ABSTRACT

Aim: To report an analysis of the concept of nurses' workplace social capital.

Background: Workplace social capital is an emerging concept in nursing with potential to illuminate the value of social relationships at work. A common definition is needed.

Design: Concept analysis

Data sources: The Cumulative Index to Nursing and Allied Health Literature, PubMed, PsychINFO, and ProQuest Nursing.

Review methods: Databases were systematically searched using the keywords: workplace social capital, employee social capital, work environment, social capital, and nursing published between January 1937 and November 2012 in English that described or studied social capital of nurses at work were included. A total of 668 resources were found. After removing 241 duplicates, literature was screened in two phases: 1) titles and abstracts were reviewed (n = 427), and 2) remaining data sources were retrieved and read (n = 70). Eight sources were included in the final analysis.

Results: Attributes of nurses' workplace social capital included networks of social relationships at work, shared assets, and shared ways of knowing and being. Antecedents were communication, trust, and positive leadership practices. Nurses' workplace social capital was associated with positive consequences for nurses, their patients, and healthcare organizations.

Conclusion: Nurses' workplace social capital is defined as nurses' shared assets and ways of being and knowing that are evident in and available through nurses' networks of social relationships at work. Future studies should examine and test relationships between antecedents and consequences of nurses' workplace social capital in order to better understand this important aspect of healthy professional practice environments.

SUMMARY STATEMENT

Why is this research or review needed?

- Social capital in the workplace has been identified as an important aspect of a healthy work environment in healthcare organizations, however little attention has been paid to organizational capital of nurses specifically.
- There is limited research evidence on nurses' workplace social capital and furthermore, there is little agreement on how to define this concept in the literature.
- The purpose of this concept analysis was to understand how nurses' workplace social capital has been used to date and to identify the essential attributes, antecedents, and consequences of the concept.

What are three key findings?

- Attributes of nurses' workplace social capital are networks of social relationships at work, shared assets, and shared ways of knowing and being.
- Antecedents of nurses' workplace social capital include communication, trust, and positive leadership practices.
- Nurses' workplace social capital is generally thought to have positive consequences for nurses, their patients, and healthcare organizations.

How should the findings be used to influence policy/practice/research/education?

- Future studies should develop and test measurement tools that operationalize the concept of nurses' workplace social capital with appropriate validity and reliability in order to measure the concept consistently and compare findings of future studies.
- Nursing leaders aiming to improve nurse retention, commitment, and job satisfaction should focus on strategies thought to enhance nurses' social capital at work such as

improving communication, engaging in positive leadership practices, and cultivating a culture of trust amongst nurses.

- Nurses' workplace social capital is associated with positive consequences for nurses, patients, and organizations therefore it adds value to organizations and should be incorporated into organizations' decision-making processes alongside economic capital.

Keywords: concept analysis, industrial relations, work organization, organisational development, communication, nurses

INTRODUCTION

One aspect of healthy work environments thought to be important to organizational success is social capital. Workplace social capital refers to the idea that networks of social relationships create value and resources for individuals and organizations (DiCicco-Bloom *et al.* 2007). While definitions of workplace social capital vary by discipline, there is growing evidence that social capital in the workplace has positive repercussions for nurses and ~~the~~ healthcare organizations ~~they work for~~ (Crow 2002, Ernstmann *et al.* 2009, Hsu *et al.* 2011).

Social capital research in nursing has often focused on enhancing patients' social capital ~~of patients~~ but researchers have recently extended the concept to nurses themselves. Although work is just beginning in this area, several authors highlight the benefits of high levels of social capital amongst nurses within healthcare organizations. In theory these include improved patient care and patient safety, increased economic capital, a happier, more productive nursing workforce, and improved nurse retention (Hofmeyer 2003, Hofmeyer & Marck 2007, DiCicco-Bloom *et al.* 2008, Ernstmann *et al.* 2009, Hsu *et al.* 2011).

Despite the benefits of applying this new concept to nursing, there is little agreement on a definition of nurses' workplace social capital. Therefore, the purpose of this study is to identify the attributes of nurses' workplace social capital by conducting a concept analysis using the evolutionary method (Rodgers 2000). Clear attributes, antecedents, and consequences related to workplace social capital in nursing, as well as a model case exemplifying the concept will be derived from a systemic literature review and critical analysis. The resulting definition will help guide nursing research and leadership practices that aim to create quality nursing practice environments that add value to patients, nurses, and healthcare organizations by fostering nurses' social capital in the workplace.

