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A contemporary understanding of nurses' workplace social capital: A response to the rapid changes in the nursing workforce

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Abstract

Aim: To provide an updated definition of the concept of nurses' workplace social capital that addresses changes in the contemporary nursing workforce.

Background: Social capital explains the components of a constructive work environment. Advancements in psychology of workplace and changes in the demographic structure of nursing workforce call for a revised version of nurses' workplace social capital.

Method: Walker and Avant's approach was implemented. Data were compiled from 'Medline' and 'CINAHL', 'Google' search engine, book chapters and expertise of nursing academicians.

Results: Nurses' workplace social capital is a relational network that is configured by interactions among healthcare professionals. Although, various attributes influence these interactions, Relational Network, Trust, Shared Understanding, Reciprocity and Social Cohesion are considered as the major attributes. A healthy relational network creates a healthy workplace which can be further fortified by effective communication, active group engagements and a supportive leadership.

Conclusions: Results of our concept analysis should establish a theoretical groundwork for nurse leaders to better build and more effectively lead the contemporary nursing workforce.

Implication for Nursing Management: Leaders' dedication to workplace social capital is the tenet of a constructive workplace, which in return can support nurses to flourish in their clinical and the other professional responsibilities.

KEYWORDS

concept analysis, nurses, nursing workforce, nursing workplace, social capital

1 | BACKGROUND

A healthy workplace is an umbrella term that captures constructive, collaborative effective and economic productivity of a workforce (Burton, 2010). A harmonious collaborative professional relationship among members of workforce is the tenet of a healthy workplace.

The nursing workforce constitutes the largest personnel in the healthcare industry (United States Department of Labor, 2015). The rapid changes in roles and responsibilities of nurses, such as gaining more autonomy in the delivery of healthcare services, have put unprecedented administrative and management challenges within the nursing workplace (Auerbach, Buerhaus, & Staiger, 2014). Furthermore, changes in the demographic structure of the nursing workforce, for example more men are opting for the profession and the diversity in ethnic/racial heritage of nurses are the other workplace challenges that must be addressed effectively and constructively (American Association of Colleges of Nursing, 2019). Many of the most pressing problems of a workforce usually are complex and formidable; these problems, in general, can be resistant to change. Application of the concept of social capital in nursing workforce can offer a pre-emptive strategy to ameliorate, if not prevent, these pressing problems. Clarification of principles of social capital within the context of nursing workplace is the tenet of its successful application in nursing management.

Read in 2014, coined the term 'nurses' workplace social capital'. Her pioneered concept analysis work, although important, was based on a relatively small sample size, seven journal articles and one book chapter. The rapid changes in the science of management along with the changes in the nursing workforce and nursing administration roles and responsibilities offer the opportunity for an updated definition for the concept of 'nurses' workplace social capital'. The concept of nurses' workplace social capital should be viewed as an evolving process and not as a 'finished product'. (Read, 2014; Walker & Avant, 2011). The overarching objective of this report is to provide an updated definition and understanding of the concept of nurses' workplace social capital and to strengthen its practical application.

2 | METHOD

We applied the concept analysis approach, developed by Walker and Avant (2011). An iterative process was implemented. The steps included: selecting the concept; determining the aims of analysis;

