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A hermeneutic–phenomenological study of paediatric intensive care unit nurses' professional identity following hospital redesign: Lessons learned for managers

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Abstract

Aim: To provide insights for health care managers by exploring paediatric intensive care unit nurses' lived experience of professional identity in the context of organisational change.

Background: While professional identity improves retention of nurses and provision of quality care, outcomes of importance for managers, organisational change perturbs this identity.

Method: The study used a hermeneutic–phenomenological design. Data were collected via individual interviews, photographs, participant observation and document review. A purposive sampling strategy was used to recruit paediatric intensive care unit nurses ($n = 15$) in a large Canadian paediatric hospital.

Results: Nurses' critical care identity eroded in this organisation due to the interplay between hospital redesign and new eligibility criteria for patient admissions.

Conclusion: Interactions between multiple projects and the unit context, as well as nursing professional identity, need to be considered early on during project planning. This study fills an important gap in research concerning the management challenges brought about by the intersection of multiple changes.

Implications for Nursing Management: The results from this study bring to light three important lessons for nurse managers: 1) the specific unit context should be evaluated before a project is initiated; 2) the physical environment needs to be considered when determining staffing requirements; and 3) identity transitions need to be managed.

KEYWORDS

hermeneutics, intensive care units—paediatric, nurse administrators, organisational innovation, social identification

1 | INTRODUCTION

Globally, construction is booming in health care (Adam, Lindahl, & Leiringer, 2019; Russell, 2018). In their research programming, the authors found that hospital administrators often seize the opportunity to optimize clinical and administrative practices, in parallel to their infrastructure renewal projects (Aubry, Richer, Lavoie-Tremblay, & Cyr, 2011). The resulting organisational transformations incur distinct challenges for hospital leadership, with widespread repercussions for all those involved (Aubry, Richer, & Lavoie-Tremblay, 2014; Lavoie-Tremblay et al., 2017; Slosberg, Nejati, & Evans, 2018). Organisational change can create misalignments between employees' image of who they are as professionals and their experience at work, affecting the safe provision of patient care and the well-being of health care providers (Bochatay, 2018; Kira, Balkin, & San, 2012). Managing organisational change is a key leadership function.

2 | BACKGROUND

2.1 | Nursing professional identity

At its most basic level, professional identity can be defined as the answer to the question, 'Who am I at work?' (Ashforth, Harrison, & Corley, 2008; Kira et al., 2012, p. 34). More specifically for nursing, a recent integrative literature review by Rasmussen, Henderson, Andrew, and Conroy (2018) offers a threefold definition of nursing professional identity: *the self* (who am I?), *the role* (what I do?), and *the context* (where I do it?) (p.230). Essentially, this definition includes perceptions of self at work, role enactment and situatedness within an organisational context, concepts also salient in organisational behaviour literature (Ashforth et al., 2008; Kira et al., 2012).

Professional identity is crucial for management as it has been linked with improved retention of nurses, as well as the provision of quality care (Piil, Kolbæk, Ottmann, & Rasmussen, 2012; Rasmussen et al., 2018; Zhang, Wu, Fang, & Wong, 2017). Indeed, Zhang et al. (2017) found that professional identity was strongly linked with intention to leave among new nurses. Moreover, Piil et al.'s (2012) study of nurses in advanced practice roles suggests that professional identity encourages nurses to engage others in providing quality care.

2.2 | Paediatric intensive care unit nursing

Nursing practice in the paediatric intensive care unit (PICU) holds many unique features that make it an interesting area to study professional identity. No studies to date have explored the professional identity of PICU nurses. The PICU is a complex hospital service for children with severe illnesses who require close monitoring and treatment (Namachivayam et al., 2010). While nursing in the PICU inevitably requires advanced clinical skills and proficiency with medical technology (Dixon & Crawford, 2012), caring

for critically ill children is also particularly emotional. Compared with those practising in other specialties, critical care nurses report the highest frequency and intensity of moral distress (Dyo, Kalowes, & Devries, 2016). Recently, many PICU units have undergone *major hospital transformations*, mega-projects necessitating complex management of construction and quality improvement initiatives (Aubry et al., 2014; Lavoie-Tremblay et al., 2017). Since changes to both physical space and the organisation contribute to shaping identities (Bochatay, 2018; Kira et al., 2012; Stephenson, 2019), major hospital transformations present unique opportunities to explore nursing identities.