Background

The term ‘social capital’ was coined by American education scholar L. J. Hanifan (1916) to describe ‘goodwill, fellowship, mutual sympathy, and social intercourse among a group of individuals and families who make up a social unit’ (p. 130). He proposed that these intangibles make life worthwhile to people in their everyday lives and that social capital was a kind of social investment created by getting people in the community to socialize and work together (Hanifan 1916).

Modern use of the term social capital originated in the works of three social scientists: Bourdieu, Coleman, and Putnam (Castliglione *et al.* 2008). Bourdieu’s (1979) version of social capital is understood in the context of symbolic capital and critical theories focusing on classism in societies. According to this perspective, social capital is the sum of actual or potential resources accessible only to individuals belonging to a specific network or social group of wealthy elite or upper class people. Coleman’s conceptualization of social capital extended the idea from individuals to groups of people and is inclusive of all social classes. Additionally, Coleman added the idea that social capital has the productive capacity to create outcomes that otherwise would not be achievable (Coleman 1988). Lastly, social capital in Putnam’s (1993) work refers to features of social organization such as trust, social norms, and networks that can improve the efficiency of society by facilitating coordinated actions.

Since the early work of Bourdieu, Coleman, and Putnam, social capital has taken off in many directions, making it difficult, if not impossible, to articulate one clear, undisputed meaning of the concept (for a thorough history and examination of conceptual issues in the theory and concept development of social capital see Castliglione *et al.* 2008). Furthermore,

social capital has taken on various meanings and frameworks as it has been adopted and applied by various disciplines, including nursing.

Workplace social capital in nursing

Workplace social capital, also referred to as organizational, occupational, or employee social capital, was developed by researchers in the disciplines of organizational behaviour and management who saw the potential application of social capital to the organizational context (Nahapiet & Ghoshal 1998, Leana & van Buren 1999). Nurse researchers have recently adopted the concept (Hofmeyer 2003) viewing it from socio-ecological (Hofmeyer & Marck 2008), network (Hsu *et al.* 2010, Brunetto *et al.* 2011), structural (Crow 2002), and complex adaptive systems (DiCicco-Bloom *et al*. 2007) perspectives. Nurses' workplace social capital has not been clearly defined or analyzed and implies many different meanings depending on its definition and use. For example, workplace social capital may be viewed as resources from relationships available through or possessed by an individual nurse, a nursing unit, an interprofessional healthcare team, or an organization as a whole. In addition, pieces of social capital *theory* have been misused as defining attributes, adding to the confusion about the meaning of the concept. It is not surprising that the concept of workplace social capital in nursing has been defined in many ways, some of which are not entirely coherent.

Nurses' workplace social capital contributes to a distinct body of nursing knowledge because it captures the personal and organizational benefits of building strong networks of interpersonal relationships at work. From a theoretical perspective, workplace social capital helps explain how positive working relationships with others adds value to nurses' practice environments, contributing to better outcomes for nurses, patients, and healthcare organizations through improved communication, teamwork, and access to greater information, support, and

resources. High levels of social capital have been associated with nurses' well-being, retention, cooperation, and patient safety (Hofmeyer 2003, Ernstmann *et al*. 2009, Kowalski *et al.* 2010). Therefore, it is reasonable to suggest that creating healthy workplace cultures where nurses can build positive working relationships and develop social capital will lead to professional practice environments where nurses and patients thrive.

Workplace social capital has international appeal - it has been studied widely in several disciplines including nursing, sociology, and management. The nursing literature, though small, spans several countries including Australia (Brunetto *et al.* 2011), Germany (Ernstmann *et al* 2009, Kawalski *et al* 2010), Canada (Hofmeyer 2003, Hofmeyer & Marck 2008), Taiwan (Hsu *et al.* 2011), and the United States (Crow 2002, DiCicco-Bloom *et al.* 2007). Thus, the concept is relevant to nurses from several countries around the world.

Before further research can be conducted to examine the relationships between antecedents and consequences of nurses' workplace social capital, the concept requires clarification. As it stands, the concept has been explained by different authors using various theoretical frameworks and numerous (and often incongruent) attributes, antecedents, and consequences. This confusion in the literature around what constitutes workplace social capital in nursing and difficulty distinguishing antecedents from attributes makes it challenging to understand and use the concept. Therefore, the purpose of this concept analysis is to clarify the concept of nurses' workplace social capital.

