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The social construction of nurse educator professional identities: Exploring the impact of a community of practice through participatory action research

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Abstract

Aims: The aim of the study was to explore whether, and how, professional nurse educator identity is co-constructed by a community of practice.

Design: A critical participatory action research (PAR) methodology was used as it extends the principles of action research by seeking purposeful and sustainable social change that recognizes participants as researchers and generators of knowledge.

Methods: Twenty-two sector-based nurse educators employed as either nurse educators or clinical nurse educators participated in the critical PAR. Multiple methods of data generation were pursued in a cyclic and sequential manner consistent in an action research process. Three distinct phases of the research across 2015–2017 involved the generation of data before, during and after the establishment of a nurse educator community of practice. A social constructionist lens of analysis was used to explore the social and relational outcomes. The COREQ checklist was used to appraise the study report.

Results: A sustained period of community of practice engagement enhanced the participants' relationships and shifted their perceived professional identities towards being validated nurse educators with a stronger collective sense of their roles.

Conclusion: For this group of nurse educators, participation in the research resulted in collective meaning-making, praxis, knowledge generation and the co-construction of their professional identities.

KEYWORDS
action research, community of practice, construction, education, identity, nurse educator, nurses, professional

1 | INTRODUCTION

The development of identity as a nurse educator provides guidance for the necessary development of knowledge and orientation that facilitates specialization and differentiates the nurse educator role from other nursing roles. Improvements in health outcomes potentially sensitive to nursing practice have been associated with having adequately qualified and well-educated nurses (Aiken et al., 2014). In 1997, the International Council of Nurses recognized that nursing specialists required additional education and training, with teaching

defined as one of the areas of specialty practice (Russell, 1997). Nurse educator expertise is crucial to the retention, maintenance and enhancement of the nursing workforce and associated desired health outcomes (WHO, 2018). Globally, the construction of nurse educator identity has been explored in the context of academic or bachelorette nurse education roles and found limited teacher training (Lazzari et al., 2019) and role transition support (Barrow & Xu, 2021; Shajani, 2020).

In Australia, health workforce reforms have resulted in a significant investment of resources focused on the development of education in clinical practice (Australian Government National Health and Hospital Reform Commission, 2009). The investment included funding 9847 nurse or midwife educator positions nationally (Australian Institute of Health and Welfare, 2015). This funding equates to an annual salary budget of close to one billion dollars (NSW Government, 2019). Sector-based nurse educators work in health-care settings such as hospitals and community health services, as opposed to higher education institutions. Importantly, these nurse educators support new nursing graduates who, internationally, have been found to have higher rates of clinical errors than their more experienced peers do (Africa & Shinners, 2020).

Despite subsequent investment and policy recommendations for nursing education, there is little evidence that indicates if, or how, sector-based nurse educators have achieved a specialized level of expertise as educators. A cross-sectional survey of nurse educators from Australia (n = 138, 15% response rate) found that fewer than half of the respondents were confident in their skills as nurse educators and less than 10% perceived themselves as expert nurse educators (Oprescu et al., 2017). In New South Wales (NSW), a Local Health District (LHD) enquiry into nurse educator practice (n = 38, participation rate 84%) found low nurse educator work satisfaction with regard to their own professional development (30% satisfied) and involvement in scholarship or research (30% satisfied; Fairbrother et al., 2015). Larger studies with Australian sector-based nurse educators have described participant role ambiguity and confusion (Sayers, 2013) and a perception of nurse educator roles as being undervalued (Sayers, 2013; Thornton, 2015). These findings are consistent with those found internationally (MacPhee et al., 2009; Manning & Neville, 2009). Internationally, a lack of nurse educator expertise and leadership has been proposed as a gap in frontline strategic workforce development (Daly et al., 2020).

As of 2021, national reviews of nursing education in Australia have consistently overlooked the gap in nurse educator professional development. In 2019, the Australian Government commissioned a national independent review of nursing education (Australian Government Department of Health, 2019). The terms of reference for the review did not include anything about effective education in relation to nurse educator recruitment, professional identity, role satisfaction, development or retention. The focus, rather, remained on nursing clinicians and their undergraduate education and preparation for practice with a recommendation of increasing academic conjoint roles (Australian Government Department of Health, 2019). Other national reports on health-care reform and efficiency have failed to outline what effective nursing education involves (Productivity Commission, 2015).

This paper reports the findings of a participatory action research (PAR) project from an Australian regional NSW LHD. The project explored how the establishment of a community of practice (CoP) facilitated praxis that enhanced nurse educator perceptions of their professional identities as nurses with educator expertise.

2 | BACKGROUND

In consideration of nurse educator preparation and development, there are parallels to be drawn with issues faced by school teachers. In a review of teacher education in Australia, Bahr and Mellor (2016) outlined the 'real world' challenges and uncertainties faced by teachers and highlighted a need for new approaches to teacher professional learning and development. The authors argued that ways of knowing need to look beyond traditional reductionist-type approaches that involve regulatory and competency-driven frameworks towards developmental and collaborative projects (Bahr & Mellor, 2016). One of the key questions asked by the authors was—'how do we best develop a strong professional identity, what are its features, what experience is most generative? (sic)' (Bahr & Mellor, 2016, p. 50). In the teaching literature, it has been argued that the development of teacher identity is a precursor for ongoing development and understanding of practice (Goodnough, 2011).

In the health-care context, an alternative to reductive quantitative research methods includes a constructive approach that offers nurses an avenue for praxis and development of nurse educator professional identity. By looking to their own communities and sharing work experiences in a narrative and reflective way, nurse educators can learn from each other and co-construct their identities (Hoeve et al., 2014). The identity that is fluid and constituted, rather than inherited, suggests an active social interactional process that aligns with social constructionist theory (Gergen, 2015). However, the structure of health-care systems and management of nursing work can obstruct opportunities for relational engagement or the 'uncoupling' of workplace relationships (Habermas, 1987). These barriers mean that a community of practicing professionals is not homologous with a CoP.

