



Translational Mobilisation Theory: A new paradigm for understanding the organisational elements of nursing work



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ABSTRACT

Translational Mobilisation Theory (TMT) is a generic sociological theory that explains how emergent projects of collective action are progressed in complex organisational contexts. Grounded in a substantial programme of research on healthcare work, it has value for understanding the organisational component of the nursing role for educational, practice and research purposes. This paper introduces Translational Mobilisation Theory, outlines its core components, and considers its application to nursing using ethnographic research on the organising work of nurses as an empirical reference. Organising work is a neglected element of the nursing function and lacks theoretical foundations. As the complexity and intensity of healthcare continues to accelerate this is an important gap in existing frameworks of understanding.

What is already known about the topic

- Integrated care is a hallmark of healthcare quality and safety.
- Nursing has long been acknowledged as the organisational glue in healthcare systems, but this lacks empirical, theoretical and conceptual foundations.

What this paper adds

- Introduces Translational Mobilisation Theory and illustrates its value for describing and explaining the organisational components of nursing work for educational, practice and research purposes.
- Provides a framework for making visible, a hitherto invisible element of the nursing role: healthcare trajectory management.

1. Introduction

This paper introduces Translational Mobilisation Theory (TMT) (Allen and May, 2017) and illustrates its application to the organisational dimension of nursing work. There is a growing appreciation that high quality healthcare depends not on individual brilliance but on ensuring that all the necessary elements (materials, knowledge, people) to meet patient need are aligned in social time and space. Nursing has an important role in managing these arrangements, and is often referred to as the ‘glue’ in healthcare systems. Although widely acknowledged anecdotally, this component of the nursing role lacks empirical, theoretical and conceptual foundations. As the complexity and intensity of work in modern healthcare systems continues to increase this remains

an important gap in the profession’s understanding.

This article draws together two components from a longstanding programme of research on the work of nurses (Allen, 2001, 2004; Dingwall and Allen, 2001): primary ethnographic research which examined in-depth the organisational elements of the nursing role in a tertiary hospital in Wales (Allen, 2015) and Translational Mobilisation Theory (Allen and May, 2017), a generic sociological theory, arising from this empirical work and designed to describe and explain emergent projects of collective action in conditions of organisational complexity. The paper has four parts. First, it traces the historical antecedents of nursing’s organisational function and its subsequent marginalisation in the professional mandate and knowledge base. Second, drawing on insights from the ethnographic study (Allen, 2015), it summarises nurses’ organising work and the features of healthcare that make this necessary. Third, it introduces Translational Mobilisation Theory and illustrates its application to the organisational components of the nursing role. Fourth, it considers the value of Translational Mobilisation Theory as a ‘theory for’ nursing and its use for educational, practice, and research purposes.

2. Organising work and nursing knowledge

Since its emergence as a formally recognised occupation in the mid nineteenth century, nursing has always entailed an organisational component. In her *Notes on Nursing* Nightingale argued that:

“Bad sanitary, bad architectural, and bad administrative arrangements often make it impossible to nurse. But the art of nursing ought

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to include such arrangements as alone make what I understand by nursing, possible”.

(Nightingale, 1860/1969: 8)