3 | METHOD

3.1 | Research design

This study therefore aimed to explore PICU nurses' lived experience of professional identity in the context of a major hospital transformation. A hermeneutic-phenomenological design was used to uncover this phenomenon (Benner, 1994; Frechette et al., 2020; Heidegger, 1927).

3.2 | Study setting

The study site is a 32-bed PICU in a large Canadian paediatric teaching hospital that underwent a major transformation two years prior to data collection. The PICU layout changed from a majority of multi-patient rooms to all single-patient rooms in order to enhance privacy and comfort for families, as well as infection prevention. Moreover, since the PICU capacity increased significantly, the eligibility criteria were revised to allow for more admissions of patients with chronic conditions. In terms of staffing, the unit dealt with nursing shortages both pre- and post-transformation, with participants sharing this shortage intensified post-transformation.

3.3 | Recruitment and data collection

Following ethics review boards' approvals, the head nurse emailed information about the study to PICU nurses. Participants were recruited by the Principal Investigator (PI, first author) during team meetings for each shift. A purposive maximum variation sampling strategy was used (Polit & Beck, 2012) to recruit 15 PICU nurses who experienced both the old and the new unit (see Table 1). This sampling strategy is most commonly used in phenomenological research as it allows selecting participants who have rich knowledge of the phenomenon (Mapp, 2008). Demographics concerning gender, age, educational background, work experience and experience with the project were included as these are anticipated to shape the lived experience of professional identity. The PI had no prior relationships with participants.

TABLE 1 Participant demographics

Demographics	Nurse participants (n) (%)	
Gender		
Female	11	73
Male	4	27
Age (y)		
25-30	3	20
31-35	8	53
36-40	1	7
40+	3	20
Nursing experience (y)		
0-5	3	20
6-10	5	33
11-15	4	27
16+	3	20
PICU nursing experience (y)		
0-5	8	53
6-10	2	13
11-15	3	20
16+	2	13
Education		
College (technical)	3	20
University	12	80
Job status		
Full-time	6	40
Part-time (2/wk.)	2	13
Part-time (4/wk.)	7	47
Shift		
Day (8 h)	4	27
Evening (8 h)	2	13
Night (8 h)	3	20
Day-evening (12 h)	5	33
Evening-night (12 h)	1	7
Involvement in transformation		
Active role	3	20
Passive role (orientation)	8	53
Not involved	4	27

The PI collected data between September 2018 and March 2019 through individual interviews, photographs, participant observation and document review (see Table 2), until data saturation was reached (Carnevale, 2002). A provisional interview guide was used to capture multiple facets of PICU nurses' lived experience of a major hospital transformation (Benner, 1994). Specific questions used to elicit nurses' narratives concerning professional identity in this context were 'What brought you to the PICU?' 'What does it mean for you to be a PICU nurse?' and 'What has this changed for you as a PICU nurse?' All audio recordings were transcribed verbatim with the support of a professional transcriber; all transcripts were reviewed by

the PI to ensure fidelity of transcription. Four types of notes were written throughout the study (Bernard, 2002): jottings, field notes (thick descriptions and analytical notes), a reflective log and a methodological log.

