

The process of developing the Professional Identity of the Nurse Case Care Manager: a Grounded Theory study

Maria Bertuol¹, Veronica di Niro², Cristina Tagliabue², Valentina Ventre², Piero Cusenza², Chiara Taffurelli⁴, Leopoldo Sarli¹, Giovanna Artioli³

¹Department of Medicine and Surgery, University of Parma, Italy; ²Post graduate Specialization in "Case /Care management in hospital and on the territory for health professions", University of Parma, Italy; ³Azienda USL-IRCCS di Reggio Emilia, Italy; ⁴University Teaching Hospital, Parma, Italy

Abstract. *Background and purpose.* The Nurse Case Care Manager (NCCM) is still an emerging figure in the Italian healthcare context. The knowledge of the dynamics inherent in the process of identity development shows how they can be decisive for the affirmation and recognition of this new role. The aim of the study was therefore to analyse the psychosocial processes of developing the identity of the NCCM for a better understanding of the variables that influence its development. *Methods.* A qualitative study with Grounded Theory method was conducted. From December 2018 to January 2019, 20 semi-structured interviews were given to the NCCM of the Emilia Romagna Region and the Lombardy Region. The analysis of the material has led to a structuring of the theoretical model on the processes of development of professional identity. *Results.* Two main conditions have been identified: that of the "LOST CASE CARE MANAGER" and that of the "CASE CARE MANAGER DIRECTOR". This process requires time, perseverance, courage and personal skills. Two transversal background concepts have been identified, namely "available space" and "relationship with the family". *Conclusion.* The process of developing the NCCM's professional identity encounters several obstacles. Among these, in particular a lack of recognition by operators highlighting the need for greater organizational clarity in the context in which the professional operates, in order to facilitate the inclusion of the NCCM clarifying skills and effectiveness profile. (www.actabiomedica.it)

Keywords: professional identity, influence factors, professional competences, culture evolution, Case Manager, nurse, development, Grounded Theory, case management, care management

Introduction

Nurse Case Care Manager (NCCM)

The decentralization of treatment, the increase of the complexity of the cases and available services has led to the birth of the Case Management model in 1960 (1). A scoping review in 2016 examined in particular the definition, the theoretical bases, the components and the interventions of the Case Manager (CM) (1). It has emerged that the significant variability of terminology, the gap in a common understanding of the definition of Case Management model, and the varied contexts in

which a professional person works with several resources and in different communities have gone ahead with the development of models varied for competences and task, penalizing a study of effectiveness.

In short, it emerges that the model of Case Management deals with short-medium-long term assistance, the participation of the community and the support of a person with different health conditions in various welfare settings.

Two in particular are the dimensions that identify the process of CM's work: the management dimension, where the object is organization, human resources and welfare dimension, where the focus of intervention is

the patients' care needs (2). Consequently there is a superimposition between the role of Case Management and the one of Care Management. Depending on the National reality in which their work is done, they take on a different taxonomy, even if, in fact, both of them are connected with the same model. In our context they go by the name of Case Care Managers (CCM).

The professional identity of the Nurse Case Care Manager (NCCM)

Some ambiguities of the role noticed in literature reflect the need to define the professional identity of such a figure. Their identity in itself includes a series of aspects that can be significant for their professional recognition, for the attainment of the outcome and job satisfaction (2,3,4,5). The professional identity is a complex concept, it is dynamic with various characteristic levels. The "self-concept" (6), in particular, can be understood as the way in which a person thinks of oneself and, in this specific case, for nurses, it concerns the knowledge and beliefs related to their role, behaviour and values defining their jobs. Nurses build up their own self-concept, perceiving in their job, which are the values and the reference culture both in the specific context of their welfare setting and in the more general one of the nurse as a member of a category of the nursing profession (7,8). The self-concept is therefore closely related to the concept of the self-professional (9). In this aspect several authors agree on the fact that the inner image of the professional is contradictory with the public one which is often distorted and stereotyped: it is depicted as subordinate to the medical profession, with little chance of career, causing dissatisfaction about their role, negatively influencing the internal recognition (9,10). Professional identity and self-concept may undergo changes due to interactions with colleagues, other health staff and patients (9). The identity construction, in fact, includes the sense of belonging to a group and the interpersonal relationships (11). Smith, in a revision of the literature, shows what the psychosocial factors involved in the transition from nurse to CM are (12): motivation, expectations, work satisfaction, but also the main sources of stress that originate from the fact of not feeling prepared to cope with the critical issue related to the role. The

study also emphasizes that the inadequate training is a factor negatively associated to the definition process of the CM's professional identity, who feels responsibility without power. This aspect has been pointed out even in other researches on Case Management (1,10,13).