A CoP affords an opportunity to overcome workplace isolation and other barriers that can impede socially medicated aspects of identity construction. Central themes related to the establishment, function and sustainability of a CoP include 'mutual engagement', 'joint enterprise' a 'shared repertoire' and belonging, participation and collaboration (Wenger, 1998). The intersection of nurse educator professional identity and communities of practice was the focus of a literature review that found only five papers that used a CoP in the context of nurse educators (Woods et al., 2016). Cain (2018) explored the impact of a CoP on United States College nurse educator (n = 11) identity and found that the CoP provided a sense of belonging and shared professional language.

In addition to limited nurse educator CoP studies, action research has been found to be an under-used methodology in nurse educator research (Woods et al., 2016). Action research used for the professional development and advancement of student nurse clinical supervision roles ($n = 10$) and the creation of a 'Clinical Supervisor Charter' demonstrated a tangible outcome for the participants (Ryan & McAllister, 2020). However, professional development projects may be limited when they do not challenge or seek to change the broader practice conditions that enable or constrain professional practice (Kemmis et al., 2014).

The purpose of the current critical PAR was to generate actionable knowledge and shared meanings to address issues faced by the NSW LHD nurse educators. By drawing on the voices and knowledge of the educators themselves, a PAR methodology shines a light on the language used by the participants. From a social constructionist perspective, Gergen (2015) argued that language is a pre-condition for thought. This prerequisite means that people who share a common culture and language acquire common concepts and shared categories. However, language itself is not something that simply pre-exists and is taken up by humans; it is not transcendental. 'It belongs to the life of a community … and it is activated in praxis as the structuring principle of that praxis' (Crossley, 1996, p. 14). Praxis is a foundational construct for nursing, where learning, research and practice is associated with professional growth and practice development (Fowler & McGarry, 2011). 'If language is indeed the place where identities are built, maintained and constructed, then this means that language is the crucible of change, both personal and social' (Burr, 2015, p. 64). The action of the research, which included communicative action (Habermas, 1987), was focused on the generation of shared meanings and understandings, rather than the production of external knowledge (Kemmis et al., 2014). Central to the critical aspect of the PAR was the establishment of a nurse educator CoP.

3 | THE STUDY

3.1 | Study aim

The aim of the current study was to explore whether, and how, professional nurse educator identity is co-constructed by a CoP.

3.2 | Design

A critical PAR methodology was used for the research. Critical PAR extends the principles of action research (Reason & Bradbury, 2008) by seeking purposeful and sustainable social change that recognizes participants as researchers and generators of knowledge (Kemmis et al., 2014). Multiple methods of data generation were pursued in a cyclic and sequential manner consistent in an action research process.

3.3 | Participants

Purposeful sampling (Sandelowski et al., 2013) was employed to target the experiences of nurse educators from a previous NSW LHD baseline study (Fairbrother et al., 2015). The Australian regional LHD covers over 20,000 square kilometres and is comprised of non-metropolitan, rural referral, district and community-based hospitals and community services employing approximately 2884 nurses and midwives, including 65 in nurse educator roles (NSW Health Ministry, 2018). Potential participants were employed by the LHD as Nurse Educators (NE) or Clinical Nurse Educators (CNE), roles as described in the NSW public health system (state) award (NSW Government, 2019). A participant information sheet and consent form were emailed to all of the LHD nurse educators.

The facilitator of the research was an academic nurse educator and doctoral student who remained actively involved in the co-construction of meaning with the participants. Face-to-face information sessions were convened across multiple LHD sites with potential participants of the research. At these sessions, the lead researcher informed attendees about his role as a doctoral student and awareness of the LHD baseline study findings. Importantly, the lead researcher highlighted that cycles of data generation and action often require a prolonged commitment compared with other forms of research (McDonald, 2012). Due to the unknown aspects of an action research project, it was acknowledged that fully informed consent is an unrealistic goal; rather, consent was renegotiated at each new phase as the project progressed.

3.4 | Data generation

There were three distinct phases of data generation. These occurred before, during and after the establishment of the nurse educator CoP. Phase 1 commenced in late 2014 and led up to the formation of the CoP in mid-2015. Phase 2 spanned an 18-month period of generative action and meaning-making associated with the CoP. Phase 3, in 2017, offered a final stage for the participants to reflect on their experience and research outcomes.

3.5 | Phase 1

Phase 1 offered opportunities for participants to suspend the everyday focus and operational action of their work activities. Suspension of the mundane can be a precursor to a revitalization of the public sphere and provides an opportunity to establish or re-establish relationships beyond daily operational interactions (Kemmis et al., 2014). To facilitate this process, participants gained access to an online login-protected learning management system (LMS) and two online surveys: The Teaching Perspectives Inventory (TPI) and The Capability Of Nurse Educators (CONE) questionnaire. Both surveys were completed prior to participant interviews. The

TPI is an open-access online self-report and self-scoring multi-item inventory to measure five contrasting perspectives (Transmission, Apprenticeship, Developmental, Nurturing and Social Change) of what it means to teach (Collins & Pratt, 2011). Automated report back to participants included a graphic profile of results, explanations of the perspectives and a 10-step interpretation guide. For each perspective, the graph also illustrated a breakdown of the 'beliefs', 'intentions' and 'actions' subscore components. Alignment of these scores suggests that a teacher is connected to their teaching practice (Collins & Pratt, 2011). The CONE was developed as a tool sensitive to the complexity of nurse educator roles with capabilities, rather than competencies, reported as a better way to describe specialty practice associated with nurse educator roles (McAllister & Flynn, 2016).