3.4 | Data analysis

Data were analysed in an ongoing fashion using the hermeneutic method described by Benner (1994). Narrative syntheses were created for each case and compared and contrasted through a back-and-forth movement from part to whole (hermeneutic circle) to identify common and divergent meanings (Benner, 1994; Gadamer, 1976). The analysis was supported by the NVivo 12 Pro software, and oversight was ensured by two senior qualitative researchers; they reviewed narrative syntheses and a sample of interview transcripts and field notes to support the interpretative process. In accordance with hermeneutic philosophy, the PI documented reflections about how her own horizon of significance (i.e., experience as a nurse, health care manager, doctoral student and mother) interfaced with her work as a researcher in her reflective log (Benner, 1994; Gadamer, 1976). Carnevale's (2002) four criteria for rigour in qualitative nursing studies, credibility, confirmability, saturation and transferability, were used to guide this study (see Table 3).

4 | RESULTS

PICU nurses' lived experience of professional identity in the context of a major hospital transformation can be portrayed through the heuristic of erosion of their critical care identity. Indeed, the higher proportion of patients with chronic versus acute illnesses and the human resource-environment interplay undermined their sense of being critical care nurses. Moreover, the coping mechanisms used to mitigate challenges engendered by the transformation further accentuated the erosion of their identity.¹ Table 4 presents the elements PICU nurses experienced as constitutive of their PICU identity. Nurses' constant monitoring of patients is particularly central to their critical care identity, as participants in this study reacted defensively to questions about the necessity for incessant monitoring (e.g., 'this is critical care').

4.1 | Increased proportion of patients with chronic versus acute illnesses

As a result of changes in PICU eligibility criteria, more patients with chronic conditions were being cared for on the new unit. PICU

¹All names of participants are pseudonyms. [...] means words have been omitted to make reporting more succinct. [text] is used by the authors to contextualize the data. Quotes have been translated from French by the PI and back-translated for accuracy.

TABLE 2 Details—data collection methods

Data collection method	Details	Number; duration
Individual interviews	• Semi-structured and audio-recorded • Private room on the unit • Ideal to elicit the experienced meaning (Kvale, 1996)	<i>n</i> = 15 nurses; average duration of 58 min/ interview
Follow-up interviews	• In situ • Facultative • Form of member checking	<i>n</i> = 9 nurses; average duration of 15 min/ interview
Photographs	• Photovoice methodology (Wang & Burris, 1997) • Participants took pictures of changes they considered meaningful or images that reminded them of these changes	<i>n</i> = 28 photographs
Participant observation	• Observation of day/evening/night shifts in the PICU and shadowing of nurses • Observation is also important since phenomenon can be veiled (Benner, 1994; Heidegger, 1927)	<i>n</i> = 91.5h; average twice a week, in three-hour blocks <i>n</i> = 46 informal interviews in the field
Document review	• Available documents about the major hospital transformation • Included presentations, project charters, progress reports, etc.	<i>n</i> = 142 documents and 47 files (when files were reviewed globally, documents were not counted)

TABLE 3 Strategies to ensure rigour

Carnevale (2002)'s criteria for rigour	Strategies used in the study
Credibility	• Method triangulation—use of multiple data collection methods • Discussion of analysis/findings with experts (PICU research group, nursing researchers, etc.) • Prolonged engagement in the field (6 months) • Reflexivity (reflective log)
Confirmability	• Member checking (follow-up interviews) • Audit trail (detailed field notes and interview transcripts)
Saturation	• Flexibility in sample size • Flexibility in quantity of data collected (number of hours of observation, number of interviews, etc.) • Method triangulation
Transferability	• Method triangulation • Description of context in great detail

nurses reported that these patients were less stimulating since they require more basic versus specialized care (ID1):