For Nightingale, ‘nursing’ entailed being responsible for creating the environments that foster healing and health. Her healthcare improvements had as much to do with increasing the productivity of staff and enhancing sanitary conditions as with directly attending to the comfort of patients (Dingwall et al., 1988). In recent history, however, the profession’s self-understanding has neglected the organisational dimension of the nursing role, foregrounding the direct rather than indirect dimensions of patient care. This reflects the outworking of a number of interrelated trends: the promotion of a professional mandate based on an emotionally intimate relationship between practitioner and patient (Allen, 2001); technical and organisational changes in healthcare precipitating the expansion of nursing jurisdiction to include clinical skills previously restricted to medicine (Allen, 1997); and the replacement of nursing models of organisation with general management technologies in healthcare systems (Carpenter, 1977; Strong and Robinson, 1990; Duffield et al., 2007). The significant advances in nursing’s empirical and theoretical knowledge over the last fifty years have been dominated by subject-oriented approaches that foreground patients’ experiences of health and illness and nurses’ supportive role in ameliorating these effects through the promotion of a holistic biopsychosocial approach to care (Watson, 2008). While existing models acknowledge the patient’s social and physical environment as relevant for nursing practice (Fawcett, 1984), the focus is almost exclusively on how patients experience their health and not on “the patient-and-nurse-in-the-health-care-setting experiencing health and nursing care” (Bender and Feldman, 2015: 98). Indeed, in contradistinction to this predominantly phenomenological conceptualisation of patients, nursing’s understanding of the healthcare setting is dominated by object-oriented approaches in which the environment of care is portrayed as external to nursing practice, responsible for circumscribing the work that nurses do, and ultimately what nursing can be. While providing the impetus for educational innovation, research agenda and political action, one effect of this dominant framing is to render invisible nurses’ work in mediating the relationships between direct patient care and the organisational context in which this takes place (Allen, 2004).

3. Healthcare trajectories, emergent organisation and the organisational components of the nursing role

Healthcare is a quintessential example of an evolving activity accomplished in conditions of complexity and the challenges of coordination are well known. First, healthcare is a work of ‘many hands’ (Aveling et al., 2016); patients receive input from different providers and specialists and these relationships are conditioned by differences in knowledge, occupational cultures, social worlds, power and prestige. Everyday service provision is characterised by action and knowledge that is distributed across time and space, fragmented and multiple understandings of the patient (Mol, 2002), and staff that make largely independent contributions to care (Allen, 2015). Second, the challenges of coordination are compounded by the fact that this complex system of work is embedded in an inherently turbulent environment. Healthcare organisations have rather less control over their inputs, outputs and work rhythms than do other services and industries. Thus the care of individual patients has to be balanced with the care of whole populations and providers have to manage competing demands on their time. Third, healthcare is unavoidably ‘people work’ and thus has characteristics that are not present when the object of work is inanimate (Strauss et al., 1985). Individual’s care can take unexpected twists and turns, increasingly common in an aging population with multiple health conditions and care needs. Patients and their families have a view on these processes too: they are both producers and consumers of healthcare. Thus, the challenges of healthcare coordination arise not only

from the uncertainty of attending to injury, disease or frailty, but also from the complexity of the division of labour and the turbulence of the work environment. This dynamic relationship is captured by Strauss et al. (1985) in the notion of a healthcare trajectory, which refers to (a) the unfolding of a patients’ health and social care needs, (b) the total organisation of work associated with the management of those needs and (c) the impact of this on all those involved. Strauss et al., characterize the challenges of managing these relationships as analogous to those confronting Mark Twain’s celebrated Mississippi River pilot:

“the river was tricky, changed its course slightly from day-to-day, so even an experienced, but inattentive pilot could run into grave difficulties; worse yet, sometimes the river drastically shifted in its bed for some miles into a new course. [...] Some of the various contingencies may be anticipated, but only a portion of them may be relatively controllable, [...] stemming as they do, not only from the illnesses themselves but from organizational sources”.

(Strauss et al., 1985: 19–20)

Poor coordination in healthcare has important consequences for healthcare quality and safety, and increasingly organisations are adopting techniques derived from systems engineering and management science to support service delivery. Yet while pathways, care bundles and checklists, have a valuable contribution to make, there will always be some elements of healthcare work that cannot be controlled by such means. In such an inherently complex and unpredictable system, there are great swathes of activity that depend for their success on emergent forms of organisation mediated by human actors in response to contingencies. My ethnographic research demonstrated that nurses’ organising work arises from the requirement to address this need.

“Their location in the sites of care and at critical departmental and organisational interfaces casts nurses in a pivotal role in mediating the relationships between the heterogeneous actors through which patient and population needs are addressed. [...] Not only is this work an essential driver of action, it operates as a powerful countervailing force to the centrifugal tendencies inherent in healthcare organisations which, for all their gloss of rationality, are actually very loose arrangements.”