The semi-structured in-depth interviews served to guide participants to reflect on their 'taken for granted' beliefs about their practice. This method is aligned with the assertion that active and proactive critical self-reflection is a key characteristic of PAR (Kemmis et al., 2014). Participants were asked how and when they moved into their first teaching role, whether they received any orientation (and support), how they viewed themselves as professionals and how they viewed their TPI scores. Throughout the interview process, the interviewer was conscious of being involved in the co-construction of the conversation with the interviewees. The interviews were conducted at a time and location suitable to each participant. Prior to the interviews, a tablet device and an audio application were tested for recording quality and recordings were saved as MPEG Audio Layer-3 (MP3) files.

3.6 | Phase 2

Phase 2 spanned an 18-month period of meetings, action and meaning-making associated with the establishment of the CoP. To facilitate participation, sub-group meetings that ranged from 2 to 4 h were held across three LHD sites and participants selected meeting dates using the *Doodle Poll* application. A participant for each site helped to book meeting rooms with audiovisual equipment to allow the presentation of the Phase 1 data and group conversations were audio recorded for later analysis. Subsequent meetings included group goal setting and the establishment of associated activities. In addition, two whole-of-group meetings of 6 h duration were held at a mutual fourth site 12 months apart (see Figure 1). Over the year in between these two meetings, participants were encouraged to use the LMS site for asynchronous communication and discussions, along with the maintenance of a private journal. LMS folders were created for CoP goal-aligned activities and participants were allocated to group pages based on their chosen activities. The lead facilitator worked with each group to track the activity and provided stimulus postings on the LMS site. At the whole-of-group meetings, the participants were asked 'as educators, what are our current strengths?' and the *Poll Everywhere* platform was used to collate group responses.

3.7 | Phase 3

Phase 3 provided opportunities for participants to reflect and comment on the research data and associated outcomes from Phase 2 that included perceptions of their professional identities. To facilitate reflection on 2 years of the research, a simple professional identity visual analogue scale (PIVAS) tool was provided to the participants immediately before an interview (Appendix S2). The tool consisted of two 200-mm lines representing 2015 and 2017, with 'nurse' at one end and 'educator' at the other end. The lines allowed the measuring of interval data to calculate individual scores and group mean ratings for the two periods. For example, a line marked 20 mm from the nurse end equated to a score of 0.1 (10%). Participants were asked to reflect back on the time just before they joined the research in 2015 and mark their perception of their professional identity at that point in time. The present time of 2017 indicated the time just before the Phase 3 interviews. Rather than using statistical data to make claims about the participants' identities, the participants' interpretations of these scores were explored through a dialogical and relational process.

Participant interviews used semi-structured interview questions aligned with the personal value narrative template (Wenger et al., 2011), designed to explore the outcomes of participation in a CoP. The following questions were included to explore the impact of participation in the community over the 2 years.

- How did participation change you as a professional (prompts considered—skills, attitude, identity, self-confidence, feelings)?
- How did participation affect your social connections (number, quality, frequency, emotions)?
- How did participation help your professional practice (ideas, insights, material, procedures)?
- How did your participation change your ability to influence your world as a professional (voice, contribution, status, recognition)?

3.8 | Ethical considerations

To protect participant anonymity, along with the use of participant pseudonyms, the effort was made to avoid descriptions about participants' roles such as the specific site, location or nursing specialty of a participant. Only the lead researcher and participants who provided signed consent forms gained access to the community of practice online site and meetings. In consideration of the ethical issues and dilemmas associated with collaborative and participatory forms of action research, additional PAR principles as outlined by Locke et al. (2013) were included in the formal ethical procedures. The study conformed to the National Statement on Ethical Conduct in Human Research 2007 (National statement on ethical conduct in human research 2007, 2018) and ethics approval to complete the PAR was obtained from the LHD and university human research ethics committees.