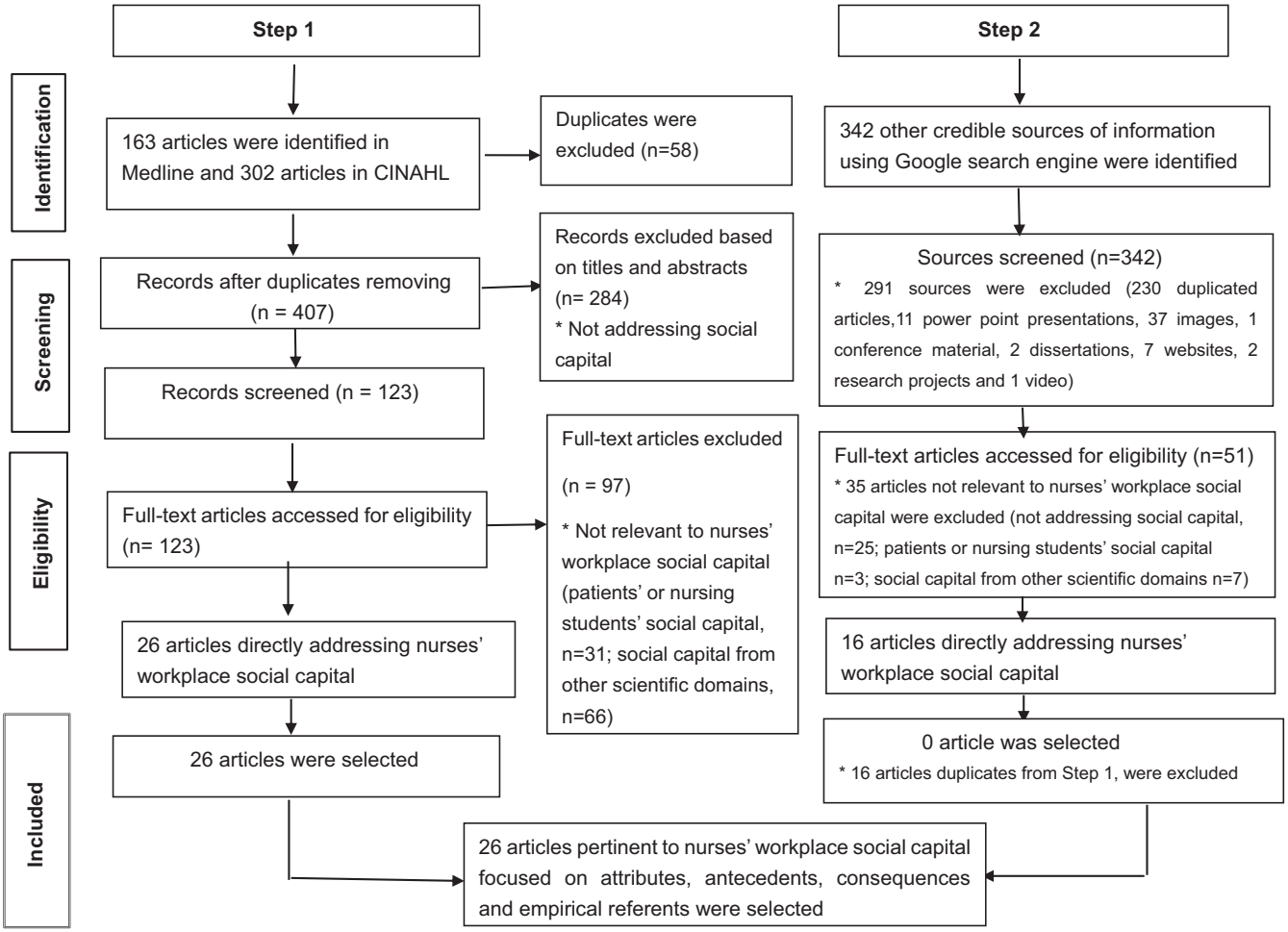

FIGURE 1 A two-step process was implemented in selecting the final 26 peer-reviewed articles

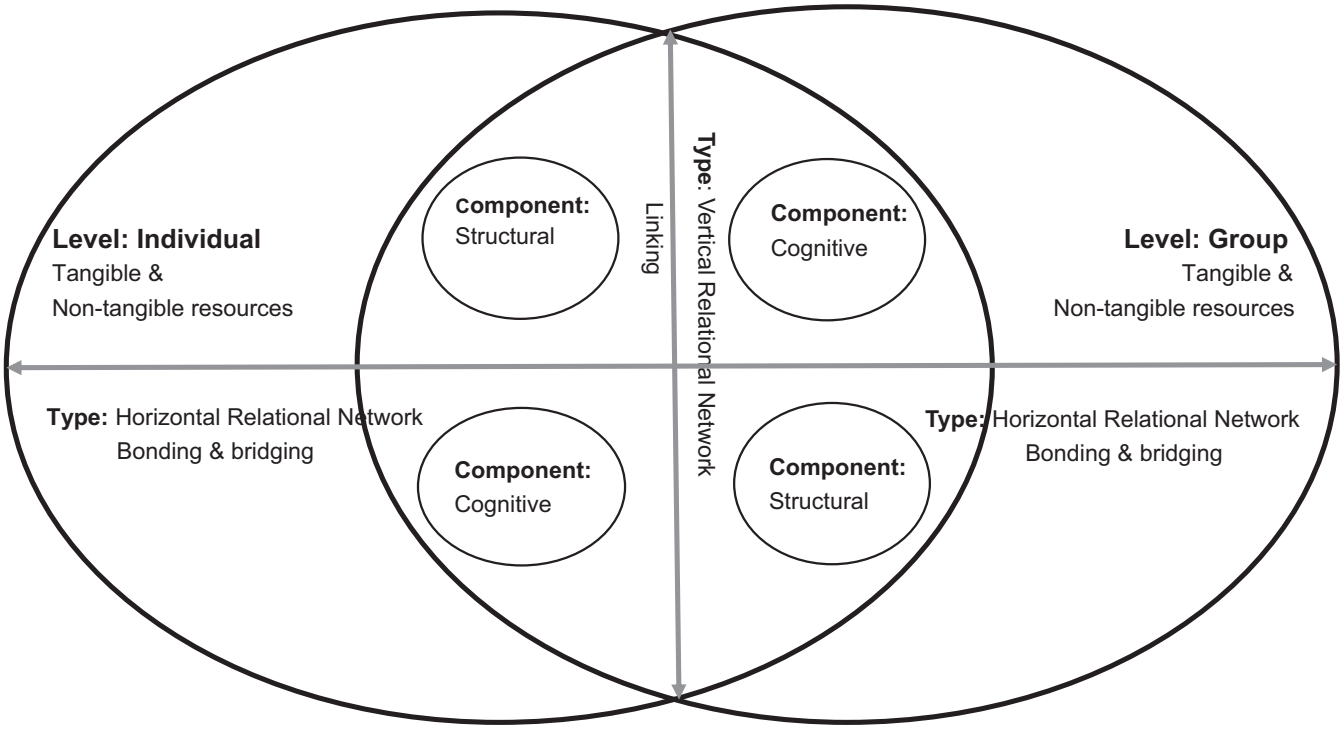

FIGURE 2 Nurses' workplace social capital and its classifications. Three classifications of workplace social capital within the field of nursing: Level, Types and Components. These classifications are distinct but interdependent. At each stratum, individual and group, tangible and non-tangible resources derived from the network of relationships are observed; under the Type classification, social capital is grouped into horizontal and vertical, where bonding, bridging and linking interactions are described. The structural social capital explains the configuration of the relational network (the extent and intensity of social interactions); while the cognition component addresses the assets (e.g. trust, reciprocity, sharing, cohesion) embedded in the structure

discovering the usage of the concept; determining the defining attributes; and identifying antecedents and consequences and defining the empirical referents (Walker & Avant, 2011).