(Allen, 2015: 132)

Drawing on Actor Network Theory, I argued that nurses are the ‘obligatory passage points’ in healthcare systems. An ‘obligatory passage point’ is a focal actor in a network through which all others must pass (Cressman, 2009). Through their organising work, nurses channel, refract and shape all the activity that contributes to patient care. I coined the term ‘translational mobilisation’ to refer to these processes and to capture the ordering work nurses do in bringing all the components of a healthcare trajectory together, their mediating work in managing the inter-relationships in healthcare processes, and the energy they inject into the system through their work and its involved and continuous character. It is challenging to study this activity. This work is done on the fly and is woven through the warp and weft of everyday nursing practice. Better understanding of these processes and the interdependence of nursing practice and healthcare organisation, has important implications for both the quality of patient care, the efficiency of healthcare systems and professional practice. Translational Mobilisation Theory has the potential to close this gap in nursing’s theoretical and conceptual foundations.

4. Translational Mobilisation Theory

4.1. Origins

Translational Mobilisation Theory is a middle range theory that explains and describes the organisation of projects of collective action characterised by emergence, complexity and uncertainty (Allen and

Box 1

Precepts of Translational Mobilisation Theory (Allen and May, 2017)

1. Collective, goal-oriented action in institutional settings is mobilised through projects which have contingent outcomes.
2. A project is an institutionally sanctioned socio-material network of distributed action and actors that follows a trajectory through time and space.
4. Strategic action fields are located in institutional contexts, and create the resources that enable, and the conditions that shape, project mobilisation.
5. Projects in complex social systems are mobilised through the mechanisms of object formation, articulation, translation, reflexive monitoring and sensemaking.
6. The mechanisms of project mobilisation connect the domains of practice and the domains of organisation through processes of sensemaking.
7. There is a reciprocal relationship between the production and reproduction of institutionally sanctioned agency and the production and reproduction of institutional structures and objects.

May, 2017). Its immediate intellectual antecedents lie in my ethnographic study of the organising work of hospital nurses (Allen, 2015), but beyond healthcare, cooperative activity of all kinds increasingly is produced through fluid organisational processes as classic bureaucratic models (Gerth and Mills, 1946) are replaced by networked organisational forms (Castells, 2009). In collaboration with Carl May I built on my study of nursing work and combined it with conceptual insights from Normalization Process Theory (NPT) (May and Finch, 2009; May, 2013a,b) to develop a sociological theory of emergent organisation wherever this is found.

Translational Mobilisation Theory characterises and explains the mechanisms through which participants are enrolled in emergent projects of collective action and create institutional identities for the objects of their practice in order to mobilise cooperative activity through time and space. Through these processes they produce and reproduce the institutions that condition practice. The term institution is used here to refer to any recognisable social form that is a pattern of, and a pattern for, behaviour (Hughes, 1936). The main precepts of Translational Mobilisation Theory are summarised in Box 1.

As a generic theory Translational Mobilisation Theory makes no assumptions about the practices involved in mechanisms of mobilisation and how these are distributed in any particular case; this must be discovered rather than assumed. In some contexts translational mobilisation work will be evenly distributed between actors, in others, it might fall disproportionately to particular occupational groups or be accomplished primarily through technologies. As I have argued, however, in healthcare, nurses undertake a large proportion of this activity, with some estimating that this accounts for more than 70% of the work they do (Furaker, 2009). For this reason Translational Mobilisation Theory is of value in describing and explaining the organisational dimension of nursing work and nurses role in the mobilisation of healthcare trajectories. In the following sections I consider the core components of Translational Mobilisation Theory, and illustrate how these can be applied to nursing, drawing on my ethnographic study.

4.2. Domain assumptions

Translational Mobilisation Theory is founded on a number of

Box 2

Translational Mobilisation Theory: Domain Assumptions.