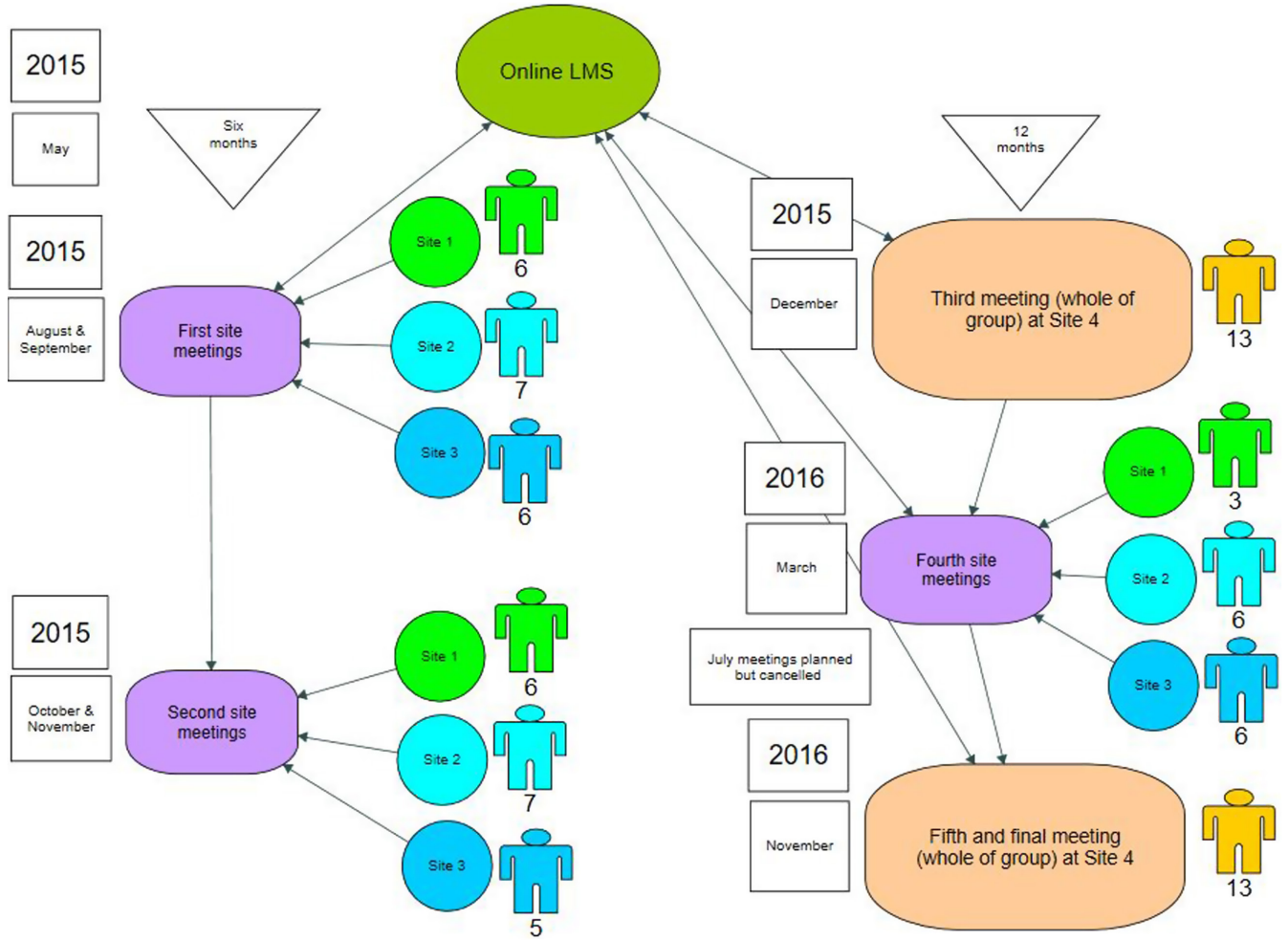

FIGURE 1 Phase 2 methods

3.9 | Data analysis

All interviews were audio recorded and transcribed using QSR International's NVivo (version 11). The lead researcher then used NVivo (version 11) for the first three phases of Braun and Clarke's (2006) six phases of thematic analysis. This consisted of becoming familiar with the data, the generation of initial codes and the arrangement of data for potential themes as thematic discussion points. The initial analysis helped to set the scene for the subsequent collective thematic analysis and meaning-making (Kikooma, 2010) by all participants who attended the first Phase 2 meetings. The group analysis was a distinct critical, participatory and empowering aspect of the research as there was no 'external' team of expert researchers doing the analysis.

Descriptive statistics were used to describe the CONE demographic data, along with the TPI and CONE mean scores and standard deviations. All of the Phase 1 data generated were de-identified and shared at the first CoP meetings. This included the TPI and CONE group mean scores, the interview thematic discussion points and sample quotations. For the PIVAS scores, the group mean and standard deviations for 2015 and 2017 were calculated and used as a reference point for reflection during the Phase 3 interviews.

A social constructionist lens was drawn to analyse the data generated during the research. Social constructionism highlights how common understandings of the world are historically and culturally located and dependent on particular social arrangements (Gergen, 2015).

3.10 | Rigour and credibility

The rigour and credibility of the findings from the PAR hinged around the concept of trustworthiness. Trustworthiness involves following through on promises, accountability and a shared sense of value congruence and justice (Mullins et al., 2020). Credibility was enhanced through the ethical aspects of benevolence, integrity and fairness, which helped to ensure the research was respectful, accountable and competent whilst being inclusive of shared learning and committed partnerships (Mullins et al., 2020). The maintenance of a research audit trail and alignment with PAR philosophical foundations enhanced the dependability and confirmability of the research. Confirmability is linked to the transparency and audibility of the methods and data generated. Through communicative action (Habermas, 1987), the pursuit of mutual understanding and

unforced consensus provides validity to the knowledge generated (Langlois et al., 2014). For the current study, this meant that data generated through multiple methods (quantitative and qualitative) were employed for action stimulus. 'Action stimulus for personal as well as social transformation' helps to address professional issues and challenges, and 'equity among PAR co-participants contributes to the critical capacity of the group to achieve mutual understandings (Langlois et al., 2014, p. 228).

The PAR reporting was checked using the COnsolidated criteria for REporting Qualitative research (COREQ) checklist (File S1).

4 | FINDINGS

4.1 | Phase 1

Twenty-two nurse educators consented to participate in the action research. This entire group (100% participation) engaged in Phase 1. During Phase 2, one participant left the LHD, one gained a non-educator position and one was seconded to a non-educator position. During Phase 3, three additional participants withdrew from the research. By the end of 2017, 16 of the participants had completed Phase 3 (73% participation rate for the whole data generation period). The demographic data presented in Table 1 were derived from the CONE survey.

The majority of participants ($n = 17$, 77.3%) reported having never received an organization award or commendation for their teaching. Half of the group reported having never presented any work at a professional conference or led any professional projects such as research, education or professional development, during the previous 2 years.

4.2 | The TPI and CONE surveys

The majority of participants stated they were not surprised that their dominant TPI teaching perspective was apprenticeship. The TPI Apprenticeship perspective is defined as an assimilation to social norms process dependent on a teacher expert model (Collins & Pratt, 2011). Variance across the participants' sub-scores indicated that their preferred teaching styles lacked theoretical underpinnings. The overall CONE results demonstrated that participants with greater than 4 years of nurse educator experience perceived themselves to be more confident and knowledgeable of the contextual nature of learning compared with their less experienced colleagues.