2.1 | Data sources

We implemented a two-step intensive literature review, which began by identifying articles published in English language. The first step consisted of searching the most comprehensive scientific and clinical literature database, 1946–2019, using the 'Medline' and 'CINAHL' search engines. We used the search terms "social capital", "nursing" or "nurse" or "nurs*" with proper Boolean operators to conduct our literature search. We opted to use the search term "social capital" in lieu of "workplace social capital" because this search term is more comprehensive and inclusive of the concept of 'workplace social capital'.

Our initial search was refined by limiting the results to full-text, peer-reviewed journals, published in English language. This process yielded a total of 163 articles in 'Medline' and 302 in the 'CINAHL' (Figure 1). All the 465 articles were imported to 'EndNote', and a total of 58 articles were eliminated because of duplication. This step was followed by scanning of titles and abstracts of the remaining 407 articles. Publications that had not addressed the concept of social capital were excluded. Reference lists of these selected articles were reviewed for additional sources of information. The final selection from the step 1 of our search strategy yielded a total of 26 articles directly addressing nurses' workplace social capital.

In the second step, we used the search engine 'Google' and conducted additional search for credible sources of information. The search terms used in this step were "social capital", "nursing" or "nurses" or "nurse" with proper Boolean operators. Our initial search yielded a total of 342 sources of information. The retrieved sources of information were manually reviewed, and 291 were excluded because of either duplication or the source of information did not meet the eligibility criterion of a 'full article'. The contents of the remaining 51 sources were screened. A total of 35 articles were excluded because they were not relevant to nurses' workplace social capital. The remaining 16 articles were duplicates from the step 1 of our search strategy (Figure 1).

All the articles were read carefully to reduce the likelihood of knowledge bias in identifying the social capital usage; the 26 articles pertinent to nurses' workplace social capital were selected to define attributes, antecedents, consequences and empirical referents to address the objective of our analysis (Walker & Avant, 2011). In addition, six book chapters on social capital were reviewed. Finally, the authors held multiple in-person meetings with two nursing academicians with expertise in the theoretical and practical concepts of social capital. Different sources can be helpful in delineating the meaning of a concept (Walker & Avant, 2011).

3 | RESULTS

3.1 | Development and evolution

The term social capital was first coined by L.J. Hanifan in 1916 (Hanifan, 1916). However, this concept became well-known and popularized by the work of the French social scientist, Pierre Bourdieu (Bourdieu, 1986). According to Bourdieu, capital is not exclusive to economic concepts; additionally, he rationalized that human interactions and social exchanges are not solely based on self-interest and monetary gains. Peirre Bourdieu grounded his conceptualization of social capital on theories of social reproduction and symbolic power (Bourdieu, 1986).

The notion of social capital has been adapted and expanded by scientists across different scientific domains, such as economics, political sciences or health care. For example, In 1993, Robert Putnam adapted this concept and morphed it for application in the field of public health (Putnam, 2000), which was reinforced by the work of Richard Wilkinson 3 years later (Szreter & Woolcock, 2004; Wilkinson, 1996). Each rendition of social capital reflects the technical interpretation of the adapter and mandates of his/her different scientific domains and most likely the social norms and values of the time (Coleman, 1988; Grootaert, Narayan, Jones, & Woolcock, 2004; Kawachi, Subramanian, & Kim, 2008; Putnam, 2000; Wilkinson, 1996).

The term social capital' was introduced into the field of nursing in mid-1990s (Hsu, Chang, Huang, & Chiang, 2011). Since then, its conceptualization and definition in the field of nursing have been evolved and redefined. The first article addressing nurses' workplace social capital was published by Pesut in 2002. Our literature review yielded three distinct classifications of social capital within the field of nursing: (a) Level, (b) Types and (c) Components. These classifications are distinct but interdependent. We have developed a visual schematic of the inter-relational of these classifications (Figure 2). The main framework and the components of social capital are depicted in circles; meanwhile, the types of social capital are indicated by arrows, reflecting the direction of the relational network.

As shown in the Figure 2, social capital is organized into two strata in the 'Level' classification, Individual and Group (Ernstmann et al., 2009; Kowalski et al., 2010). The social capital at the individual stratum refers to the tangible and non-tangible resources derived from the network of relationships around a person; expansion of these resources beyond a person encompasses the group social capital. Under the 'Type' classification, social capital is divided into bonding, bridging and linking. Bonding and bridging social capital describe intra- and/or inter-group's relationships and are regarded as a horizontal network, while linking social capital is a vertical network that defines relationships across different strata of power (Andersen et al., 2015; Middleton et al., 2018; Sheingold & Sheingold, 2013).

Finally, under the 'Components' category, social capital is grouped as structural (the extent and intensity of social interactions in the relational network) and cognitive (the assets of social capital) (Hofmeyer, 2013; Vagharseyyedin, Zarei, & Hosseini, 2018). The notion of a three-dimensional (structural, relational and cognitive) social capital has been proposed (Nahapiet & Ghoshal, 1998) and used by several nursing researchers (Chang, Huang, Chiang, Hsu, & Chang, 2011; DiCicco-Bloom et al., 2007; Read & Laschinger, 2015); however, the relational social capital (e.g. trust, reciprocity) constitutes the assets of social capital. Therefore, throughout this manuscript we refer to the two-dimensional structure of social capital. Figure 2 captures the overall configuration and complexity of nurses' workplace social capital. This complexity calls for a clear clarification of the concept within the context of contemporary nursing workforce, given its significance in contributing to a healthy workplace. A thoughtful and comprehensive definition is useful in clarifying a concept (Walker & Avant, 2011).