Aims

The aim of this study is to analyse the psychosocial processes of the development of a professional identity who carries out the job as Nurse Case Care Manager (NCCM) in a hospital facility and/or on the territory, in the context of the National Health System. In particular, the NCCM's perceptions have been studied in depth regarding their role and the importance they give to their activity and the relationship system.

Method and procedure

Study design

It is an exploratory study that adopts a qualitative research strategy on the method of the Grounded Theory (GT).

The GT is a research method that originates from the field of sociological research inspired by the so called "interpretative paradigm" (14,15). It seemed to be the most appropriate methodology for this study under discussion for the setting-up of a theoretical model regarding the psychosocial process that verifies in the construction of the NCCM's identity process.

Participants and setting

The analysis unit of this research project is the nurse working as Case Care Manager or Case Care Manager, both in hospital and national territorial contexts. The participants were through a sampling of suitability.

In the course of the research, the initial avalanche sampling was adopted, so as to recruit further participants from the first NCCMs involved. According to the data analysis the theoretical sampling followed until the achievement of the conceptual density (16). In

line with the principles of the methodology Grounded Theory, the sample was not pre-arranged numerically (17, 18).

The settings in which the research was done were hospital services/wards and the territorial services where the roles of Case, Case Care Manager in Emilia Romagna and Lombardy are done.

Inclusion criteria

Nurses working as Case or Case Care Manager, who gave their consent to participate in the research, have taken part in the study.

Study population: sample recruitment

The people in charge of the structures involved have been informed personally by the research team concerning the aims of the study and the type of required collaboration. The Italian Association Case Manager has spread the request for taking part in the research through the Association’s internet site. Some NCCMs were recruited during the Master’s at the University of Parma in “Case Care Management in hospital and on the territory for the health professions”. The professional people eligible for the protocol were contacted and informed via e-mail directly by the research team. Date and place for data research were shared through e-mail or phone contact.

Instrument

The selected means was a semi-structured fact-finding interview, with the main aim of collecting data.

It is led by an interviewer who uses the outline of a survey with a series of questions asked of all the people interviewed without needing a set order, leaving space for any further information (19, 20). The interviews were conducted by two researchers who had proper training on the matter. An observer was present who took notes of the observations which emerged during the interview.

In the course of this study interviews lasted between 30 and 50 minutes and were audio-recorded. All the people interviewed were asked if they would participate in a second meeting. The setting where the interview took place was a private place chosen by the participant.

The interview was built up by the team on the basis of the aims of the research (see table 1), since they wanted to inquire into the field of competences, the perception of the role on behalf of the NCCMs and the other professional people who collaborated the interfering factors and favouring the transition of the role and finally the field of the expectations.

Analysis and data encoding

Coherent with the methodological approach of GT, the research team analysed the data, at the same time as their collection. The construction of a theory rooted in data or of a theoretical model is possible thanks to the construction of conceptual categories. This analytic process consists of three phases: an initial coding through the use of codes or labels, a focusing coding that group the labels in conceptual categories and a theoretical coding with the construction of the model (16, 21).

Table 1. Semi-structured interview grid

Opening question: used to open free communication and report on the skills of the new role	Do you feel you could talk about a significant episode of your new professional activity? Could you tell us what skills are required in performing the functions of Case/Care Manager compared to when you were a nurse?
In-depth questions: to understand the process and the main changes	What is your perception of the role and, in your opinion, what is the perception of the others? What influenced the role shift? Are there any factors that have hindered or facilitated the change? Can you tell us about a meaningful episode?
Closing question: has functions to express expectations and requests	What are your expectations for this profession? Would you like to add something you think is important that you didn't say before? Thank you for your availability

Ethical considerations

Before starting the interview the participants were asked to sign an informed consent including an advisory note that clarified how the survey was a voluntary participation, with the possibility to withdraw at any time, and the note specified precisely the information on the study carried out.