4.3 | Phase 1 interviews

All participants ($n = 22$) participated in an initial interview which was conducted across the LHD at five different sites. The average length

TABLE 1 Participant demographics

Demographic	Category	*n*	%
Age range (years)	30–39	4	18.2
	40–49	12	54.5
	>50	6	27.3
Position title	CNE	16	72.6
	CME	1	4.6
	NE	5	22.8
Years nursing experience	6–12 years	6	27.3
	13–19 years	5	22.7
	>20 years	11	50.0
Years nurse educator experience	<1 year	2	9.0
	1–4 years	7	31.9
	5–9 years	9	40.9
	>10 years	4	18.2
Highest qualification	Hospital certificate	1	4.7
	Bachelor degree	2	9.5
	Graduate certificate	7	33.3
	Graduate diploma	4	19.2
	Master degree	7	33.3
	Total	21[a]	
Education major?	Yes	8	36.4
	No	14	63.6

Abbreviation: CME, clinical midwifery educator (left research after Phase 1).

[a] One participant did not complete the survey section on highest qualification.

of the interview was 73 min. Qualitative coding resulted in 32 codes that were condensed to seven thematic points of discussion, which were: Being the clinical expert; perceptions of nurse educator practice; competing demands or expectations; lack of support; working in silos; lack of organizational direction or learning objectives and feeling undervalued.

Fourteen of the participants described a difficult transition to their nurse educator role. Participants without any previous formal teaching experience talked about limited resources, guidance or support to facilitate their transition. Very few participants discussed any formal orientation and 13 participants (59%) stated that they received or experienced 'no orientation' to their current nurse educator roles.

> *The only thing that you go in with, to these roles, is your clinical background … It was very much find your feet as you go*
>
> (Julie).

Over three quarters (78%) of the coding that focused on perceptions of professional identity included comments where participants expressed that they felt more like a registered nurse with expertise offering clinical support than a nurse with educator expertise. When discussing their identities, many participants talked about their clinical backgrounds, expertise and currency of practice in relation to their credibility as an educator. Being the clinical expert was described as having either clinical competency and expertise or an expert command of knowledge in a field. Technical competency was the most frequently mentioned term, often described as skills and equipment-related expertise that is highly valued by clinical staff.

> *My thinking is all about my nursing head*
>
> (Julie).

> *I do not feel like an educator, it just feels like I am a support person. I am just one of the other guys. I am a registered nurse and I am clinically relevant*
>
> (Alice).

A lack of training to be an educator was also matched by a lack of professional development as an educator. The majority of participants did not belong to any educational professional groups nor attended education professional conferences. Some stated that they had never even considered educator or teaching competencies or standards. Rather, they discussed how membership of such groups or conference attendance aligned with their clinical specialty (for example, emergency nursing). When asked about nurse educator groups or professional standards, only three participants were aware of the Australian Nurse Teachers Society (ANTS) Standards for Nurse Teacher Practice (ANTS, 2010).

The participants commonly talked about a lack of support for professional development as an educator. Whilst some had pursued higher education qualifications with an education focus/major, many participants had not pursued nurse educator development. Nearly all of the participants talked about the lack of support for education and particularly for professional development as an educator.

> *It's not a matter of me thinking what courses can I go and do that will make me a better educator because that's not the culture of this organization*
>
> (Penny).

> *I did not get much guidance or support. The clinical staff did not know what I was supposed to be doing either. So I guess I was a bit directionless*
>
> (Kerry).

Many participants talked about working in silos and feeling isolated. Several participants talked about the way CNEs, in particular, tend to stick to their specialty area. With some areas only having one CNE, there were limited opportunities to work with other CNEs.

> *One thing I miss in my role, because I am isolated, is that networking which is really important with other nurse educators*
>
> (Evelyn).

> *For many years, it's been silo type work*
>
> (Kath)

Many of the participants expressed that they felt that their roles as educators were undervalued. Participants talked about education not being recognized as a specialty of its own and how staff do not value the nurse educator role.

> *It's not really valued … to develop an educator in the educator domain isn't as valued by the managers as having a clinical specialist. They are looking at CNEs to support the staffing mix more than to develop the staffing*
>
> *(Harper).*

> *I think that the job description became very watery as acuity became greater on the ward. So, a lot of the time you were being used as an extra pair of hands*
>
> *(Julie).*

4.4 | Phase 2

Phase 2 involved the construction of CoP goals (see Appendix S1) and professional development activities. The site meetings had an average duration of 3 h and the whole-of-group meetings went for 6 h. Early discussions and perceptions of professional identity are

presented by the following five themes: Holding on to being a nurse; losing a circle of friends; the gatekeeper; on being the clinical expert and feeling undervalued.

The two themes 'holding on the being a nurse' and 'losing a circle of friends' spoke to a sense of loss or nostalgia for the participants' former roles as clinical nurses.

> *I still very much want to be a nurse*
>
> (Emma).

The participants talked about how they felt they had been separated from their working peers. One participant talked about the difficulty of working with colleagues when she commenced her new educator role and the impact on her work relationships.

> *Some of my best friends used to be the people I worked with, and I have a couple that I am still close to socially, and I am friendly with everyone. But my actual social people are not my work colleagues anymore since I have been in this job. There is an element of us and them, and I am one of them now*
>
> (Emma).

Another participant commented on the notion of ambiguity and the challenge of not having a clearly defined role. This ambiguity contributed to participants not feeling part of the nursing team.

> *That seems to be the overriding theme through it all isn't it? Where do you sit within the educator and clinical, you know … we are sort of … you do not have a delineated role*
>
> (Beverly).

> *I do not see it like a high school teacher … it is something different*
>
> (Marge).

Despite prompting, Marge was not able to clarify how or why her identity differed from these other educators/teachers.

Described as not quite sitting with management and not quite sitting with clinical staff, participants talked about the problem of being seen as a gatekeeper and the clinical expert.

> *It affects the relationship because staff still see you as the gatekeeper … through a competency you tell me I can or cannot do something. Our identity still has that big brother component. Big brother is watching you. I do not want to be the stand over person. I do not want to be the big brother*
>
> (Leila).