Theoretical framework

Rodgers' (2000) evolutionary approach of concept analysis was used. This six-step model includes identifying the concept of interest, sample selection, data collection, data analysis to identify attributes, antecedents, consequences, and related concepts, identifying a real-life

model case, and identifying implications and hypotheses for further development of the concept. These steps allow the researcher to examine how the concept is currently used in order to uncover attributes of the concept as well as the contextual basis of the concept (Rodgers 2000). This process aims to provide a clear idea of what is currently meant by the concept of interest with attention to contextual and temporal aspects, while laying the groundwork for further clarification or concept development as the concept evolves through ongoing use and application.

Data sources

The Cumulative Index to Nursing and Allied Health Literature (CINHAL), PubMed, PsychINFO, and ProQuest Nursing databases were systematically searched using the keywords: workplace social capital, work environment and social capital, workplace social capital, and employee social capital and nursing. English-language articles published from January 1937 (the earliest date for CINHAL) to November 2012 that described or studied social capital as it relates to nurses' workplaces or work environment were included. Articles about patients' social capital or workplace social capital of non-nurses were excluded.

RESULTS

Initially 668 resources were identified using the search keywords. Sources were exported to RefWorks bibliographic management software and 241 duplicates were removed. Titles and abstracts of the remaining 427 original sources were reviewed. Sources with ambiguous titles or without abstracts were included at this stage. After initial screening was completed, 70 original articles remained for full manuscript retrieval. These documents were retrieved and reviewed using the *a priori* inclusion criteria, resulting in a final sample of seven journal articles and one book chapter to be included in the concept analysis. Seven journal articles and one book chapter

met the study inclusion criteria. The results of the concept analysis include the attributes, antecedents, and consequences of workplace social capital in nursing. A real-life model case was selected by the author.

Uses of the ~~C~~concept

To date, research on workplace social capital in nursing has used the concept as social support networks for problem solving, a vital (ecological) resource, shared values, convictions, and social norms, mutual trust, shared understandings, and an important source and indicator of health and wellbeing for employees and organizations. The concept of nurses' workplace social capital has been thought of as something possessed by individual nurses, nurses as a group, ~~as well as~~ and healthcare organizations. The current study framed workplace social capital in nursing as nurses' organizational social capital, meaning that it belongs to or is accessed by individual nurses and groups of nurses within the context of their workplace. ~~healthcare organization they work for.~~

Definitions of nurses' workplace social capital (Table 1) have been derived from several different theoretical frameworks of social capital from the sociology and political science disciplines. Early on, the definitions of workplace social capital applied to nursing were simplistic and vague: "an organization's well of shared values" (Crow 2002) and "a complex mix of structural elements of networks and ties and cognitive elements of norms of trust, cooperation, reciprocity, and resilience" (Hofmeyer 2003). DiCicco-Bloom and colleagues (2007) attempted to clarify the concept by creating a model of social capital that combined the theory of complex adaptive systems with the network theory approach of Nahapiet and Ghoshal (1998) who stated that social capital is "the sum of the actual and potential resources derived from the network of relationships possessed by a social unit" (Nahapiet & Ghoshal 1998). This model delineated

three dimensions or types of social capital with seven defining attributes but did little to clarify the concept and the model has not been used in further research since publication.

Hofmeyer and Marck (2008) applied an ecological lens to the idea of workplace social capital in nursing, defining the concept as trust, mutual understanding, and shared values and behaviours that join members of social networks and communities, making cooperation possible. Their work highlights the social and economic value of social capital in healthcare organizations, as well as the power of nurses' relationships to create value and healthy working environments that benefit nurses, patients, and organizations (Hofmeyer & Marck 2008).

Next researchers borrowed from Bourdieu's (1979) idea of social capital as resources from relationships (Ernstmann *et al.* 2009, Kowalski *et al*. 2010). The fact that these authors went back to the ideas of Bourdieu instead of building on the work of nursing colleagues who had already looked at workplace social capital may reflect lack of clarity of the concept, disagreement with the conceptualizations used by others, or lack of awareness of the literature. Brunetto and colleagues switched gears again ~~slightly~~ by focusing on the quality of network relationships and their influence on access to resources. Finally, Hsu et al. (2011) employ the definition of Nahapiet and Ghoshal (1998), signifying a return to the network theory approach of workplace social capital in nursing and a lack of agreement about the meaning of the concept.