The participants were informed they could modify or eliminate the collected data if and whenever they wanted. The document also declared that the interview would have been audio-recorded and the collected data would have been disclosed in strictly anonymous form. The starting of the survey was subordinated to the opinion of the Ethical Committee of the Area Vasta Emilia Nord. The CE expressed a positive opinion on 09/10/2018 (protocol N. 2018/0112764).

Each author declares that he or she has no commercial associations (e.g. consultancies, stock ownership, equity interest, patent/licensing arrangement etc.) that might pose a conflict of interest in connection with the submitted article

Results

Twenty professional people took part in the research, their average age was between 45 and 75 with a standard deviation of 5.51. 95% were women. As reported in table 2, it can be deduced that 20% of the participants is attending a Training Master's in Case Care Management, 60% has already obtained it and the remaining 20% never got it. The total years of service as a nurse is 21.3 years, while the average number of years of service as a Nurse Case Care Manager is 3.37. The NCCMs work in different contexts.

The first phase of the collection, analysis and data codification was carried out during 8 interviews, decoding parts of texts considered important with labels deriving from the results of reflections prompted by the analysis. In the first phase 223 strings of interest were identified. Labels were made from the strings and then grouped in categories. The second phase of data collection provided a theoretical sampling of 12 NCCMs, in order to diversify the experiential sources as much as possible. With a further 331 strings of interest a saturation

Table 2. Socioeconomic characteristics of participants (N= 20)

Age	Gender	Total length of service	Length of service in the role of Case or Case-Care Manager and department	Master's degree
49	F	28	5, Residential Home	Yes
47	F	26	2, Infectious Diseases	In progress
41	F	18	3, Surgery	In progress
43	F	24	2 years 6 months, Residential Home	In progress
40	F	18	1, Neurosurgery	In progress
44	F	25	10, Breast Unit	Yes
49	F	30	1, HNS	No
33	M	11	5, Oncology	Yes
44	F	15	Medical Area	Yes
40	F	15	5, Oncology Medicine	Yes
45	F	18	2, Vascular Medicine	Yes
42	F	12	5, Long-term care	Yes
47	F	25	1, HNS	No
57	F	34	3, Medical Area	No
45	F	23	8, Hospice	No
45	F	23	2, Surgery	Yes
45	F	26	3, Long-term care	Yes
40	F	18	2, HNS	Yes
31	F	8	1, HNS	Yes
48	F	29	3, HNS	Yes

tion of the categories was reached. Each category had a precise definition so as to represent all the observed concepts.

The formulation of concepts happened through the creation of a conceptual map, to organize more abstract ideas. Starting from the elaborate concepts, the connections emerging among them were identified up to the theoretical modelling (Table 3).

The theoretical model (Figure 1) is characterized by two main conditions: condition 1, the one of "Lost Case Care Manager" that is the initial phase of the process, and a final condition, the one of "Case Care Manager Director", reached through an intermediate phase of the process. Two background concepts transversal to the entire process also emerged: the "available space" and the "relationship with the family". The first concerns a further consequence of lack of company directives, the

Table 3. Identification and definition of conditions

CONDITION	CONCEPTS	EXCERPTS
LOST	Unclear role	<i>“my perception of the role is quite confused...I feel a bit as if I am in a centrifuge”</i>
CASE	War climate	<i>“we nurses.. do not help ourselves... We fight against one another”</i>
CARE	Enemy nurse	<i>“you will realize over time, and it is sad, that the worst enemy of the nurse, is the nurse himself/herself”</i>
MANAGER	Fractional vision	<i>“the putting together of my patients’ fragmented stories.”</i>
CASE	Acting as the glue	<i>“you also have to... keep directing a lot of things”</i>
CARE	Feeling different	<i>“that patient said, that nurse over there... really makes the difference in this ward.”</i>
MANAGER	Satisfaction	<i>“I think it is a key role... he/she acts as glue that keeps everything together”</i>
DIRECTOR	Acquired recognition	<i>“[...] It is a question of trust gained because in the end I bring you the result”</i>
BACKGROUND CONCEPTS		EXCERPTS
RELATIONSHIP WITH THE FAMILY		<i>“it is a satisfaction to see people who recognize you as the person who helped them overcome a difficult moment.”</i>
AVAILABLE SPACE		<i>“We act within a framework so... very wide... on a very fragile track... Yes, references are still a little scarce”</i>

available space, at initially experienced as a negative factor: *“we act within a framework so... very wide... on a very fragile track... Yes, references are still a little scarce”* [C 3-8; I 7; S 31] and subsequently it turns into autonomy. The second concerns the **relationship with the family**. Immediately this is a motivating force for the NCCMs, that stimulates them to go on with their work, and the appreciation recognized by patients and their families evolves in a fulfilling relationship, as shown below: *“it is*

a satisfaction to see people who recognize you as the person who helped them overcome a difficult moment” [C 1-10; I 6; S 18].