3.2 | Defining attributes

Defining attributes are clusters of characteristics that represent the core meaning of a concept. The essence of a scientifically valid concept analysis pivots on identifying these defining attributes. Numerous characteristics of social capital have been identified in nursing publications (Andersen et al., 2015; Chang, Huang, Chiang, Hsu, & Chang, 2012; Chang, Chu, Liao, Chang, & Teng, 2019; DiCicco-Bloom et al., 2007; Ernstmann et al., 2009; Firouzbakht et al., 2018; Hofmeyer, 2003, 2013; Hofmeyer & Marck, 2008; Hsu et al., 2011; Jafari, Pourtaleb, & Khodayari-Zarnaq, 2018; Kowalski et al., 2010; Laschinger, Read, Wilk, & Finegan, 2014; Middleton et al., 2018; Norikoshi, Kobayashi, & Tabuchi, 2018; Pesut, 2002; Read, 2014; Read & Laschinger, 2015; Sheingold, Hofmeyer, & Woolcock, 2012; Sheingold & Sheingold, 2013; Shin & Lee, 2016, 2017; Tei-Tominaga & Nakanishi, 2018; Vagharseyyedin et al., 2018; Van Bogaert, Kowalski, Weeks, & Clarke, 2013; Vardaman et al., 2012) (Appendix A). However, five of these characteristics, Relational Network, Trust, Shared Understanding, Reciprocity and Social Cohesion, are the most frequently stated in the literature; thereby, these attributes have been considered as the essential determining attributes of nurses' workplace social capital (Walker & Avant, 2011).

Relational network has been parsed into a range of terms, for example, the structure of relations, the social networks and networks of social relationships, the configuration of relationships, the pattern of relationships (Appendix A). Relational Network suggests that nurses develop and maintain social capital through supportive connection and cooperation, at different levels of intensity and density, with each other and the other healthcare professionals. The configuration of the relational network can be vertical (linking social capital) and horizontal (bonding and bridging social capital).

Trust (trust and mutual trust) is one of the most critical characteristics of social capital (DiCicco-Bloom et al., 2007). With a high level of trust, nurses feel they can rely on colleagues and are not afraid to expose self-vulnerability as they believe others can accept the spirit of corrective action and will not take advantage of them (DiCicco-Bloom et al., 2007; Hofmeyer & Marck, 2008; Hsu et al., 2011). Thereby, trust can remove the barriers of knowledge sharing,

which is essential for establishing a successful team. According to Read's concept analysis, Trust is an antecedent of social capital (Read, 2014). However, almost all the publications in this field have highlighted the term 'Trust' as the core, but not the antecedent, characteristic of social capital.

Shared Understanding is a broad attribute summarized by the terms of shared vision and aims, shared attitude, values and norms, shared codes and paradigm, among many others (Appendix A). Essentially, Shared Understanding creates a common subjective system of notification about 'what is right and what is wrong' and embodies collective goals of a group (Hsu et al., 2011). This attribute assists with changes in personal perceptions that are needed in forming a better understanding of acceptable workplace behaviours and essential for managing and constructively addressing organisational challenges.

Reciprocity is another attribute of nurses' workplace social capital. Reciprocity extends beyond meeting the expected roles and responsibilities; furthermore, it neither belongs nor relies on a formal reward system. Reciprocity is not 'tit-for-tat' or reciprocal altruism, but it indicates the willingness of the nurses to help others on a voluntary basis without prior negotiations (Hofmeyer, 2003, 2013; Norikoshi et al., 2018).

Finally, nurses' workplace social capital is unified by the attribute of social cohesion. This attribute can be described as generating group unity to support and nourish a sense of community and a sense of belonging; in other words, social cohesion promotes the feeling of 'I am one part of the total sum'. Nursing workforce is an amalgamation of people with diverse backgrounds. Diversities in culture, social believes and norms and ethnic heritages are components of our contemporary nursing workforce (Hofmeyer, 2013). A constructive social cohesion at workplace can facilitate and emphasize respect and tolerance for diversity and variations in ideas and approaches. This attribute of nurses' workplace social capital promotes team integrity (Hofmeyer & Marck, 2008).

3.3 | Antecedents

Development and establishment of a constructive and productive nurses' workplace social capital depends on multiple pre-requisites or antecedents. Effective leadership is an important antecedent. (Hofmeyer, 2013; Read, 2013; Read & Laschinger, 2015) Effective leaders distinguish between leadership and management. The basic element of constructive leadership for nurse leaders is to create harmonious relationships with and among the members of the nursing workforce and the other healthcare professionals (Hofmeyer, 2013). Another antecedent is effective communication. Positive and constructive communication, one definition of effective communication, are the crux of productive interaction and relationship development (Read, 2014; Vardaman et al., 2012). Poor and inappropriate communication can have deleterious consequences that will destroy nurses' workplace social capital (Hofmeyer, 2013). The other important antecedent includes, but not limited to, a proactive engagement in group events. Social capital can be activated and improved by engagement in formal or informal activities (Andersen et al., 2015; Pesut, 2002; Shin & Lee, 2017). Although an array of behavioural precursors can influence the nurses' workplace social capital, the aforementioned three are the most important ones.