Attributes

According to Rodgers' (2000) the main purpose of a concept analysis lies in identifying the characteristics or attributes common to the conceptual idea represented by the word or expression subject to analysis. Importantly, the phrase workplace social capital in and of itself is not the concept; it is a symbol representing a cluster of ideas. Thus, identification of the

attributes of a concept provides access to and description of the underlying ideas and meaning currently represented by a particular word or phrase (Rodgers 2000).

The attributes of nurses' workplace social capital identified in this study are a) networks of social relationships at work, b) shared assets, and c) shared ways of knowing and being. Combining these attributes results in the following definition of nurses' workplace social capital: Nurses' shared assets and ways of being and knowing that are evident in and available through nurses' networks of social relationships at work.

The first attribute of nurses' workplace social capital is networks of social relationships at work. Throughout the literature emphasis on the value of social relationships and making connections with other people was prominent. In other words, nurses' workplace social capital is situated in and created by the relationships nurses develop at work. This includes relationships with other nurses, other healthcare professionals, or people in differential positions of status, power, and/or authority than oneself. From a theory standpoint, these different types of relationships were labelled as bonding, bridging, and linking structures of social capital, respectively (DiCicco-Bloom *et al.* 2007, Brunetto *et al*. 2011).

The second attribute, shared assets, was identified by numerous terms in the literature including collective capital, social credits, social resources, and social currency. Nurses who are members of workplace social networks have access to various resources through their relationships with others. Assets of social capital are accessed by and exchanged between members of a social network in healthcare organizations by virtue of shared membership in that group. Examples of shared assets include support, cooperation and teamwork, information, and opportunities, all of which have social value and can be shared amongst nurses and other members of a healthcare team within an organization.

The final attribute is shared ways of knowing and being. Authors repeatedly referred to nurses' workplace social capital as a climate or culture of shared values, understandings, beliefs, practices, social norms, and vision that enhance nurses' capacity to excel in their jobs. In other words, workplace social capital of nurses is the culmination of ways of knowing and being of the individuals that make up the group. Hofmeyer and Marck (2009) referred to this attribute as a sense of collective consciousness or social connectedness, whereas DiCicco-Bloom (2007) coined the term 'transformative shared understandings' to describe the knowledge and meanings shared by those who work together. This latter term also infers that our interactions and relationships with others change us, thus workplace social capital is a dynamic process that continually evolves as resources are exchanged and relationships between group members develop over time.

Antecedents

Antecedents are those events or conditions that lead to the occurrence of a concept (Rodgers 2000). Current antecedents of nurses' workplace social capital include communication, trust, and positive leadership practices.

Positive communication, the exchange of information, ideas, emotions, etc. is a precursor to workplace social capital because it is necessary for building relationships and exchanging assets such as information, ideas, and encouragement. As pointed out by Hofmeyer and Marck (2008), increasing the flow of quality information through relationships is an important strategy for nurse leaders who wish to increase social capital within their healthcare organization.

Trust was defined in the literature as belief in and reliance upon the good qualities of others including honesty, integrity, and reliability (DiCicco-Bloom *et al.* 2007, Hofmeyer & Marck 2008) as well as fairness, truth, and honour (Crow 2003). Trust is a pre-existing

condition for nurses' workplace social capital because it is an essential aspect of building positive relationships with others. When high levels of trust are present, individuals are more willing to offer resources such as time, support, and information to ~~others~~ colleagues based on the belief that others will not take advantage of them and will reciprocate in the future (Hofmeyer & Marck 2008). Since nurses' workplace social capital involves sharing assets, trust between members of an organization is a key component of relationships that enables this sharing to happen.

Finally, positive leadership practices were cited by most authors as an important variable leading to the development of nurses' workplace social capital. Hofmeyer and Marck (2009) suggested that nurse leaders can strengthen nurses' social networks at the unit and organizational levels by building a culture of trust, resilience, and solidarity. Recommended strategies ~~suggested~~ towards these ends include supporting interdisciplinary patient safety clinical rounds, sharing leadership with nurses when possible, and providing nurses with resources like equipment, space, and time (Hofmayer & Marck 2009).

Consequences

Consequences are outcomes that result from a concept (Rodgers 2000). Outcomes of nurses' workplace social capital can be divided into three main categories: benefits for nurses, benefits for patients, and benefits for organizations.