Practice theory	Focused on the concrete and material activities through which social and organisational life is accomplished.
Ecological approach	Concerned with the dynamic inter-relationships involved in collective action in context.
Process view of organisation	Understands stable social structures as dynamically produced and reproduced by people pursuing strategies in response to an environment
Mediated action	Attends to how social action is mediated by artefacts
Socio-materiality	Conceives of activity as distributed between human and non-human actors.

domain assumptions. First, it is a practice theory, and as such focuses on the concrete and material activities through which organisational life is accomplished, rather than lived experiences or psychological processes (Nicolini, 2012). Second, it adopts an ecological approach to collaborative activity (Hughes, 1951). It is concerned with the network of dynamic interactions between people, materials and technologies in collective action. Third, Translational Mobilisation Theory takes a process view of formal organisations (Strauss et al., 1985; Hernes, 2014). Seemingly durable social structures, such as professional roles and organisational routines, are conceptualised as on-going accomplishments that come into being through social action. Fourth, Translational Mobilisation Theory draws on insights from Cultural Historical Activity Theory (Engeström, 2000), which highlight the fact that we never interact directly with the social world; all activity is mediated through artefacts of some kind. This might include material artefacts, such as tools, technologies and instruments, or cognitive artefacts, such as categories, heuristics and methods. This leads to the final domain assumption, derived from Actor Network Theory (Latour, 2005), which is to conceptualise collaborative work as distributed not only between people, but across materials and technologies (Box 2).

4.3. Core components

Within this overall framework, Translational Mobilisation Theory comprises three main components: the project (the focus of action and what is done), the organising logics and meaning structures of strategic action fields (where it is done), and the mechanisms (how it is done).

4.3.1. The project

The Project is the primary unit of analysis in Translational Mobilisation Theory and provides a frame for understanding the ecological relationships in collective action. A project is an institutionally sanctioned, goal-oriented enterprise, constructed by the community that gathers around it, and has an associated division of labour, tools, technologies, practices, norms, rules and conventions. Projects are both planned and emergent and they follow trajectories through social time and space. In all cases, however, the concern is with time-bounded cooperative action of some kind. Projects are different from recurrent

processes or ‘lines of work’ (Strauss et al., 1985) such as the activity of the X-ray department, or a professional caseload, which will include participation in multiple projects.

In its application to nursing, healthcare trajectories are the projects of interest and these can be framed at different levels of granularity depending on the purpose. It could refer to a patient trajectory through a particular in-patient episode – my ethnographic study made visible the work of nurses in mobilising patient trajectories in the hospital context; it could refer to a critical juncture in a trajectory, such as the management of transfers of care from one service to another – much of nurses’ organising work is concerned with mediating organisational interfaces; or it could refer to the on-going management of long-term care arrangements – unpublished data from the same study also highlighted the critical role of nurses in supporting patients’ on-going care arrangements in the community context.

4.3.2. Strategic Action Field

Projects generate and are given their form by Strategic Action Fields (Fligstein and McAdam, 2011). Strategic Action Fields are meso-level social orders created on a situational basis when actors interact with knowledge of one another under a common set of understandings about the purposes of the field, the relationships in the field and the field’s rules. Within Translational Mobilisation Theory, Strategic Action Fields define the institutional contexts in which projects are mobilised and provide the resources that shape collective action. These include:

- a **Structures:** elements of a Strategic Action Field that stratify social relations (for example, social roles, divisions of labour, professions, hierarchies, departments, units, teams);
- b **Organising logics:** elements of a Strategic Action Field that provide a set of normative conventions that define the scope of possible action, and shape its purpose (for example, recovery, rescue, efficiency, recuperation, rehabilitation, palliation);
- c **Materials:** elements of a Strategic Action Field that provide agents with the physical artefacts to support their practice (for example, tools, technologies, bodies, knowledge);
- d **Interpretative repertoires:** elements of a Strategic Action Field that provide agents with the cognitive artefacts for sensemaking (for example, classifications, scripts, categories, discourses, routines).