3.4 | Consequences

The primary outcomes of a constructive workplace social capital on the nursing workforce are lower level of emotional exhaustion and mental distress; while, it increases self-related healthy behaviours and an overall job satisfaction (Kowalski et al., 2010; Middleton et al., 2018; Sheingold & Sheingold, 2013; Shin & Lee, 2016). The other benefits of a constructive social capital include fortification of intention to stay, enhancement of organisational and professional commitments and knowledge sharing (Chang et al., 2012, 2019; Hsu et al., 2011; Sheingold & Sheingold, 2013). Social exclusion can be one negative caveat of the nurses' workplace social capital. Social exclusion has been defined as prevention or denial of accessing to rights, opportunities and resources that are available to members of a tightly bonded group of individuals (Béland, 2011). Findings from several research suggest that social capital can lead to social exclusion due to over strong bonding among nursing staff (Hofmeyer & Marck, 2008; Tei-Tominaga & Nakanishi, 2018).

The positive consequence or outcomes of a constructive social capital extends beyond the nursing workforce; its positive consequences reverberate on the quality of healthcare services delivered to patients and the reputation and financial well-being the healthcare organisations. Constructive and higher nurses' workplace social capital have been reported to yield better quality of care for patients, better clinical risk management, improved patients' safety, evidence-based practice adoption and unit effectiveness (Chang et al., 2012; Ernstmann et al., 2009; Jafari et al., 2018; Laschinger et al., 2014; Shin & Lee, 2016, 2017).

3.5 | Empirical referents

Empirical referents are the means for recognizing the defining attributes rather than the tools for measuring the concept (Walker & Avant, 2011). Empirical referents can be either specific actions or actual work phenomenon, for example, marginalization of ageing nurses (Bu & Jezewski, 2007).

We have identified an array of empirical referents from the literature and have classified them under the five core attributes (Appendix B). For instance, under the theme of 'Trust', we have included the following behaviours: 'It's safe to ask others for assistance or information' (Hofmeyer, 2003, p. 13), 'expose self-vulnerability based on the belief that their peers will not take advantage of them' (Hsu et al., 2011, p. 1,386) and 'nurses can

rely on co-workers at the workplace' (Tei-Tominaga & Nakanishi, 2018, p. 10 of 13). These empirical referents elaborate the occurrence of the concept of 'nurses' workplace social capital' and its five attributes.

3.6 | Proposed revised definition of nurses' workplace social capital

Read initially defined nurses' workplace social capital as 'nurses' shared assets and ways of being and knowing that are evident in and available through, nurses' networks of social relationships at work' (Read, 2014, p. 1,004). The author has emphasized, although implicitly, the relational network and assets that are embedded within this network; however, the characteristics, structure and function of nurses' workplace social capital are not clear according to Read's definition, especially given the contemporary changes in nurses' workplace. Therefore, we have revised the definition of nurses' workplace social capital to: *'A relational network configured by respectful interactions among nursing professionals and between the other healthcare professionals. These interactions are characterized by the norms of trust, reciprocity, shared understanding and social cohesion. This relational network contributes to creating a healthy workplace, which is fostered and fortified by effective communication, active group engagements and a supportive leadership'*. We believe this updated definition captures the changes in the demographic and sociocultural values of nurses' workplace and should help with the practical application of social capital, especially when addressing challenges in the contemporary nursing workforce.

4 | IMPLICATIONS FOR NURSING MANAGEMENT

Nurse leaders should dedicate time and effort to improve workplace social capital for their nursing staff, given its positive consequences. A holistic understanding of the concept of social capital is the tenet of a healthy work environment for nurses. This healthy environment can encourage nurses to flourish in their performance and responsibilities towards their patients, colleagues and healthcare organisation administration.

Effective leadership is essential, as it is a key antecedent to the development of workplace social capital. Organisational leadership and management training in social capital opens the opportunities for betterment of skills in administration. These skills are pivotal in creating a favourable work environment for the nursing staff and a positive atmosphere in the workplace. In a positive workplace, the nursing workforce is willing to communicate, participate and to respect diversities in opinions, social and cultural values and norms (albeit disagreements). Meanwhile, one caveat of nurses' workplace social capital, the potential for social exclusion, should not be ignored. Social exclusion because of over bonding among the members of a workforce could limit the opportunities for growth and expansion. The balance between limiting and developing bonding social capital needs further exploration in research and practice. The integrated description of classification (Figure 2) offers a direct way for facilitating nursing leaders to consider different kinds of workplace social capital when conducting interventions at workplace and potential opportunities for research in management.

5 | LIMITATIONS

Our concept analysis has two limitations. First, the resources that we used, although from a wide range, were limited to English language. Therefore, this updated definition of nurses' workplace social capital most likely did not capture publications in other languages. Secondly, our concept analysis focused on the most five frequently cited attributes. Nevertheless, these attributes, which demonstrate the core meaning of social capital, easily can distinguish the concept of nurses' workplace social capital from the other concepts in nursing. Furthermore, application of these five attributes meets the required methodological criteria of concept analysis proposed by Walker and Avant in 2011. Finally, we acknowledge that other attributes are emerging in response to the seismic changes in nurses' workplace and workforce; however, these attributes must be systematically and scientifically evaluated before acceptance as core attributes. Despite its limitations, our study has its strength. Our analysis is the first comprehensive review and assessment of literature on social capital and incorporation of the spectrum of changes in nurses' workplace and workforce since 2014, when Read first analysed the concept of nurses' workplace social capital.