'The nurses get a little annoyed because [...] when you decide in your career to say 'I want to be a pediatric intensive care nurse', you want to do pediatric intensive care. [...] I am not saying that we don't like long-term patients or more chronic [patients], but I think that's another specialty in itself [...] Patients [with chronic conditions] are taking nursing resources that were trained in critical care, it's expensive because we have a residency program, and there is a whole investment on the part of the organisation to train a critical care nurse who after six months decides to leave because she is tired of not progressing, because she always has chronic patients. Then again, we realize that we are canceling more surgeries because we are understaffed and the nurses who are trained are with patients who

have trachs, who are chronic, who could be on the floor'. Interview Rolland

The frustration generated by working outside the scope of what nurses consider the critical care specialty is compounded by their perception that this clientele monopolizes scarce specialized nursing resources and accelerates their depletion. Indeed, nurses do not find in caring for these patients with more chronic conditions the adrenaline-driven atmosphere and ongoing learning that define critical care nursing (ID5 and ID4), the absence of which feeds their desire to leave the PICU. As Rolland's interview excerpt attests, participants report a vicious cycle whereby this clientele with chronic conditions push critical care nurses to leave their jobs, with a resulting increased nursing shortage, and ultimately limited spaces for critical care admissions, further eroding critical care nursing identity. PICU nurses also express higher moral distress in caring for this clientele as they often doubt the likelihood of these children returning to normal life or having a quality of life after their hospitalization (ID2).

TABLE 4 Elements of PICU nurses' identity

Professional identity typology (Rasmussen et al., 2018)	PICU identifiers	PICU identity details	Interview and field note excerpts
<i>Self—who am I?</i>	ID1—specialized nurse	Offer cutting-edge care for unstable children	'You are not a nurse if you don't want to save your patients... being specialized helps to do more complex care that saves more lives'. Yollanda (I) 'We come to Intensive Care to do critical care... they [patients with chronic conditions] do not need intensive care... they are not necessarily unstable'. Fabienne (I)
	ID2—value children's quality of life	Possibility for patients to return to normal life or have a quality of life after their hospitalization	'What stimulates me is a patient who is equipped (ID6), and that there is hope [...] for him to have a return to his normal life'. Bernadette (I)
<i>Role—what I do?</i>	ID3—constant monitoring	Necessity for constantly monitoring of patients	'What I like is that, I'm going to speak for myself about critical care, my patient is always monitored, and [...] questioning myself all the time in relation to my knowledge (ID4)'. Henri (I)
	ID4—ongoing learning	Unpredictability of clinical situations stimulates nurses to develop and maintain integrated expert knowledge	'The reality of PICU, it's that a patient is going to change in an instant (ID5)... It's data [concerning patient condition] that if taken individually does not mean anything, but when you accumulate it and it's not necessarily that you've seen this situation before, but you know it [patient condition] can turn to such and such a thing'. Rose (I)
<i>Context—where I do it?</i>	ID5—adrenaline-driven environment	Patient instability and quick nursing interventions required keep nurses on their toes	'I think nurses who work in critical care are people who need a little adrenaline'. Cindy (I) 'It's not minutes, it's just seconds, but often it makes the difference between – he [patient] starts to move as he wakes up and he pulls a little on his stuff ... versus I see him move, he begins to fidget, I arrive, he's in a panic, he has a pulse of 200, he is in diaphoresis, all his dressings peel off...'. George (I)
	ID6—high presence of technology	Equipment for specialized and urgent care is readily accessible	'We work in a safe environment, meaning we know where all our tools are, the ambu, and all the things when we need to do something fast (ID5)'. Rose (I)

Abbreviations: FN, field notes; I, interview; ID, identity elements.

Moreover, patients with chronic conditions, who are generally more stable, challenge the necessity for constant patient monitoring in the PICU (ID3). PICU nurses often cannot continually monitor patients with chronic conditions due to a higher patient load, with the rationale that these patients were previously cared for on paediatric floors, where nursing monitoring is less frequent. While PICU nurses recognize that certain patients with chronic conditions can be left alone, they remain uncertain as to the clinical risks posed by leaving PICU patients unmonitored. Night nurses are additionally torn by the challenge of adequately monitoring patients, as parents of patients who require prolonged hospitalizations often wish clinicians to prioritize sleep over care. Participants mentioned parents often voiced dissatisfaction (e.g., 'sighs' and 'whining' (Interview Rose)) when nurses monitored patients at night. In sum, PICU nurses struggle to maintain what they feel is adequate monitoring in the PICU against the downward pull of chronic patient stability and parents advocating for their child's sleep.