> *We employ our CNEs based on their specialty knowledge and skills, not on their education qualifications*
>
> (Carol).

The participants discussed an organizational culture that does not appreciate educators. Misconceptions about the educator role being pulled to 'work on the floor' or taking a patient load were described as common events. Participants also described a lack of appreciation and inequality between nursing and medicine in the context of staff professional support.

> *It is just difficult when there is different rules for different people*
>
> (Gloria).

> *I do not think that the staff actually value educators very highly in lots of areas*
>
> (Kayla).

During the early Phase 2 meetings, participants also identified a range of misconceptions about their roles. A 'spotting fires' reactive approach to education was perceived as the focus of management. The participants also perceived that clinical staff believed an effective educator is about 'being on the floor'. A range of misconceptions of staff who were new to educator roles were revealed and included 'hidden light bulb moments' where staff start to understand the complex levels of governance and professional development beyond the coal face of clinical practice.

After the second site meeting, it became apparent that the subgroup of participants who had chosen to help develop the group philosophy of learning has made minimal progress. In response, the lead facilitator posted guides and literature related to philosophy formulation on the LMS site. During the whole-of-group meetings, the participants were also asked a series of questions that ranged from the earlier TPI data, principles of learning and teacher metaphors. Over the course of Phase 2, the participants started to express perceptions of being a facilitator of learning, rather than a clinical expert. A shared preferred metaphor of the educator as a gardener, rather than a factory supervisor, captured this change. In the factory supervisor metaphor, the educator monitors productivity and maintains performance checklists, whilst the gardener nurtures the conditions that provide learning opportunities (Erickson & Pinnegar, 2017).

At the final whole-of-group meeting, the participants were asked the same group question that had been asked 12 months previously at the first whole-of-group meeting (*as educators, what are our current strengths*?). The two word clouds generated were displayed to the group (see Figures 2 and 3) and as a result, during the final meeting, the participants were able to co-construct a group philosophy of learning based on shared values and emotions about education and learning.

> *Getting those definitions and the philosophy that we helped extract as a group out of doing what we did. I think that helped change my perspective a lot and consolidate the sense of what I was trying to do*
>
> (Leila).

> *I think the first one is about what we do, whereas the second one is more about how we … like, it's more feeling words and emotions, like 'fun', 'passionate', 'cheerful' they are emotional words*
>
> (Carol).

During the Phase 2 period, nine of the participants took up ANTS membership, six became actively engaged in nurse educator conferences and one participant had a journal paper published. Ten participants gained experience in the design and development of an online postgraduate course for their LHD nursing staff. A sub-group developed a draft 3-year transition framework for new CNE nurse educators to help address the orientation and transition issues many of the participants had experienced.

4.5 | Phase 3

Sixteen participants completed the PIVAS scale and engaged in the final interview. As seen in Figure 4, the overall PIVAS 2015 mean score of 0.39 suggested that the participants recalled that, prior to joining the CoP, they tended to identify as a nurse, or with the clinical aspects of being a nurse, rather than as an educator. Nearly two years after joining the CoP, in 2017, a mean score of 0.75 suggested that the participants perceived their identity to be more as an educator or with the education aspects of their role than as a clinical nurse.

Three quarters of the participants recalled that, back in 2015, they identified predominately as nurse and 25% predominately as an educator. In 2017, 6% of the participants (only one participant) perceived their identity to be predominately as a nurse and 94% perceived their identity to be predominately as an educator.

Whilst these results represent the 2017 reflections of the participants (retrospective and current self-analysis), the 2015 PIVAS results were very similar to the 2015 Phase 1 interview results. In Phase 1 (2015), 78% of the participants' interview comments related to professional identity focused on the clinical expertise of their nursing roles and 22% on aspects of educator expertise. These findings indicated a degree of congruency between these data sets across the three phases of the research. Consistent with the PAR methodology, the changes in perceived professional identities found in the PIVAS scores became a focal point for the final interviews.

FIGURE 2 The 2015 Community of Practice strengths word cloud

4.6 | Interview themes associated with perceived identity shift

Five themes were associated with the participants' perceived identity shifts associated with participation in the community of practice. These themes included networking, relationships and communication; validation of the role; confidence in the role, praxis: learning, research and the nurse educator practice and identity shift related to other factors.

4.7 | Networking, relationships and communication

With new and stronger workplace relationships, the participants talked about how new connections provided an opportunity to learn about themselves and their roles. This was described as an opportunity to go beyond their everyday silos and cross-pollinate.

> *And you definitely learnt things about other areas of the hospital when normally you are locked into your own areas. So there was a lot of cross-pollination that is really beneficial*
>
> (Audrey).

This outcome was particularly the case for participants who worked at smaller remote sites of the LHD and normally had minimal contact with educators beyond their local area or zone.

> *I think it has given me more courage to say to other educators how about we get together, you know, and network*
>
> (Evelyn).

The participants talked about how the networking resulted in professional friendships that went beyond their usual formal LHD meetings. This outcome was described as 'grass roots collaboration' that built ongoing working relationships.