6 | CONCLUSIONS

Workplace social capital has been receiving more scholarly attention, and gradually it is becoming embedded within the nursing workplace. We have tried to further refine the present knowledge of nurses' workplace social capital to accommodate the social and cultural changes of the nursing workforce. We have attempted to facilitate further use of this concept at the nursing workplace with the objective of achieving positive outcomes for the nursing staff, patients and the healthcare organisation at-large. The results of our concept analysis should establish a theoretical groundwork for the nursing leaders to better build the contemporary social capital in nursing workplace.

This concept analysis, which is based on a wide range of scholarly resources, denotes a definition of the concept of nurses' workplace social capital that addresses the workplace needs of the modern nursing workforce.

CONFLICT OF INTEREST

Authors do not have any financial and/or other professional interests that might conflict with the professional ethics of conducting of this research and publishing the findings.

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APPENDIX A

Characteristics of social capital in the selected nursing publications

TABLE A1 Characteristics of social capital in the selected nursing publications

Authors	Terms
Chang et al. (2019)	The supporting social network of the profession; a supportive personal network
Firouzbakht et al. (2018)	Trust; networking; social interaction; the norms, values, and beliefs on individuals; group coherence; committed management
Jafari et al. (2018)	Networks; norms; social trust; a set of norms; total resources; values; common values; shared believes; the pattern of interpersonal relations; the emotional quality of the relationships; mutual interactions
Middleton et al. (2018)	Social structure; social networks; norms and attitudes of the group; trust; reciprocity; features of a social organisation
Norikoshi et al. (2018)	The available goodwill source; the structure and content of the actor's social relations; trust; cooperation; solidarity; harmony; social cohesion; affirmation; exchange of appreciation; unrestricted information sharing; access to strength; altruistic reciprocity
Tei-Tominaga and Nakanishi (2018)	Mutual understanding, shared aims, unifying members of social networks and communities; social relational aspects of work
Vagharseyyedin et al. (2018)	Interpersonal trust; reciprocity; mutual aid; a sense of belonging; attitudes, beliefs and values (solidarity, reciprocity and trust); associational links or activity; social network; common understanding and goals; mutual support; employee's sense of organisational atmosphere; bonds among nurses
Shin and Lee (2017)	Collaboration; interpersonal network; trust; common values; common goals; connectedness; quality and quantity of social relationships; external trust, solidarity and empowerment; participation and affiliation; internal trust, solidarity and harmony; social cohesion with co-workers; conflict management
Shin and Lee (2016)	The resources derived from the networks of social relationships at work; shared assets; shared way of knowing; support; cooperation and external trust, solidarity and empowerment; participation and affiliation; internal trust, solidarity and harmony; social cohesion with co-workers; conflict management
Andersen et al. (2015)	Networks; shared norms, values and understanding; trust; cooperation; common understanding; cooperation
Read and Laschinger (2015)	Interpersonal relationships; the configuration of relationships; the nature or quality of relationships; shared meanings and understandings of the group; a sense of community; trust; reciprocity; social relationships

(Continues)

TABLE A1 (Continued)

Authors	Terms
Laschinger et al. (2014)	The resources derived from the network of relationships; the pattern of relationships; the affective quality of relationships; trust; reciprocal interaction; shared understanding about the nature and goals of the work
Read (2014)	Defining attributes: networks of social relationships at work (relationships with other nurses, other healthcare professionals, or people in differential positions from oneself); shared assets (support, cooperation and teamwork, information and opportunities); shared ways of knowing and being (shared values, understandings, beliefs, practices, social norms and vision)
Hofmeyer (2013)	Relational norms; networks; mutual understanding; shared values; common goals; behaviours that bind the members of human networks; the structure of relationships; norms of trust; trust and solidarity; collective action and cooperation; information and communication; social cohesion and inclusion; empowerment; reciprocity; resilience to manage conflict; network ties; mutual understanding; shared aims and ethic values; team structure
Sheingold and Sheingold (2013)	The quality of relationships and networks; a sense of belonging; reciprocity; groups and network (group membership); trust and solidarity; collective action and cooperation; information and communication; social cohesion and inclusion; empowerment and political action; shared values; shared vision; external trust, solidarity and empowerment; participation and affiliation; internal trust, solidarity and harmony; social cohesion with co-workers; conflict management
Van Bogaert et al. (2013)	Social structure; trust; reciprocity, shared values; perceived mutual trust
Chang et al. (2012)	Social interaction; trust; shared vision; shared code; shared paradigm; trustworthiness; shared representations, interpretations and system of meaning; connections among members (network); the same mental models
Vardaman et al. (2012)	The sum of standing and trust; an individual's network of relationship; a product of the quality and nature of connections; a sense of self-efficacy
Sheingold et al. (2012)	Group and networks; trust and solidarity; collective action; information and communication; social cohesion and inclusion; empowerment and political action; informal social networks; group membership; reciprocity; group cohesion, information flows across networks
Hsu et al. (2011)	Social interaction; trust (credibility and benevolence); shared vision (collective goals and aspirations); social resource; the network of relationships
Kowalski et al. (2010)	Shared values; mutual trust; a durable network of relationship of mutual acquaintance and recognition; membership in a group; the structure of relations; collective value; common convictions and values; a resource helping people to cope with stress and foster salutogenetic potential
Ernstmann et al. (2009)	A network of relationships; the structure of relations; collective value; mutual trust; social networks; common values; common conviction; a sense of community; social relationships
Hofmeyer and Marck (2008)	Group and networks; trust and solidarity; collective action and Cooperation; information and communication; social cohesion and inclusion; inclusive teams
Dicicco-Bloom et al. (2007)	A network of relations; different types of linkage; quality or substance of interactions; shared knowledge and understanding; reciprocating; cooperating; trusting; transformative shared understanding; bonding; bridging; fluid alliances
Hofmeyer (2003)	Trust; cooperation; reciprocity; resilience to uncover social interaction; social cohesion; networks; generalized reciprocity and resilience; social connectedness; cooperation; a set of narratives of juxtaposed social interactions; resilience in effectively managing conflict, diversity and change
Pesut (2002)	The currency of relationship exchange; the stock of active connections; trust; mutual understanding; shared values; behaviours binding members of human networks and communities

Note: Articles are listed in a chronological order.