It is these resources that facilitate and give shape to the practices through which projects are mobilised and the mechanisms that drive action.

Translational Mobilisation Theory directs attention to the structures within a Strategic Action Field. In the healthcare context, these are typically complex, and include the patient and their social network, different organisations, departments, professions and occupations. While the higher order aims for patient care may be shared, the communities involved often have singular concerns, reflecting their respective roles and responsibilities. Nurses’ work in the mobilisation of healthcare trajectories involves understanding and skilled negotiation of these relationships, with professional hierarchies and differences in power and status compounding the complexity of this task.

Organising logics in a Strategic Action Field provide the normative conventions that drive action. Healthcare, like other organisations, is characterised by contradictory logics. The patient and their family have their own logic in utilising healthcare services and these may or may not be in alignment with the prevailing logics of healthcare professionals, which in turn can be in tension with management logics. Nurses find themselves at the intersection of competing logics and have an important role in mediating these relationships. This is captured beautifully by Chambliss (1997):

“In the complex hospital organization embedded in a complex society, nursing finds itself at the intersection of competing occupational groups and moral ideologies and this competition is the

source of its ethical problems. Each day, nurses juggle the orders of physicians, the needs of patients, the demands of families, the rules of the law, and the bureaucracy of the hospital, and their own physical and emotional limits.”

(Chambliss, 1997: 93).

The nurses observed in my ethnographic study actively managed these logics, and on a daily basis accomplished a multitude of accommodations between the needs of patients and the needs of the organisation. These were difficult trade offs and in describing this work I highlighted the dangers of nurses becoming enrolled in management logics that privilege efficiency over patient-centredness, observations that have particular salience in the context of growing concern for care and compassion in healthcare.

Across the Strategic Action Field, actors draw on and accomplish their work through interaction with an array of materials – tools, technologies and bodies of knowledge – which influence healthcare trajectories in important ways and condition how care is organised. In my ethnographic study, I showed how bed management was a central mechanism for ensuring that patient needs were aligned with the materials required. In healthcare the ‘bed’ is far more than an everyday artefact used for rest and sleep, but includes a whole host of associated materials: people, expertise, space and technology. Nurses have a central role in matching patients with ‘beds’ and ensuring people are allocated the right bed with all its associated resources. This is particularly pertinent in managing hospital discharge where there are marked differences in the materiality of the hospital and community that have important implications for how work is accomplished in these different contexts.

The Strategic Action Field also provides the cognitive and relational resources with which actors make sense of and order projects. People do not arrive in healthcare settings as ready-made patients. Actors draw on range of interpretative repertoires to make patients up, that is, to translate the presenting individual into a form that enables them to perform their activities. These include patient and family understandings of illness, injury and recovery; diagnostic classifications deployed by medical staff; risk assessment scores used by nursing staff; and management categories relating to bed occupancy and length of stay. It might also include informal categories deployed by staff in managing their work. Given this multiplicity of perspectives, the question then arises as to the conditions that are necessary to enable concerted action. This brings us to the final component of Translational Mobilisation Theory: Mechanisms.

4.3.3. Mechanisms

Translational Mobilisation Theory specifies five mechanisms through which projects of action are progressed by agents in a Strategic Action Field. In line with the domain assumptions of the theory, mechanisms are conceptualised as performative. On the one hand, they mobilise action in organisational contexts. On the other hand, through their enactment in practice, they produce the structures and normative resources that define the Strategic Action Field. Mechanisms link organisation and practice and describe and explain social action in its institutional context through the interactions between:

- a **Object Formation:** practices that create the objects of knowledge and practice and enrol them into a project;
- b **Reflexive Monitoring:** practices through which actors evaluate a field of action to generate situational awareness of project trajectories;
- c **Articulation:** practices that assemble and align the elements (people, knowledge, materials, technologies, bodies) through which object trajectories are mobilised within projects;
- d **Translation:** practices that enable practice objects to be shared and differing viewpoints, local contingencies, and multiple interests to be accommodated in order to enable concerted action;

e **Sensemaking**: practices through which actors interpret, order, construct and account for projects and at the same time produce and reproduce institutions.