Lost Case Care Manager

The NCCMs, in the initial phase of their identity path, experience a state of confusion that make them feel **Lost**: *“there is a lot of space that leaves you a little un-*

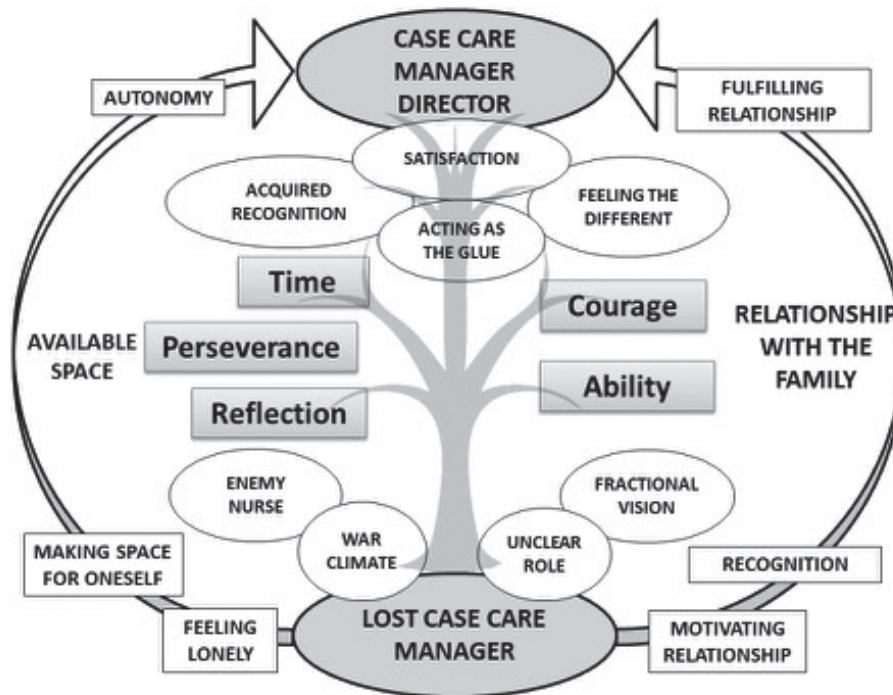


Figure 1. Representation of the theoretical model

comfortable at the beginning” [C 3; I 1; S 4], “my perception of the role is quite confused... I feel as if I am in a centrifuge” [C 3; I 20; S 93]. Defining concepts are showing which contribute to the lack of company directives, that creates the state of confusion in the professional. The **unclear role** negatively influences not only the perception nurses have of themselves, but also the one of their colleagues and of the whole team: “there is no precise definition inside the various Companies.”, “you are made do something different and maybe it is not clear to the group what you are going to do.” [C 8-3; I 3; S 8]. This is one of the reasons why a **climate of war** is established, that obstructs the initial phases of the process in which the professional figure is that of an **enemy nurse**: the colleagues themselves seem to be less inclined to the change and to the acceptance of the new role: “you will realize over time, and it is sad, that the worst enemy of the nurse, is the nurse himself/herself” [C 8; I 2; S 1], “we nurses ... do not help ourselves. We fight against one another” [C 8; I 8; S 17].

Another concept identified in the NCCM’s competences is “the putting together of my patients’ fragmented stories.” [C 2; I 2; S 1]. It is about a new required competence compared to the previous work as nurse, which represents, in its initial phases, a big effort to change course and that is evident in the concept of a **fractional vision**.

Transition process

To identify the entire identity formation process there were 5 concepts that allowed the evolution of the professional until the final condition. The first is the concept of **time**, which takes on several nuances. Time is necessary in order for changes to take place: “I want to give myself time to... know how to wait too” [C 3-6; I 13; S 58] it is the privileged means that the NCCM use to be able to express themselves in their new working role as professional, far away from the fast “pace” of the ward nurse: “I am lucky I can dedicate time, all the necessary time to a fact-finding interview...” [C 4-9; I 15; S 69] and finally as I expected “I hope the CMs... make things clear, as to the ones who can develop their profession over time and integrate with one another. [C 6; I 4; S 7].