APPENDIX B

Empirical referents of nurses' workplace social capital

TABLE B1 Empirical referents of nurses' workplace social capital

Attributes	Empirical referents
Relational network	- 'The employees involved in decisions about changes at the workplace' (Andersen et al., 2015, p. 812)
	- 'Connections among members: with whom and with what frequency' (Chang et al., 2012, p. 1794; Hsu et al., 2011, p. 1,385)
	- 'Emphasis on teamwork and the value of every member's contribution' (Dicicco-Bloom et al., 2007, p. E19)
	- 'People in the work unit cooperate in order to help develop and apply new ideas' (Firouzbakht et al., 2018, p. 188; Middleton et al., 2018, p. 6 of 14)
	- 'People keep each other informed about work-related issues in the work unit' (Firouzbakht et al., 2018, p. 188; Middleton et al., 2018, p. 6 of 14)
	- 'Problems are raised and resolved quickly and effectively' (Hofmeyer, 2003, p. 13; Hofmeyer, 2013, p. 784)
	-'Leaders value what you do, and you are able to use skills and knowledge' (Hofmeyer, 2003, p. 13)
	- Feedback is helpful and constructive' (Hofmeyer, 2003, p. 13)
	- 'Cooperate within and across the network by sharing knowledge and resources (information, advice, favors)' (Hofmeyer, 2013, p. 785)
	- 'Linking across networks to leverage resources from leaders for organizational benefit, service delivery outcomes and individual career advancement' (Hofmeyer, 2013, p. 784)
	- 'Cooperate with others outside their unit to create partnership' (Hofmeyer, 2013, p. 784)
	- 'Access to the strength of others to overcome difficult situations' (Norikoshi et al., 2018, p. 78)
	- 'Start having relationship with others while showing appreciation to each other' (Norikoshi et al., 2018, p. 77)
	- 'Unrestricted information sharing in the unit' (Norikoshi et al., 2018, p. 77)
	- 'Nurses have access to essential information for making informed decision' (Shin & Lee, 2017, p. 268)
	- 'In our unit there is favorable work climate' (Van Bogaert et al., 2013, p. 1673)
	Indicators with potential compromising impacts
	- 'Deliberately withhold crucial information' (Hofmeyer, 2003, p.14; Hofmeyer, 2013, p.784)
	- 'Problems between people are ignored, until eventually erupting' (Hofmeyer, 2003, p. 14)
	- 'Calls for new work practices are resisted' (Hofmeyer, 2003, p. 14)
Trust	-'Trust in the ability of the other teams to do the job well' (Andersen et al., 2015, p. 812)
	- 'Rely on the nurses I work with' (Chang et al., 2012, p. 1798)
	- 'Nurses have confidence in one another' (Chang et al., 2012, p. 1798)
	- 'Overall, nurses are trustworthy' (Chang et al., 2012, p. 1798; Ter-Tominaga & Nakanishi, 2018, p. 3 of 13)
	- Conduct 'discussion or behavior-corrective action with the assumption that the group will accept the spirit of the corrective action' (Dicicco-Bloom et al., 2007, p. E 21)
	- Be more likely to admit a mistake (Dicicco-Bloom et al., 2007)
	-'We trust each other' (Ernstmann et al., 2009, p. 343; Kowalski et al., 2010, p. 1657)
	- 'Staff will not suffer while reporting their own or colleagues' errors' (Ernstmann et al., 2009, p. 341)
	- Nurse can trust the manager (Firouzbakht et al., 2018; Middleton et al., 2018)
	- 'It's safe to ask others for assistance or information' (Hofmeyer, 2003, p. 14)
	- 'Feel trusted by leaders, colleagues and others' (Hofmeyer, 2003, p. 13)
	- 'Trust others in the unit, including strangers' (Hofmeyer, 2013, p. 784)
	- 'Trust hospital executives and clinical leaders in the organization' (Hofmeyer, 2013, p. 784)
	- 'Individuals will expose self-vulnerability based on the belief that their peers will not take advantage of them' (Hsu et al., 2011, p. 1,386)
	- 'People are willing to cooperate without strict behavioral control' (Hsu et al., 2011, p. 1385)

(Continues)

TABLE B1 (Continued)