The application of these mechanisms for understanding nursing work is illustrated below.

Object Formation is concerned with how actors use the available interpretative resources to create the objects of their practice. In healthcare, patients are imbued with multiple organisational identities. The understanding of a patient that emerges for the purposes of medical diagnosis is different from that generated by nurses concerned with care needs, and different again from that produced by allied healthcare professions concerned with rehabilitation, or managers concerned with patient care episodes and length of stay. At any one time, a number of different versions of the patient can be in circulation with information pertinent to healthcare trajectory management distributed in time and space. In the case of nursing, my study illustrated that nurses' organising work entails maintaining an awareness of these different understandings of the patient and creating 'trajectory narratives' which encapsulated the current status of patients' overall trajectory care. In terms of the theory, trajectory narratives are the objects of practice that are produced by nurses to support the organisation and coordination of healthcare work. Generated initially through the nursing admission process, trajectory narratives are continuously reviewed and revised in response to the changes in a patient's care. This brings us to the second mechanism in Translational Mobilisation Theory: Reflexive Monitoring.

Reflexive Monitoring refers to the processes through which actors collectively or individually appraise and review activity (May and Finch, 2009). In a distributed field of collective action, Reflexive Monitoring is the means through which members accomplish awareness of an overall project trajectory. Conditioned by the wider institutional context, Reflexive Monitoring has different degrees of formality and intensity depending on the project.

In the case of nurses, the mobilisation of healthcare trajectories includes updating narratives as a result of the conversations held with providers interacting around the case, and undertaking purposive work to refine content through consulting the medical record and other information sources. It also requires an awareness of the organisational context: workflows, demand patterns and resource availability. Nurses shift their attention from the individual to the organisation and combine this clinical and organisational knowledge in a distinctive professional gaze, focused not only on the patient and their nursing care needs, but their overall trajectory of care and the organisational relationships and resources that support this. By dint of this work, nurses hold a privileged 'panoptic' view of the totality of activity in healthcare systems – I called this 'healthcare trajectory awareness' (Allen, 2015).

The third mechanism in Translational Mobilisation Theory is Articulation (Strauss et al., 1985). Articulation is a secondary work activity that refers to the actions, knowledge and resources necessary to enable collaboration around a shared object of practice. It is the work that makes the work, work. Healthcare is complex; decisions must be made about what should be done, by whom, how, where and with what materials. The more elements involved in the process the more complicated this becomes. Because patient care is often uncertain, emergent and unpredictable, alignment of all the activities in a trajectory cannot be taken for granted and, as I have argued, for all their formal structures and processes, large aspects of healthcare work are loosely coupled. While activity might be interdependent at the level of the patient, project participants are distributed in time and space and for much of the time undertake their work in parallel.

While not formalised as such, in the site of my ethnographic study it was largely taken for granted that nurses would organise patient care trajectories and there is evidence to indicate that this is a general phenomena (Allen, 2004). Nurses combined their awareness of individual patient trajectories with their understanding of organisational processes to undertake temporal articulation, which aimed to ensure

that things happened at the right time and in the right order (Bardram, 2000), 'material articulation', which aimed to ensure the availability of resources and materials to support action (many catastrophic safety incidents arise because of the unavailability of materials and equipment), and 'integrative articulation', which aimed to ensure the coherence of project work.

"In the ebb and flow of personnel through the clinical areas, it was to nurses that junior doctors, allied health professionals and others turned to clarify their contribution and it was nurses who took responsibility for ensuring materials, technologies and tools were available to support activity. Moreover, because healthcare providers came together to align their work infrequently, nurses mediated these relationships. Whether in response to acute, time-critical events, emergent contingencies or simply part and parcel of progressing routine scheduled interventions, nurses made an essential contribution to the alignment and integration of actors necessary for trajectory mobilisation and this large invisible work was highly consequential for service quality"

(Allen, 2015: 55)

The mobilisation of healthcare trajectories requires more than the alignment and integration of activity, it also depends on Translation, and the fourth mechanism of Translational Mobilisation Theory.