Perseverance and **courage** are other two relevant concepts which emerged from the analysis, personal characteristics common to the interviewees, necessary to support the most difficult phases of the process and to

overcome barriers and obstacles: “I have started to take my own space, to elbow my way through, put my foot down and say: “that’s enough!” I must do that and I will. Do you agree or not? It is not my problem!” [C 7; I 2; S 6], “i.e., someone thought I was crazy, after working all day you stay longer, work more hours for what...?” [C 7; I 6; S 23], “well, I think being more courageous is difficult while training, but I think courage is a gift a NCCM must have” [C 7; I 1; S 1].

Another concept is represented by the **skills** that include the “technical” abilities belonging to this role (organizational, managerial, relational, financial, all part of health education), and the ones concerning the personal sphere (communication and human skills together with empathy, flexibility and ability to mediate). These skills can be interpreted as the result of the intersection between formation and experience. Finally **personal reflection**, which means thinking carefully and scrupulously, which allows the professional the possibility to look ahead: “we have more possibilities to be able to look even further” [C 3; I 19; S 92].

Case Care Manager Director

The intersection of the above listed factors leads to the achievement of the second condition, the final one, where the NCCMs mature their own abilities and competences, as much as to recognise and be recognised as course **Director**: “a more articulated solution is required, maybe the NCCM has a wider vision and is able to put together the interventions of various professionals and ... more areas of a person’s life” [C 2-3; I 1; S 1], “you must also... take other factors into consideration” [C 2; I 13; S 21], “this role is positive and I experience it, as the most important potentiality in a nurse” [C 3; I 12; S 52]. The NCCMs feel the **glue** as they create networks, join and catalyse the path of a cure “I think it is a key role... he/she acts as glue that keeps everything together” [C 2; I 13; S 19]. The NCCMs who were interviewed feel the need to do something different that would help to gain excellent results and they say they **feel different** from the others: “training that really helped me a lot and amplified the skills I already had” [C 4; I 10; S 44], “..that patient said: that nurse over there... really makes the difference in this ward” [C 10; I 16; S 31].

The concept of **satisfaction** for the NCCMs derives, in the last phase, from the work done, from the aims reached, from the feeling of being efficient in their

work, resolving the conflict. This brings us to the final concept which is the **required recognition**, not only by the patient or the family, but also by the team which perceives the NCCM as a point of reference, with a special role in course management, as shown in the following: “[...] it is a question of trust gained because in the end I bring you the result” [C 1; I 12; S 39], “now there is no longer this friction, on the contrary I think I am a support to them even if the colleagues are always the same” [C 1; I 15; S 47].

Discussion

Most of the theories that form the model of this study are supported by previous literature. Grounded Theory research has allowed to develop a model that attempts to describe the process of developing identity of the nursing professional who is to play the role of NCCM: the director of change.

Ambiguity of the role is a concept that has emerged in our model. According to the analyses carried out, the health authority was unclear about the competence profile of the NCCM. In the literature, several authors have described this phenomenon (8, 9, 19, 21-24) and it has been highlighted that clarity in the role is necessary to reduce the risk of overlapping skills between professionals, since it is in the duplication of functions and roles that the peculiar effectiveness of one specific professional figure vanishes and the consequent acceptance by the other within the pre-existing system (25).

This may also be due to the semantic confusion of the interventions of the NCCM, the lack of a definition of the model as introduced (1), and the resistance to change, a common component of the group which adversely affects the process of identity formation (26).

The nurse who becomes NCCM immediately changes work context is no longer mainly part of the nursing team, but acts as a link with other professionals. The study shows that in the initial phase of the process, the relationship with fellow nurses becomes an obstacle to identity formation. In the literature it has also been noted that nurses indicate in particular the conflict dimension as a potential problem in the work environment (27).

At the beginning, fundamental aspects of the role that the NCCM plays in the nursing nucleus enter into

crisis: relational, communication, teamwork, trust, coordination, preventing integration and collaboration. From the analysis of the research, however, the NCCM is well integrated in the inter-professional team and in the literature it is highlighted that this is a fundamental feature to obtain comprehensive care and respond to the complexity of health care, objective of the Case Care Management model (2).