4.2 | Physical environment–human resource interplay

In addition to chronic patient stability, the interplay between physical environment and human resources further fractures nurses' capacity for sustained patient monitoring (ID3). With the all single-patient room design and increased room size of the new PICU (see Figure 1), nurses do most of their monitoring from an alcove situated outside the patient room, about five metres away from the following patient room on either side (Document Review, floor plan of new unit). These new features of the physical environment are problematic for constant monitoring, especially when critical care nurse–patient ratios of 1:1 or 1:2 are not upheld, which is often the case due to a nursing shortage, and during breaks and meals when nurses cover each other's patients:

'When you [...] cover each other for breaks, it's really big [referring to the distance between patients] because



FIGURE 1 Photograph taken by Evelyne (participant pseudonym) [Colour figure can be viewed at wileyonlinelibrary.com]

when you're in a room, you do not quite see your patients next door. [...] So you end up with four patients, five patients, that you don't see, that's difficult. [...] So we are always running around like headless chickens, going from one room to another [...] I don't always feel good because I don't feel like I'm doing my role as a nurse in terms of safety'. Interview Jacqueline

Compared with monitoring in multi-patient rooms where nurses can easily see several patients simultaneously, monitoring multiple patients over larger separated spaces requires nurses to rely more heavily on technology (i.e. scopes) and run around from room to room to check on patients. PICU nurses in this study express feeling powerless and not fully accomplishing their role of critical care nurses because of their inability to constantly monitor patients, a difficulty they associate with increased safety risks for patients.

4.3 | Coping mechanisms

Although much problem-solving occurs with assistant head nurses in order to alleviate monitoring challenges faced by nurses, three recurring coping mechanisms can be witnessed: nurses punctually transfer surveillance responsibility to parents; patients' rooms are switched; and ultimately, nurses rely on faith that everything will be all right.

When monitoring multiple patients during their shift or during breaks and meals, nurses will often rely on parents to observe children and report any abnormal occurrence. Although nurses recognize that parental surveillance does not afford the same quality monitoring that a nurse would, they feel stuck because they themselves cannot constantly monitor as many patients:

'It's stressful and a bit frustrating to realize that you have a professional responsibility to ensure monitoring of patients and to make sure that they are safe, but that you are unable to accomplish it adequately. Then, sometimes, it's even embarrassing in front of parents because [...]

I'll tell them "does it bother you to stay in the room for one hour because I'm on my own to monitor patients." So you impose on parents that they monitor their own child because you are not able to monitor them properly'. Interview Evelyne

Evelyne speaks eloquently of the dilemma faced by nurses who enlist parents to support patient monitoring, perceiving parental supervision as a lesser evil than leaving patients alone. Nurses are not lulled by the punctual transfer of surveillance responsibility to parents; they are aware that this responsibility never truly escapes them, and feel the burden of not fully accomplishing their duty as a critical care nurse, further chipping away at their critical care identity.

Moreover, patients, whom PICU nurses consider 'sacred' (Field Notes 20 FEB), are frequently changed rooms to allow for patient pairings and reduce overtime requests. As patients change conditions, are admitted or discharged, children are moved rooms to allow each nurse to care for more patients. PICU staff have coined this recurrent moving of patients 'Le Clan Panneton' [home moving company] (Field Notes 4 SEP). Undeniably, changing rooms for reasons other than medical necessity, with the associated image of *Le Clan Panneton*, clashes with the critical care ideal (ID1) and the sanctity accorded to patients.

