me and we
201 can work out and look we have been strategic and how we've allocated some of the support
202 shifts so that we can buffer. Obvious, to me it's not the solution; to me there's a bigger
203 problem here and I need to work out how to work this out and there's something sitting on for
204 at least 18 months, the problem for me is the person involved doesn't see this at all. So their
205 perception of the situation is very different to the person's perception of ... so there's a
206 mismatch between the two personalities between the two and they're also perfectionist and
207 they feel that their way to be a perfectionist is to be strict and to ask lots of questions and to
208 promote the base but softening and to the learner, requires a lot of patience and the (pauses) I
209 still don't know what the answer is. But the other part of that is they're incredibly sensitive
210 and if I said this to them, they'd be devastated. They'd be absolutely devastated so that's why
211 I have to balance up, do I destroy one person for everyone else or it might work better to
212 trying to challenge them in a way that they then start to reflect upon their job and that's sort of
213 approach I have taken. I've tried to look at opportunities that we could do things differently
214 and have discussions around that by ... yeah. It's hard I think sometimes we can be sacrificial
215 in education as well, sometimes it's easy for us to be targeted so. And I feel why loyalty has
216 to be supported in education team so for me it's a really difficult challenge but I ... when staff
217 approach me and tell me there's an issue then I make it so that they get support, different

SN Shobha Nepali
Power relations - using power channel

SN Shobha Nepali
Perception of problem (Personality clash -
Personalities are shaped by culture - **cultural
difference as a problem**)

SN Shobha Nepali
Clash between two culturally different 'perfectionists'
Cultural difference as a problem

SN Shobha Nepali
Dilemma: one person or everyone?

SN Shobha Nepali
Cultural Difference as a Problem
Lack of open discussion on cultural difference -
Solution could be simple - power game involved?
Niceness - Cultural diversity said to be embraced.
In practical reality - seems to be problematic

Page 5 of 15 9785 words English (United States) 6:38 PM 22/06/2020

APPENDIX 10 MINDMAP OF THEMES

The screenshot displays the iMindMap software interface with a mind map titled "What Matters at Work". The central node is "What Matters at Work", which is highlighted with a dashed blue selection box. Four main branches radiate from the center:

- Togetherness and Teamwork** (blue branch):
 - Helpful Attitude
 - Team Spirit
 - Getting Along
 - Supportive Colleagues
 - Workplace as Family
- Having a Good Shift** (orange branch):
 - Having Fun at Work
 - Helping Each Other
 - Getting to Breaks
 - Productive Shift
 - Patient and Parent Satisfaction
- Support at Workplace** (purple branch):
 - Getting Trusted
 - Having Good Challenge
 - Great Seniors
 - Seniors as Safetynet
 - Learning from Seniors
- Attraction, Motivation, Satisfaction** (green branch):
 - Area of Interest
 - Patient Preference
 - Career Goals
 - Opportunity to Grow
 - Autonomy in Practice

The software interface includes a menu bar (FILE, HOME, INSERT, LAYOUT, DESIGN, VIEW, TOOLS), a toolbar with icons for Brainstorm, Mind Map, Share, and various editing tools, and a Windows taskbar at the bottom showing the time as 6:20 PM on 22/06/2020.

APPENDIX 11 CLINICAL PROGRESS LADDER