Benefits of workplace social capital for nurses discussed in the literature included a positive, healthy work environment that embraces a culture of teamwork, support, cooperation, and respect. In theory, nurses would be able to access shared resources that allow them to do their job more effectively and provide safer patient care. In empirical studies, nurses' workplace social capital was associated with lower levels of emotional exhaustion (burnout), more

autonomy in decision making (Kowalski *et al.* 2010), and increased cooperation (Ernstmann *et al*. 2009). Nurses who experienced high levels of social capital were likely to be happier at work, leading to increased job satisfaction and better quality of work-life (Hofmeyer 2003).

Positive consequences for patients included better nursing care and improved safety. High levels of workplace social capital amongst nurses were associated with increased risk management behaviours and better patient safety (Ernstmann *et al*. 2009). Nurses' workplace social capital may enhance patient care and patient safety by improving access to information, knowledge, resources, and support, and enhancing cooperation and teamwork of nurses as members of interprofessional teams.

Finally, the benefits of nurses' workplace social capital spilled over to the organization. Workplace social capital is thought to contribute to healthy nursing practice environments which are may lead to improved job satisfaction and lower turnover intentions. In addition, social capital was linked to increased organizational commitment of nurses (Hsu *et al.* 2011) which ~~leads~~ has been linked to increased nurse retention. Another consequence that benefits healthcare organizations is gains in economic capital stemming from the cost savings of having a happy and productive nursing workforce who provide excellent patient care and stay in their jobs.

Model ~~C~~case

A model case is a real-life example of the use of the concept that demonstrates all of the attributes of the concept (Walker & Avant 2011). Due to the inductive nature of Rodgers' (2000) evolutionary approach to concept analysis, model cases should be identified rather than constructed by the investigator. Hofmeyer (2003) suggests that narratives are a powerful tool to capture the essence of workplace social capital in nursing, thus the model case was selected from

Tilda Shalof's (2004) book "A Nurse's Story" which provides a rich narrative of a nurses' practice working in a hospital intensive care unit (ICU).

The attributes of workplace social capital in nursing are made evident throughout Shalof's (2004) narrative. During her years as an ICU nurse ~~in Toronto~~ Tilda developed a network of social relationships with nursing colleagues, physicians, and other people at her hospital. As Tilda spent more time on the unit she developed positive social relationships with her nursing colleagues, demonstrated by the following passage:

> By then I knew all the other nurses because of our overlapping schedules. I easily joined the group gathered at the nursing station, the buzz of their conversation now comforting and familiar. It felt as much like a social gathering as part of the daily work routine (Shalof 2004, p. 85).

Through ongoing communication and interaction, she also developed relationships with non-nursing colleagues such as physicians. For instance, Tilda wrote about taking care of a post-operative lung transplant patient who was crashing:

> Quickly, the room filled with people – the surgeon and his residents who had just performed surgery; other nurses who'd come in to help me; the respiratory therapists; and Dr. Jessica Leung, the senior medical fellow. Dr. Darryl Price stood at the foot of the patient's bed, quietly surveying the scene before him. 'We've increased his oxygen,' I told him. 'I've already called for a stat chest. I drew a set of 'lytes and a troponin and I have a chest tube all ready in case he's blown a pneumo. I just did an electrocardiogram.

> Here it is.' Darryl's gaze didn't leave the patient before him, and he pursed his lips in consternation. Clearly, he was seeing something that none of us were seeing. 'Have I forgotten something?' I asked. He cleared his throat. 'The family. We have to speak with the family.' 'But what can we tell them? He's crashing and we don't know what's going to happen.' 'That's exactly what we have to tell them. Look, there are enough people here to take care of this situation now. I have a feeling it's just a mucous plug or fluid overload and they'll be able to fix it. Tilda, I want you to come with me' (Shalof 2004, p. 193-194).

This passage showed that the nurse and physician have developed a strong working relationship evidenced by their easy exchange of ideas in a difficult situation. It was also evident that the healthcare team members viewed one another as resources (assets) upon which they could rely on to help them solve problems (e.g. responding to a dying patient) and provide the best possible patient care.