Translation is derived from Actor Network Theory (Latour, 2005) and in Translational Mobilisation Theory refers to the processes through which the objects of practice of one actor are translated into the objects of practice of another in order that settlements (agreements) on the status of an object are accomplished to enable projects to progress. These are always selective representations; constructed with particular purposes in mind. In preparing a patient for surgery for example, the ward nurses must ensure specific information is provided that will support the work of operating theatre staff, i.e. whether the patient has dental caps and crowns and when they last ate and drank. Other information, such as their dietary preferences, social networks or mobility is simply not relevant.

Settlements can have different degrees of permanence. In some instances this may involve the translation of a practice object into an entity that has durability and can be transported between groups, such as the version of a patient represented in a risk assessment proforma, cognitive functioning assessment, or a laboratory report. In other circumstances, settlements might be relatively short-lived and bounded by the requirements of the situation, such as the agreements reached on the status of a patient during daily interactions between nursing and medical staff at the bedside.

Translation can be achieved in different ways. A whole host of organisational artefacts are designed for this purpose; like the structured preoperative check-list in the example above. But it is also the case that the mobilisation of healthcare trajectories depends in large part on the role of human mediators for translational work and nurses have a key role in this regard. One of the advantages of trajectory narratives for mobilising healthcare trajectories is that they can be modified for different audiences for the purpose of information sharing. My study showed that nurses draw on their relational knowledge of the social structures of healthcare systems and take the perspective of others to modify the content of the story so that this meets the purposes of the recipient. Through the telling and retelling of different versions of trajectory narratives, nurses enable the 'patient' to function as a 'boundary object' to enrol the network of actors into cooperative activity.

"[H]ealthcare work is not managed or coordinated around the patient as conventionally portrayed [...] Rather it is the object of the patient in all its interpretative flexibility that enrolls the work of actors into recognisable patterns of action – what service managers call pathways of care – and it is nurses who are central in bringing about the translations through which this is accomplished. This is

patient-centred healthcare, but not as it is conventionally understood. It is less a case of services being organised around the needs of the patient, and more a case of the ‘patient’, by dint of the work that nurses do, holding services together, however fragmented these might be”

(Allen, 2015: 135)

The final mechanism in Translational Mobilisation Theory is sensemaking and refers to the processes through which agents create order in conditions of complexity (Weick, 1995). Sensemaking runs through object formation, reflexive monitoring, articulation, and translation, and draws attention to how the material and social processes by which members organise their activity, account for their actions, and construct the objects of their practice, are performative. That is, they give meaning and substance to the institutional components of Strategic Action Fields that shape current and future action. Thus the structures and maxims through which the ordering of projects is achieved are themselves in a continuous state of becoming as a result of this activity. For example, in deploying a risk assessment tool the nurse is constructing a particular version of the patient, but in the application of the tool in practice is at the same time enacting and performing the tool’s precepts in ways that condition future use. Thus while Strategic Action Fields order social action, they may also be negotiated, interpreted and stretched by participants. For the purposes of understanding nursing work, sensemaking underlines the interdependence of nurses’ organising practice and the environment for care, nursing agency in mediating these relationships and the inherent political and ethical dimensions of this work.

Translational mobilisation mechanisms are complex and characterised by flux and becoming. The provision of a framework should not be taken to imply stability and rationality in these inherently fluid and entangled processes. Furthermore, the core components of Translational Mobilisation are inter-related: the mechanisms of mobilisation connect domains of practice (projects) and the domains of organisation (Strategic Action Field) through processes of sensemaking. Thus there is a recursive relationship between the production and reproduction of social action and the production and reproduction of social institutions. The relationship between the core components of Translational Mobilisation Theory are set out in Theory Fig. 1.