> *Gave us that non-structured space to be open and honest and explore things really like as if you were doing it with a group of friends outside of the work environment. I do see that we do collaborate much more that way and*

FIGURE 3 The 2016 Community of Practice strengths word cloud

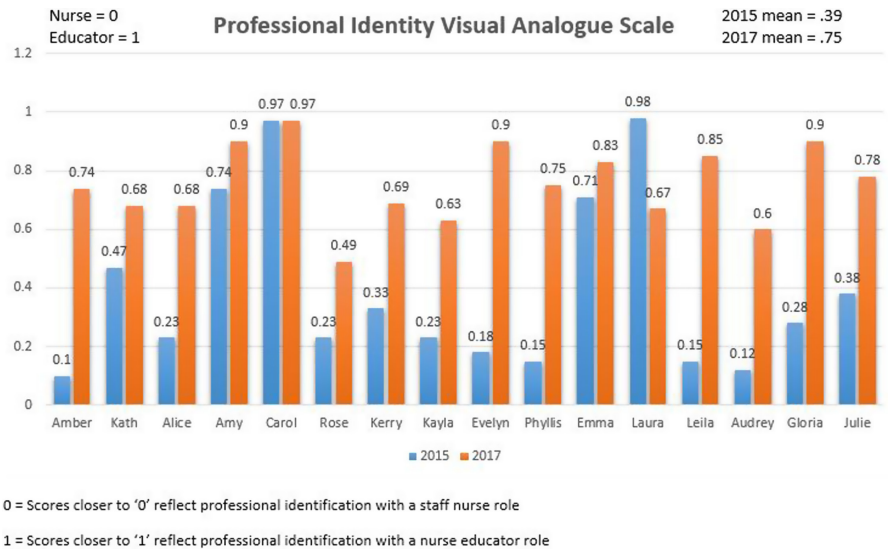

FIGURE 4 Professional identity visual analogue scale results

back each other up. I have a good relationships now on the back of this

(Julie).

Definitely the rapport between a few of us is much, much stronger and I can identify with some of those people. I probably would not have had that rapport prior. Like I would have professionally known them but I do not know if I would have felt as comfortable

(Amy).

4.8 | Validation of the role

The participants described feeling validated as an educator or having their thoughts of what their role should be validated by the group. For less experienced participants, validation was associated with confirmation of their beliefs, new respect and a sense of collegiality that made them feel better about their chosen path.

It is that combination of validating what I thought the role should be and, I think for me as a junior coming into it, just that sense of collegiality that came out of the group

(Leila).

I think it makes you feel validated as an educator as opposed to being a nurse on the floor

(Laura).

I feel that that is part of my role here and it should be recognized as expertise in my role as the educator. I think, so for me, that is a big shift

(Amy).

Participants also described a sense of belonging and being a valued member of the COP. This affiliation extended intellectual engagement to something described as more emotional.

And feeling like I was a valued and belonging member of that group also made me integrate that sense of the role a little bit more

(Leila).

I think it related to feeling more of an educator. Because being a clinical nurse educator on the floor is quite isolating. As an educator being part of the community helped, um, feel like an educator (Laura).

4.9 | Confidence in the role

Confidence was associated with learning, competence and feeling more comfortable. These outcomes suggested that the CoP was a learning community that contributed to insights and knowledge that built confidence.

I think just that interaction, and the networking, you know, it just helped to increase my confidence and my competence because I was learning stuff from them as well

(Phyllis).

The CoP experience helped new nurse educator participants to manage or overcome their anxiety about their role. The decision by four CNE participants to continue with their nurse educator path was expressed as feeling empowered.

I know at the start I was kind of grappling with not understanding why I couldn't just get in this role and be up and running when I felt so confident in my clinical role. I think the group was a lot of it. A big part of my level of confidence and my level of understanding

(Audrey).

I think it gave me a lot more confidence… to pursue that pathway

(Leila).

With the knowledge and the bigger world perspective that I got it sort of empowered me and gave me the knowledge and confidence

(Gloria).

4.10 | Praxis: Learning, research and nurse educator practice

The opportunity to be involved in research that included learning about learning theory and principles, teaching perspectives and nurse educator practice, was perceived by the participants as being associated with professional growth and practice development. The participants talked about the 'doing' of their educator practice in a manner informed by a new perspective or focus on what nurse educator practice should entail.

I just think I have taken it on in making it more of a focus of being an educator on those days, not just being an extra person on the ward

(Rose).

At the praxis—philosophy nexus, a collective understanding of the meaning and purpose of nurse educator roles, was perceived by participants to have influenced their shift in professional identity. Participants also mentioned how the TPI survey and feedback on teaching styles, challenged their earlier beliefs and consolidated their sense of purpose or aims of their role.

Getting those definitions and the philosophy that we helped extract as a group out of doing what we did. I think that helped change my perspective a lot and consolidate the sense of what I was trying to do

(Leila).

4.11 | Perceived identity shift related to other factors

Six participants put their perceived change down to additional factors beyond their CoP experience. One participant asked whether it could be related to dropping another role for a full-time education position. Others talked about completing formal studies in nursing or health education and two participants were promoted from a CNE to an NE position during the research period. Another participant attributed her growth to a change in education governance, which resulted in her moving to an office away from her department and attending monthly CNE meetings. Whilst these changes for the LHD followed the 1st year of the study, they may or may not, have been influenced by the CoP activities.

Some participants also expressed a sense of grieving and loss in relation to losing their clinical expertise and missing being at the bedside and talking to patients. They expressed how they felt their clinical skill level had fallen away whilst they gained confidence and expertise in education.

In contrast to all of the participants' PIVAS scores, as indicated in Figure 4, only one participant (Laura) had a perceived shift away from the educator end (0.98 in 2015) towards the clinical nurse end of the scale (0.67 in 2017). Since joining the LHD from another organization in a nurse educator role, the participant talked about how she needed to be perceived more like a nurse to be accepted by the nursing staff on her ward.

5 | DISCUSSION

In Phase 1 of the research, the nurse educator participants talked about being expert clinicians and perceptions that their technical competence and ward presence provided them with credibility. An apprenticeship approach to learning identified in the TPI results aligned with the perception of being clinical expert. These perceptions resonate with clinical nursing staff beliefs found in other Australian contexts. A case study from Victoria that used focus groups (23 nurses) and semi-structured interviews ($n = 6$) to explore ward nurses' perceptions of clinical education found that ward staff value seeing CNEs in ward environments (Govranos & Newton, 2014). However, nurse educators have also reported feeling de-valued when redeployed to work on the floor as they perceive this requirement as supporting skill mix, rather than offering education (Thornton, 2018).