The second attribute of workplace social capital in nursing is shared assets. Tilda's network of relationships at work provided her with access to shared assets, situated both in the relationships themselves, as her colleagues became a source of support and knowledge, and through access to external resources (e.g. equipment, medications) ~~that are~~ required ~~to do~~ for the work at hand. For example, Tilda writes

> For the most part, I coped with whatever came up, but I noticed an uncanny phenomenon that I never figured out. Whenever I was getting out of my depth, one of them – Laura, Frances, Nicole, Tracey, or Justine – suddenly appeared. They seemed to know just what

> was needed, usually without asking me. They each had their own patients and were busy too; how did they know I needed help? (Shalof 2004, p.44).

This passage highlights some of the benefits – support, information, assistance with her work – that Tilda received from her positive relationships with co-workers.

Finally, the attribute of shared ways of knowing and being was evident in the ways in which Tilda and her colleagues engaged with one another and with patients. In one section of the book, Tilda recounted the story of an 18-year-old patient with an intra-cerebral bleed. As the team of doctors and nurses performed a thorough examination of the patient, Tilda explained the shared meaning that developed amongst the group as they watched the patient's response (or lack thereof) to each test:

> Jessica rubbed the end of the hammer among the soles of his bare feet. We all noted the abnormal curl of the toes, and we glanced at one another with a grim understanding of where this was all likely headed," (Shalof 2004, p. 122).

From this example, it was clear that the group shared a common understanding of the seriousness of the patient's condition as well as a shared sense of how to act in the given situation. These shared ways of knowing and being developed over time as the group gained practice experience and knowledge, both as individuals and as members of the group.

The nurses in Tilda's inner social network also created their own shared ways of knowing and being. For example, they found ways to use humour in their daily work to alleviate some of the stress inherent in the nature of the work they did. As Tilda put it, "Those nurses found

laughs in everything. Even if something wasn't funny, they made it so." At the same time, she and her colleagues were able to be serious when interacting with patients and their families and provided compassionate loving care to their patients.

As demonstrated, Tilda Shalof's (2004) narrative provides a rich example of nurses' workplace social capital. It shows how workplace social capital developed at the level of the individual nurse, the nursing unit, and within the context of a healthcare organization. Typically, examples used for the purposes of a concept analysis describe one event in isolation. While one example of the concept certainly could have been selected from Shalof's book, the whole book also could have been used as an exemplar of the concept. For this reason, passages that highlighted the attributes of nurses' workplace social capital in the nurse's narrative were selected.

DISCUSSION

This study adds to the literature by identifying the current attributes of nurses' workplace social capital resulting in the following definition of the concept: nurses' shared assets and ways of being and knowing that are evident in and available through nurses' networks of social relationships at work. This definition captures the essence of the concept as it is used today, with room for amendment and evolution in the future. The definition of nurses' workplace social capital emphasizes the richness and depth of nurses' knowledge and ways of being and knowing, both as individuals and as a collective group. It is through the sharing of these assets with one another that social capital is created, accessed, and accumulated. The attributes of nurses' organization social capital suggest that nurses are and have valuable resources that are not solely economic. Therefore, although economic capital is most often used to measure worth and value in healthcare, perhaps other forms of capital should also be considered in healthcare decision

making because there are many valuable assets that contribute to positive outcomes for nurses, patients, and healthcare organizations that numbers on paper are not able to capture.

This study identified several key antecedents that may help nurse managers increase social capital amongst the nurses in their organization. The findings indicate that nurses' social capital at work may be enhanced by improving communication, trust, and positive leadership practices that promote positive relationship building between nurses and their colleagues. When high levels of trust are present, nurses are more likely to offer resources, information, and support to colleagues because they know that the favour will be ~~returned or~~ reciprocated at some unknown time in the future.- Communication enables resource sharing, as well as the development of shared ways of being and knowing among colleagues. Finally, leaders who utilize positive leadership practices foster a culture of respect, trust, cooperation, and teamwork which is conducive to developing positive working relationships with others. It is reasonable to suggest that nurses who work in healthy, supportive working environments with the identified antecedents of high levels of trust, strong communication, and solid leadership are likely to develop high levels of social capital.

The identified consequences from our analysis suggest that high levels of workplace social capital amongst nurses have the potential to benefit nurses, patients, and organizations. When nurses have high social capital at work, a culture of teamwork, support, cooperation, and respect is established, allowing nurses to access shared resources that allow them to do their job more effectively and provide safer patient care. It is likely that nurses with high levels of workplace social capital tend to be more satisfied with and engaged in their jobs, leading to improved nursing retention and cost savings for organizations. Therefore, nursing leaders aiming to improve nurse retention, commitment, and satisfaction should focus on strategies thought to

enhance nurses' social capital at work such as improving communication, engaging in positive leadership practices, and cultivating a culture of trust amongst nurses.