When nurses have done their best to mitigate the risks associated with monitoring more patients over longer distances, all they have left to do is hope, have faith that everything will be all right and that someone will be there if needed:

'There was one [patient] who was supposed to go home and finally he didn't leave because he had started to vomit. Then, I was in the room, busy taking care of him, but there was no one taking care of the other patient. It was not easy. [...] Well, I relied on others, they'll hear him ring if there's something. [...] You must trust others and have faith'. Interview Cindy

In a critical care environment dominated by multiple forms of control over practice (i.e., constant monitoring and precise equipment) (ID3 and ID6), relinquishing control in favour of faith further erodes PICU nurses' critical care identity.

5 | DISCUSSION AND IMPLICATIONS FOR NURSING MANAGEMENT

This study illuminates how a unit transformation within a context of nursing shortage factored into the erosion of PICU nurses' critical care identity, revealing potential ways in which managers can provide support. The higher proportion of patients with chronic versus acute illnesses challenged nurses' critical care identity by threatening their provision of specialized care, their adrenaline-driven environment and their professional learning, as well as calling into question constant monitoring and their contribution to children's quality of life.

Moreover, the configuration of patients over longer distances did not allow nurses to constantly monitor patients, as they believed one should in critical care. Furthermore, the coping mechanisms to deal with the difficulties in monitoring further undermined PICU nurses' critical care identity, requiring managerial attention.

5.1 | Management lesson 1: projects cannot be evaluated in isolation

The study's findings are particularly enlightening for nurse managers, as they provide ammunition to advocate for evaluating changes to one's unit with a multifactorial approach, including anticipated impacts to nursing professional identity. Although it was expected for organisational change to create misalignment between identity and work (Kira et al., 2012), the current study provides new insights into how environmental features, human resources and clinical practice dynamically interact in this alignment. Indeed, this study showed how a change to the clientele, a new patient bed configuration and a nursing shortage synergistically contributed to PICU nurses' erosion of critical care identity. This study fills an important gap in research concerning 'the interconnectedness between the different types of change and the unique challenges these junctions represent' (Tucker, Hendy, & Barlow, 2014, p. 970). Furthermore, these findings reinforce the idea that projects cannot be evaluated and executed in isolation (Engwall, 2003; Tucker et al., 2014); they must be considered in light of complex project portfolios (groupings of projects/changes), as well as the organisational contexts in which they are embedded. Similarly, Taylor, Card, and Piatkowski (2018) conclude from their literature review concerning single-patient beds that design features are best evaluated 'alongside related issues, such as ... patient populations, staffing models, and inherent trade-offs' (p. 85). In this way, the interactions between multiple changes, the context and their impact (including threats to nursing identity) can be considered before initiating a project and, hence, either lead managers to decide to withhold a project or build-in mechanisms to mitigate identified risks.

At the planning phase, a profound reflection concerning these interactions must occur, including questions such as 'How will this design impact nursing (and others') activities?' and 'What can we do in this design if staffing is inadequate?' In the studied PICU, one coping mechanism used to deal with the nursing shortage was moving patients' from room to room, this option is disruptive for patients, and resource-costly for organisations (Gallant & Lanning, 2001). Had this option been brainstormed at the planning phase, the design could potentially have been adapted to better respond to this reality. In America, nursing shortages have been recurring in a cyclical fashion for the past 70 years (Blouin & Podjasek, 2019), it is time to recognize that budget cuts and nursing shortages are chronic conditions of health care and integrate these within infrastructure design considerations. The financial implausibility of increasing staffing with redesign further highlights the importance of tending early on to potential issues influencing nursing practice, such as walking

distance and visibility (Hamilton, Swoboda, Jin-Ting, & Anderson, 2018; Maben et al., 2016). Technology (e.g., video monitoring) can be one option considered in these instances to palliate, to a certain extent, the difficulties in monitoring patients over longer distances (Hamilton et al., 2018).