The participants discussed collegial and geographic isolation and working in silos. A mixed-method survey of Australian sector-based nurse educators ($n = 425$) found that seeking partnerships with academic colleagues and scholarship was not valued by hospital nurse educators (Sayers, 2013). Collegial isolation and feeling undervalued were also reported in a phenomenological study involving 11 South Australian sector-based nurse educators (Thornton, 2018). Similar organizational and geographical sector-based nurse educator isolation has been reported in New Zealand and North America (Coates & Fraser, 2014; Manning & Neville, 2009). In combination, these factors would explain why in 2015, the participants predominately identified themselves as nurses with clinical expertise, rather than nurses with education expertise.

In Phases 2 and 3, the nurse educator participants recognized a shift in their perceptions of being clinical experts to being facilitators of learning. By 2017, the majority of the participants had experienced a substantial shift in their perceived identities towards being an educator. Participants described feeling like a valued and contributing CoP member that gave them a sense of belonging. The participants talked about closer relationships, including 'professional

friendships', which took them beyond their silos and specialty areas. Consistent with Gergen (2015), the combination of new communicative networks and stronger, or intimate, relationships provided a dialogic space.

It was in this space where dialogue as communicative action contributed to the establishment of shared values and a philosophy of learning. These shared understandings were best captured by the changed word clouds. The participants talked about the 2017 word cloud representing values rather than skills, with networking, collaborating and being versatile, all valued. One participant surmised that the first word cloud was about what we do, whereas the second one was about feelings and emotions. 'Fun', 'passionate' and 'cheerful' were seen as emotional (limbic) words. As cited in Dierolf (2012), Rom Harré described how emotional words express public displays of emotion in a way that varies from culture to culture. The words expressed originate from a framework of learned vocabulary and the emotion varies with the context. This change was consistent with social constructionist theory with language being activated in praxis and belonging to, or arising from, a community (Crossley, 1996). The values being recognized by the participants were not institutional values; rather they were values arising from their collegial relationships. Values, beliefs and ethics have been found to be the most cited characteristics that define a profession (Fitzgerald, 2020). By coming to recognize shared values and beliefs, the participants had participated in the co-construction of their nurse educator identities.

If effective health workforce education is a common global goal, then the professional development and advancement of sector-based nurse educator roles require strategic support. Nurse educator issues and problems will always vary depending on local historical, social, structural and cultural differences. The global pandemic of 2019–2021 has decreased face-to-face social interaction and placed additional stressors on the health workforce and systems. In this context, the current research highlights how purposeful communities of practice can address issues faced by the global nursing education community.

Rather than one large CoP, a PAR methodology could be used to establish a network of local or regional CoPs. As found in the business sector, any process to formalize such a network needs to avoid managerial control (Murillo, 2011). Typically, CoPs in nursing have focused on the establishment of national or large-scale online CoPs (McAllister et al., 2014; Sinclair & Levett-Jones, 2011). The findings of the current study support an approach that links local networks of nurse educators across institutional contexts (clinical, college and academia). Health funding would incentivize academic- or sector-based nurse educators to take on facilitator roles to establish and sustain their local CoPs.

5.1 | Implications

The health sector can benefit from the teachings from other disciplines, with established participatory research methodologies that empower teachers/clinicians—as co-researcher participants—to engage in meaningful and purposeful change. A PAR approach can help to ensure that there is a mutually agreed on agenda, shared purpose and commitment from the research group. Along with stronger relationships and group solidarity, these factors also contribute to the sustainability of a CoP.

This critical PAR has demonstrated that through the establishment of a CoP, nurse educators can overcome barriers to communicative and collaborative action. Beyond new workplace connections and relationships, a sense of belonging and shared understandings can validate nurse education as a specialty area of nursing practice. With a stronger sense of professional identity, sector-based nurse educators are better placed to respond to workplace challenges that impact their practice. Beyond clearer perceptions of professional identity found in the current study, local or regional CoPs have the potential to facilitate role transition, satisfaction, retention and innovation.

5.2 | Limitations

Ideally, shared leadership in the research would have included the opportunity for all of the participants to engage with the management and initial interpretations of the data generated. However, engagement with the total research process was not practical, as it would have required unsustainable additional hours of the participants' time.

Participation in the research was also limited by variance in the workplace conditions of specific participants. Part-time participants found it difficult to allocate time to the community meetings and activities. Two participants expressed that they did not feel part of the research after they missed a face-to-face meeting. It became evident that the LHD management did not support the participation of some of the CNE participants to attend the PAR meetings.

With regard to the PIVAS results, there was also a risk of the participant and/or recall bias (Brito, 2017). However, the reliability of the participant scores was derived from the participants' reflective accounts of their scores. The PIVAS tool also used a common unit of analysis across time, which reduced the risk of recall bias (El-Masri, 2013). Triangulation of the Phases 1 and 3 data identified a level of congruency. Whilst a social constructionist lens does not preclude the inclusion of quantitative statistical analysis, it shifts the focus to the qualitative findings as the source of analysis and meaning (Gergen, 2015). For this reason, statistically significant PIVAS findings were not included in the results. In every phase of the research, the credibility of the findings related to trustworthiness and how the narrative resonated with the participants. Nurses, nurse educators or other health educators who find themselves facing similar issues will judge whether the research findings resonate with their situations.

6 | CONCLUSION

If, as Bahr and Mellor (2016) highlighted, being an effective educator is linked to the formation of a strong professional identity, then the methodology employed for this local study can be applied to diverse contexts to advance the role of nurse educators. The critical PAR demonstrated that for the LHD group of nurse educators, the CoP helped them to co-construct perceptions of their professional identities. Through relationships and shared knowledge, there was a measurable shift towards perceptions of being a nurse with educator expertise.

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CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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