Nurses' workplace social capital is a concept with potential to be incorporated into a middle-range explanatory theory which links leadership and organizational practices and characteristics (antecedents) to nurses' social capital and subsequent outcomes. The concept could also be used as a starting point to develop a theory of interprofessional social capital in healthcare organizations that includes all members of the healthcare team. A comprehensive model of this nature would incorporate nurses' social capital within organizations as a component of the social capital of the healthcare team and the organization as a whole, perhaps leading to a better understanding of the unique and valuable contributions of nurses to the social capital of healthcare teams and organizations.

Limitations

Limitations of the current study include a small sample size due to the small body of literature on the topic, as well as a large degree of heterogeneity amongst studies. Almost all of the studies conceptualized nurses' workplace social capital differently, using a number of different theories and models from the general social capital literature and applying it to nursing. Thus, the current analysis focused on the common threads between all of the articles, perhaps excluding some important ideas from the final attributes, antecedents, and consequences.

CONCLUSION

Workplace social capital of nurses is a valuable concept for nursing leadership research and application because it captures the value of nurses' social relationships at work for nurses, their patients, and healthcare organizations. Nurse leaders can enhance nurses' social capital at work by communicating effectively, engaging in positive leadership practices, and cultivating

trust. Nurses' workplace social capital has several positive outcomes for nurses, patients, and healthcare organizations. Therefore, the richness and depth of nurses' knowledge and ways of being and knowing, represented by the concept, are valuable resources that need to be incorporated into healthcare leaders' decision making which currently focuses almost exclusively on economic capital as its bottom line.

Future studies looking at how workplace social capital is defined by other healthcare professionals would be a next step in understanding how nurses' workplace social capital fits into the social capital of a healthcare organization as a whole, potentially resulting in a comprehensive model of healthcare interprofessional social capital. Researchers should also develop and test measurement tools that operationalize the concept with appropriate validity and reliability in order to measure the concept consistently and compare findings of future studies. In addition, being able to measure and quantify nurses' workplace social capital would provide another avenue for assessing the value that nurses add to their workplaces and help identify areas for professional and personal development.

REFERENCES

Bourdieu P (1979) *La distinction: critique sociale du jugement.* Editions de Miniuit, Paris.

Brunetto Y, Farr-Wharton R & Shacklock K (2011) The impact of supervisor-subordinate relationships on nurses' ability to solve workplace problems: implications for their commitment to the organization. *Organizational Development in Healthcare: Conversations on Research and Strategies Advances in Healthcare Management* 10, 215-237.

Cohen D & Prusak L (2001) *In good company: how social capital makes organizations work.* Harvard Business School, Boston, MA.

Coleman J (1988) Social capital in the creation of human capital. *American Journal of Sociology* 94, 945-1558.

Crow G (2002) The relationship between trust, social capital, and organizational success. *Nursing Administration Quarterly* 26, 1-11.

DiCicco-Bloom B, Frederickson K, O'Malley D, Shaw E, Crossan JC & Looney JA (2007) Developing a model of social capital: Relationships in primary care. *Advances in Nursing Science* 30, E12-E24.

Ernstmann N, Ommen O, Driller E, Kowalski C, Neumann M & Bartholomeyczik S (2009) Social capital and risk management in nursing. *Journal of Nursing Care Quality* 24, 340-347.

Fukuyama F (1999) *The great disruption: human nature and the reconstruction of social order.* The Free Press, New York.

Fukuyama F (2001) Social capital: civil society and development. *Third World Quarterly* 22, 7-20.

Hanifan LJ (1916) The rural community school center. *Annals of the American Academy of Political and Social Science* 67, 130-138.

Hofmeyer A (2003) A moral imperative to improve the quality of work-life for nurses: building inclusive social capital capacity. *Contemporary Nurse* 15, 9-19.

Hofmeyer A & Marck PB (2008) Building social capital in healthcare organizations: thinking ecologically for safer care. *Nursing Outlook* 56, 145-151.

Hsu C-P, Chang C-W, Huang H-C & Chiang C-Y (2011) The relationships among social capital, organisational commitment and customer-oriented prosocial behaviour of hospital nurses. *Journal of Clinical Nursing* 20, 1383-1392.