Attributes	Empirical referents
	- 'Trust other people's potential talent/ability, feeling that I can leave this to others' (Norikoshi et al., 2018, p. 77)
	- 'Trust nurses on own unit and on other units' (Sheingold & Sheingold, 2013, p. 796)
	- 'Can rely on co-workers at the workplace' (Tei-Tominaga & Nakanishi, 2018, p. 10 of 13)
	- 'There is trust between nurses' (Van Bogaert et al., 2013, p. 1673)
	Indicators with potential compromising impacts
	- 'Plethora of policies and rules exist' (Hofmeyer, 2003, p. 14)
	- 'It is preferable not to ask for help from others because they will judge you to be inadequate of incompetent' (Hofmeyer, 2003, p. 14)
	- 'Errors are criticized and the person is blamed' (Hofmeyer, 2003, p. 14)
Shared understanding	- 'In our team, we agree on what is the most important in our work tasks' (Andersen et al., 2015, p. 812)
	- 'There is a common understanding between the management and employees on how we should perform our work task' (Andersen et al., 2015, p. 812)
	- 'Have similar perceptions about interacting with one another' (Chang et al., 2012, p. 1880)
	- 'Nurse share the same vision' (Chang et al., 2012, p. 1798)
	- 'Nurses pursue collective goals and mission' (Chang et al., 2012, p. 1798)
	- 'There is a commonality of purpose among nurses' (Chang et al., 2012, p. 1798)
	- 'Everyone is in total agreement with hospital's vision' (Chang et al., 2012, p.1798)
	- 'All members of the group come to an agreement on a success' (Dicicco-Bloom et al., 2007, p. E 22)
	- 'We present a lot of same values' (Ernstmann et al., 2009, p. 343)
	- 'People feel understood by each other' (Firouzbakht et al., 2018, p. 188; Middleton et al., 2018, p. 6 of 14)
	- Have 'a clear vision about shared goals, why individual are working together, and the common outcomes' (Hofmeyer, 2013, p. 787)
	- 'Group members agree on the nature and working objects with each other' (Jafari et al., 2018, p. 286)
	- 'Agreement and consent dominate in our hospital' (Kowalski et al., 2010, p. 1657)
	- 'There is a common goal among nurses' (Tei-Tominaga & Nakanishi, 2018, p. 10 of 13)
	- Nurses pursue the collective goals of their workplace (Tei-Tominaga & Nakanishi, 2018, p. 10 of 13)
Reciprocity	- 'Exchanging action without equal value and negotiation' (Dicicco-Bloom et al., 2007, p. E 21)
	- Be volunteered to support others (Dicicco-Bloom et al., 2007)
	- 'Nurse and medical assistants often stayed late to help each other with tasks' (Dicicco-Bloom et al., 2007, p. E 19–20)
	- 'There is a great willingness to help one another' (Ernstmann et al., 2009, p. 343)
	- 'Offers help to another nurse who is busy, instead of sitting in the nurses' station when their work is finished' (Hofmeyer, 2003, p. 14)
	- 'People help each other out to get the work done' (Hofmeyer, 2003, p. 13; Tei-Tominaga & Nakanishi, 2018, p. 10 of 13)
	- 'A nurse offers to help another nurse, regardless of their location in the network' (Hofmeyer, 2013, p. 786)
	- 'Nurses perform tasks by helping each other, while taking other people's benefits into consideration' (Norikoshi et al., 2018, p. 78)
	- 'Colleagues act in my best interest' (Sheingold & Sheingold, 2013, p. 796)
	Indicator with potential compromising impacts
	- 'Others just do their work and are reluctant to lend a helping hand' (Hofmeyer, 2003, p. 14)
	'I will not help others who have not offered to assist me' (Hofmeyer, 2013, p. 786)
Social cohesion	- 'There is a feeling of unity in my team' (Andersen et al., 2015, p. 812; Ernstmann et al., 2009, p. 343)
	- 'There is a sense of 'we' among employees' (Ernstmann et al., 2009, p. 343)
	- 'New people are include in the team and fit in easily' (Hofmeyer, 2003, p. 13)
	- 'Can raise diverse views, ask awkward questions even to people who are unfamiliar or in positions of authorities, and remain on good terms with others' (Hofmeyer, 2003, p. 13)
	- 'Being able to disagree with one's leader and remain on good terms' (Hofmeyer, 2013, p. 787)
	- 'Appreciate diverse perspectives' (Hofmeyer, 2013, p. 787)

(Continues)

TABLE B1 (Continued)

Attributes	Empirical referents
	-'New nurses fit in easily' (Hofmeyer, 2013, p. 784)
	- 'Respect differences and diversity' (Hofmeyer, 2013, p. 786)
	- 'Show respect and courtesy to others, including the strangers' (Hofmeyer, 2013, p. 784)
	- Show 'tolerance for the varying individuals' (Hofmeyer & March, 2008, p. 150)
	- 'Hold regular team or unit celebration' (Hofmeyer & March, 2008, p. 150)
	- 'Met with coworkers in a private home, or for food/drinks' (Sheingold & Sheingold, 2013, p. 796)
	- 'Met with coworkers for a recreational activity' (Sheingold & Sheingold, 2013, p. 796)
	- 'Met with coworkers in a public place to talk or food/drinks' (Sheingold & Sheingold, 2013, p. 796)
	- 'Have a strong sense of belonging to the work organization' (Vagharseyyedin et al., 2018, p. 448)
	Indicators with potential compromising impacts
	- 'Those disagreeing are scapegoated and marginalised' (Hofmeyer, 2003, p. 14)
	- 'There are hidden norms and rules that serve to exclude some staff' (Hofmeyer, 2003, p. 14)
	- 'New staff or strangers are not readily accepted or included in the team' (Hofmeyer, 2003, p. 14)
	- 'It is safer to be silent with a different point of view, and maintain the status quo' (Hofmeyer, 2003, p. 14)
	- 'New/float nurses report difficulties 'fitting in''(Hofmeyer, 2013, pp. 787–788)
	- Older nurses who are not helping are marginalized (Hofmeyer, 2013)
	- 'Be more likely to exclude others' (Hofmeyer, 2013, p. 784)