5. Discussion

Translational Mobilisation Theory has important implications for understanding nursing work in managing healthcare trajectories. As a practice theory, it brings into view nurses’ agency and its consequences for patients, the organisation and the profession. It also offers an alternative to phenomenological understandings of ‘the patient’ and brings to the fore the multiple identities that patients might enact or be assigned by others, and the implications of this complexity for collective action.

More pragmatically, Translational Mobilisation Theory offers a framework to systematically analyse healthcare trajectories. The Project provides a structure for defining the boundaries of trajectory work, the ‘Strategic Action Field’ draws attention to the ecology of elements involved, and the Mechanisms provide a focus on the associated work of trajectory mobilisation and the nursing contribution to this. This has value for both educational and practice purposes. In the case of the former, Translational Mobilisation Theory offers a template for students to study healthcare trajectories and consider their implications for organisation and management. In the case of the latter, it opens up the possibility of a more explicit focus on the organisational components of nursing work, and the development of tools to inform the management of healthcare trajectories such that their complexity might be assessed to inform workforce planning. While considerable effort has been invested in developing workload models over the last forty years, questions remain as to their overall utility and relevance. Of

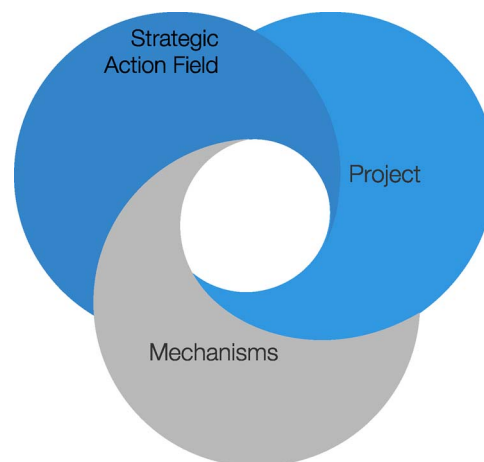


Fig. 1. The Core Components of Translational Mobilisation Theory.

Practice theory	Focused on the concrete and material activities through which social and organisational life is accomplished.
Ecological approach	Concerned with the dynamic inter-relationships involved in collective action in context.
Process view of organisation	Understands stable social structures as dynamically produced and reproduced by people pursuing strategies in response to an environment
Mediated action	Attends to how social action is mediated by artefacts
Socio-materiality	Conceives of activity as distributed between human and non-human actors.

particular concern, is the tendency of prevailing approaches to focus on clinical rather than organisational factors and to be over-determined by considerations of patient acuity. Currently factors that impact on the organisational component of the nursing role are black-boxed under ‘professional judgement’.

Beyond education and practice, Translational Mobilisation Theory has implications for nursing research and quality improvement initiatives. Because of its complexity and fluidity, the analysis of translational mobilisation is not easy. Translational Mobilisation Theory offers a framework for rigorously describing and analysing these processes in different contexts and makes possible systematic explanation and prediction, and the identification of failure points in healthcare systems which, in turn, might be targeted by improvement interventions.

6. Conclusion

In this paper I have introduced Translational Mobilisation Theory, illustrated its application to healthcare and considered how it might be applied to the organisational elements of the nursing role. There is cumulative observational evidence that nurses have an important organisational function in healthcare, but this work is largely invisible and lacks theoretical and conceptual foundations. Translational Mobilisation Theory addresses this gap and invites a radical reframing of our understanding of healthcare organisation, and the role of nurses within this. Further work is necessary for its potential to be realised, including for example, extending the original research beyond the acute hospital context, and translation of the framework into more concrete and specific formats for different applications. However, as a theory grounded (Glaser and Strauss, 1967) in empirical research on healthcare and the work nurses do, it reflects the everyday reality of nursing practice, and provides a language and a framework with which to describe, explain, support and plan this important but neglected dimension of the nursing role.

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