Kawalski C, Ommen O, Driller E, Ernstmann N, Wirtz MA, Kohler T & Pfaff H (2010) Burnout in nurses – the relationship between social capital in hospitals and emotional exhaustion. *Journal of Clinical Nursing* 19, 1654-1663.

Leana CR & van Buren HJ (1999) Workplace social capital and employment practices. *Academy of Management Review* 24, 238-555. Available at: http://www.jstor.org/stable/259141

Lin N (2001) *Social capital: a theory of social structure and action*. Cambridge University Press, Cambridge, NY.

Nahapiet J & Ghoshal S (1998) Social capital, intellectual capital, and the organizational advantage. *Academy of Management* 23, 242-266. Available at: http://www.jstor.org/stable/259373

Putnam RD (1993) *Making democracy work: civic traditions in modern Italy.* Princeton University Press, Princeton, NJ.

Rodgers BL (2000) Concept analysis: an evolutionary view. In *Concept development in nursing: Foundations, techniques, and applications* (Rodgers BL & Knafl KA, eds.). W. B. Saunders Company, Philadelphia, PA, pp.77-117.

Shalof T (2004) A nurse's story: life, death, and in-between in an intensive care unit. McLelland & Stewart Ltd., Toronto, ON.

Walker LO & Avant KC (2010) Strategies for theory construction in nursing. (5th ed.). Prentice-Hall, Upper Saddle River, NJ.

Table 1. Workplace social capital definitions and defining attributes in the current nursing literature

Authors	Definition	Defining Attributes
Crow, 2002	"an organization's well of shared values" (Fukuyama, 1999)	Shared values
Hofmeyer, 2003	"a complex mix of structural elements of networks and ties and cognitive elements of norms of trust, cooperation, reciprocity, and resilience"	Trust Cooperation Reciprocity Resilience
DiCicco-Bloom et al., 2007	"the sum of the actual and potential resources derived from the network of relationships possessed by a social unit" (Nahapiet & Ghoshal, 1998)	<u>Structural Social Capital</u>: Bonding – connecting on the basis of similarity of everyday purpose of task Bridging – connecting that supports information and resource sharing between individuals with different roles and responsibilities within an organization Fluid alliances – regrouping based on task and changing conditions, shared leadership based on knowing the value of all individuals with the work environment <u>Relational Social Capital</u>: Reciprocating – an exchange, not requiring equal value Cooperating – task-oriented actions of two or more people working together Trusting – corrective action conducted with the assumption that the group will accept the spirit of the corrective action, which is to improve practice <u>Cognitive Social Capital:</u> Transformative shared understandings – development of newly expanded group consciousness based on the input of perspectives from all members regardless of educational background

Hofmeyer & Marck, 2008	"trust, mutual understanding, and shared values and behaviours that bind the members of human networks and communities and make cooperative action possible" (Cohen & Prusak, 2001)	Groups and networks; relationships (bridging, building, linking) Trust – extent to which people feel they can trust and rely on colleagues and strangers, either to assist them or (at least) do no harm Collective action and cooperation - whether and how people work together on projects or in response to a crisis Information and communication – flow of quality information across social capital relationships in the health care organization and beyond Social cohesion and inclusion – the tenacity of social bonds and their potential to include or exclude nurses at the unit level, as members of the team, and across the organization
Ernstmann et al., 2009	"resources associated with a permanent network of relationships generated from internalized, informal standards within an organization that produces cooperation" (Bourdieu, 1979; Fukuyama, 2001).	Collective values and convictions Mutual trust
Kowalski et al., 2010	"aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition – or in other words, to membership in a group – which provides each of its members with the backing of the collectively-owned capital, a credential which entitles them to a credit, in the various senses of the word," (Bourdieu, 1979)	Collective values and convictions Mutual trust Resource for individuals and organizations
Brunetto et al., 2011	'the quality of network relationships which affects members' access to a range of resources and information" (Lin, 2001)	Structural Dimension: structures embedded within organizations that promote ties between workplace social network members Relational Dimension: rules and norms about reciprocity and obligation behaviours within organizations

Hsu et al. 2011	"the sum of actual and potential resources within, available through and derived from the network of social relationships possessed by an individual or social unit; both the network and the assets that may be mobilised through the network" (Nahapiet & Ghoshal, 1998)	Shared Vision Trust Social interaction