The relationship with the family is an emerging concept that plays an important role in the transition process being studied. When they played the role of nurses, the NCCMs interviewed claim that they did not have complete information about the patient, to have access to a fragmented and focused story on the problem of the moment. Subsequently, from NCCMs, they find themselves “putting together the pieces” of the care path and communicating with the family in a more constant way.

Family members, like the patient, do not recognize the figure of the NCCM in the organizational structure but this does not hinder the consolidation of a relationship of trust. The NCCM is recognized as a point of reference, of listening, of help and with the passage of time the relationship becomes rewarding for the professional. The link between the coordination of home actions and the care process offers the NCCM the opportunity to reconnect with care and, as a result, contributes to increasing satisfaction levels and reducing stress at work (2).

As other authors have previously analysed (5), experience as a nurse in our model is essential, reported by the interviewees as a determining factor to perform at best their function. As we have seen, the NCCMs are associated with different types of cases, instruments and timing. The experience allows them to develop skills about the reference setting.

Training is also an essential element. Franco & Tavares noted that nurses holding a Master's degree or Specialization Diploma are more competent in their profession (27), which is important to feel effective. Training in the specific managerial context is perceived as a fundamental need for some Case Care Managers (28).

The sample of our research in possession or in the course of a specific training, stated that it was useful to provide a background of skills, although the professional figure and the profile of skills were not always clarified. Training influences the development of iden-

tity not only in the transmission of content and skills that define the role, but also in the way in which it lets perceive “who” should be the NCCM.

The NCCMs interviewed focus on their personal and relational skills such as communication, empathy, courage, mediation and flexibility. The latter is a key element for nurses to be effective, not only for their patients but also for other healthcare professionals (29). For Rocco et al. (27), courage is recognized as a means to overcome difficulties and is mentioned in several interviews of our research.

Depending on the stage the NCCM is going through, confidence in the role is also a determining factor. The lack of initial clarity creates a state of confusion in the professionals that, over time, evolves on the basis of the results obtained, despite the unfavourable environment, with a problem-oriented coping strategy that allows them to face a challenge through his own resources (22). Trust in the role allows the NCCMs to persevere in a first phase of isolation and lack of recognition, thus drawing on personal skills, as well as their own skills. Finally, it is time that mitigates the difficulties and that allows to metabolize the change.

The process leads to the conclusion that the NCCMs are “different”, finally seeing themselves recognized in the role and feeling satisfied with their work. The NCCMs in this final stage of the process feel satisfied not only with what is recognized from the outside (by family members, patients, the team, colleagues) but also by how they see themselves: they perceive that they are directors of the path of care.

Conclusion

From this study emerge a variety of factors determining the identity construction “in transition”. The NCCMs interviewed built their identity step by step, developing autonomy and building welfare networks. They have encountered several difficulties, probably due to the novelty of this position within the health services and the process of integration still in place. When NCCMs take leadership positions in care management, through integration and collaborative relationships with healthcare professionals and patients, they enable timely, safe, continuous and personalised care (2). Taking into

account the importance of the management function of the NCCM, it is necessary that training mitigates the gap between theory and practice, emphasizing the importance of the study of the components of Case and Care Management (2,27).

Finally, Health Companies should allow the inclusion of the professional figure with greater clarity and managing the frictions that have been verified in the research.

Relevance to the practice

The identification of how the change takes place, at a personal and social level, ensures that the professional identity of the NCCM is enriched with new content, raising awareness of the importance of an integration of this figure within the different settings. The new aspect that we dispose allows the NCCMs to better understand the factors that hinder and favour the development of identity, increasing the awareness and the evolution of their role. The benefit will be not only the work performance but also interpersonal relationships and the sense of belonging to the group. The hope is that it will be useful to the NCCM to heal the sometimes distorted image present in collective thought.

Limits

The study imitators mainly concern the exploratory research method used: the reported data cannot be generalized and can concern only the context studied, even if the recruited professionals belong to different Italian realities and regions. Further qualitative and quantitative research will be needed, which in addition could focus on the perception of the role attributed by the whole multi-branch team to the NCCMs and the change undergone after their integration.

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Correspondence:

Maria Bertuol

Department of Medicine and Surgery, University of Parma, Italy
Via Gramsci 14, 40126, Parma, Italy.

E-mail: maria.bertuol@gmail.com