5.2 | Management lesson 2: Physical environment influences staffing requirements

Nurse staffing is a primordial consideration for nurse managers as it highly influences the provision of safe patient care (Aiken et al., 2012; Blouin & Podjasek, 2019; Halm, 2019). Blouin and Podjasek (2019) further purport that nurses undergo a cycle of disillusionment whereby frequent understaffing leads nurses to feel tired and burnt-out, causing many of them to leave the bedside, multiplying situations where nurse staffing is inadequate for the safe provision of quality care. More specifically to the PICU, unrealistic staffing to care adequately for complex patients was identified by nurses as a stress factor influencing their desire to leave their jobs (Foglia, Grassley, & Zeigler, 2010). Nurse managers therefore expend much of their time trying to fill nursing positions in order to meet the needs of their clinical settings, while balancing economic constraints. Many factors have been identified as influencing nurse staffing requirements, such as the intensity of patients and an ageing population (Blouin & Podjasek, 2019), but few studies have identified the physical environment as a staffing consideration (Maben et al., 2016). The current study contributes to a small body of knowledge, suggesting that single-patient bed configurations lead to increased nurse staffing requirements (Maben et al., 2016; Walsh, McCullough, & White, 2006). Although more studies are needed to consolidate the link between different unit configurations and staffing needs, the current study highlights how physical environment should enter into mainstream considerations for nurse staffing requirements.

5.3 | Management lesson 3: Manage identity transitions

This study highlights how nurses experience frustrations during identity transitions, and how managers can play a role in making these smoother through anticipating identity issues prior to the change. Two human resource strategies are suggested: offering educational programmes for nurses and rethinking recruitment criteria. Indeed, educational programmes have been shown to positively influence nursing professional identity (Miskelly & Duncan, 2014; Sabanciogullari & Dogan, 2015). More research is needed to investigate whether educational programmes can have these same impacts when identities are challenged by organisational change. In addition, nurse managers faced with these situations must consider the evaluation criteria of new hires, potentially favouring nurses who have a better fit with new unit characteristics. Congruence between employee and work environment attributes

is linked with higher job satisfaction, commitment, engagement and lower turnover (Boon & Biron, 2016; Kristof-Brown, Jansen, & Colbert, 2002). In the studied unit for example, the head nurse could favour nursing applicants who prefer a mix between high acuity and chronicity, so as not to constantly fall into a cycle of disappointment for nurses which fed their intention to leave. The PICU investigated provided nurses an opportunity to experience the new patient population on a small scale prior to the move, but participants reported that this was insufficient to prepare them for the drastic change in proportion of patients with chronic versus acute illnesses.

5.4 | Limitations

While attention to methodological rigour suggests the study results can apply to other PICUs, the phenomenological nature and context (e.g., the specific organisational changes experienced) of this study makes the findings ungeneralizable beyond the immediate setting. Nonetheless, this illuminating story of one major hospital transformation experienced by PICU nurses can enrich nurse managers' reflection concerning organisational change. Moreover, although the study lasted for 6 months, a more prolonged inquiry would have captured the transition process itself versus a snapshot.

6 | CONCLUSION

This study uncovers PICU nurses' lived experience of professional identity in the context of a major hospital transformation through the heuristic of erosion of their critical care identity. It illuminates how elements of an organisational transformation and context dynamically interact to undermine nurses' sense of being critical care nurses. Identity misalignment can have dire human resource consequences, and this paper suggests interesting management strategies to support nursing professional identity through changing times. Nurse managers need to advocate for nursing identity to be considered early on during project planning, and to anticipate potential interactions (positive and negative) between suggested changes and the unit context. Moreover, nurse managers must be aware that the interplay between unit design and availability of nursing resources may challenge a unit's ability to maintain standards of care. This study also furthers the understanding of PICU professional identity, a gap currently identified in the existing research. Research is needed to further identify and evaluate strategies for managing professional identity in the context of hospital redesign.

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ETHICS' APPROVAL

This study received ethics approval from the McGill University Faculty of Medicine Institutional Review Board (A05-B28-18A) and CHU Ste-Justine Comité d'éthique de la recherche (2019-1997).

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