

# **Educational Preparation of Newly Qualified Nurses and Factors Influencing Transition: A Mixed Methods Case Study**

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This thesis results entirely from my own work and has not been offered previously for any other degree or diploma.

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## **Abstract**

This thesis discusses a mixed-methods case study exploring newly qualified nurses' (NQNs) educational preparation for autonomous professional practice and factors influencing the transition process. The ontological perspective is pragmatism advocating that the research question itself is central to the study influencing methods employed. It draws on concepts of professional learning and competence (Eraut, 1994: 2004), situated learning theory (Lave and Wenger, 1991, Wenger, 1998) and workplace learning (Illeris, 2011). Engeström's (2001) Cultural Historical Activity Theory (CHAT) framework is used as a theoretical lens to explore the NQNs' two main activity systems: a higher education nursing programme and first-post employment as an NQN. The framework aids identification of disturbances in the systems. Methods of data collection included an online survey of 63 participants, 3 focus groups and individual interviews with 15 participants from across all fields of preregistration nursing: Adult, Children's; Learning Disabilities and Mental Health.

Findings suggest transition from student nurse to NQN is exciting but stressful. In preparation to be an NQN, graduate skills such as evidence-based practice and reflection skills were recognised as beneficial and transferable for problem-solving new situations. Main sources of anxiety included: the reality of being professionally accountable for their practice; fear of making mistakes; delivering complex care; missing signs of patient deterioration; and loss of confidence in their own competence and clinical decision-making. There was lack of equity in provision or type of preceptorship with some NQNs feeling unsupported. Supportive preceptorships and gaining confidence were key factors in successful transition gained by experience of significant events and advocating for patients.

Confident clinical decision-making requires tacit knowledge and experience so simulation of complex case-based learning with advanced clinical decision-making with final-year nurses is suggested. Final year placements allowing supervised practice of complex communication and care delivery supported by experienced mentors fostering learning is advocated. National standards for preceptorship need to be developed and made mandatory with guidance on content and preceptor training to include pastoral support as well as technical skills training. Universities and their local placement providers as potential employers could work more collaboratively to understand students' previous learning and how that could be built upon in joint planning for transition.

# Contents

<b>Abstract .....</b>	<b>i</b>
<b>Contents .....</b>	<b>ii</b>
<b>Acknowledgements .....</b>	<b>vii</b>
<b>List of abbreviations.....</b>	<b>viii</b>
<b>List of Figures and Tables .....</b>	<b>x</b>
<b>Chapter 1: Introduction and Context .....</b>	<b>1</b>
<b>1.1 Introduction .....</b>	<b>1</b>
<b>1.2 Professional Experience and Personal Motivation .....</b>	<b>2</b>
<b>1.3 Contextualising the Research Field .....</b>	<b>4</b>
<b>1.4 Employability, Mentorship and Preceptorship .....</b>	<b>8</b>
1.4.1 Mentorship.....	9
1.4.2 Preceptorship .....	10
<b>1.5 Research questions .....</b>	<b>11</b>
<b>1.6 Original Contribution to Knowledge.....</b>	<b>12</b>
<b>1.7 Outline of Thesis and Structure.....</b>	<b>13</b>
<b>Chapter 2: Literature Review .....</b>	<b>14</b>
<b>2.1 Introduction .....</b>	<b>14</b>
<b>2.2 Preparation for Professional Practice in Nursing .....</b>	<b>15</b>
2.2.1 Nurse Education Standards for Competence and Education .....	16
2.2.2 Nursing curricula and preparation for autonomous practice.....	19
2.2.3 Competence and Confidence .....	21
2.2.4 Confidence and Clinical Judgement.....	24

<b>2.3 Transition from Student to RN .....</b>	<b>26</b>
2.3.1 Stress and transition shock .....	27
2.3.2 Transition and Support .....	30
2.3.3 Preceptorship and Post-Registration Support .....	32
2.3.4 Summary of Literature .....	35
<b>2.4 Theoretical Frameworks.....</b>	<b>37</b>
2.4.1 Workplace Learning .....	39
2.4.2 Knowledge for Professional Practice.....	41
2.4.3 Practice theories and situated learning .....	44
2.4.4 Cultural Historical Activity Theory as a Framework for Interpretation.....	52
<b>2.5 Summary.....</b>	<b>57</b>
<b>Chapter 3: Methodology.....</b>	<b>58</b>
<b>3.1 Introduction .....</b>	<b>58</b>
<b>3.2 Choosing a Methodology .....</b>	<b>58</b>
3.2.1 Ontological and Epistemological Position.....	61
<b>3.3 Research Design and Methods .....</b>	<b>62</b>
3.3.1 Mixed Methods Approach.....	63
3.3.2 Case Study Design.....	64
3.3.3 Application of Case Study Design: Exploration of Transition from Student to NQN .....	66
<b>3.4 Participants in the Study .....</b>	<b>68</b>
<b>3.5 Data Collection .....</b>	<b>69</b>
3.5.1 Researcher Positioning .....	71
3.5.2 Ethical Considerations.....	72
3.5.3 Online Survey.....	74
3.5.4 Focus Groups.....	75

3.5.5 Reflections on practice .....	76
3.5.6 Qualitative Interviews .....	77
<b>3.6 Data Analysis .....</b>	<b>81</b>
<b>3.7 Development of the themes .....</b>	<b>84</b>
<b>3.8 Trustworthiness .....</b>	<b>89</b>
3.8.1 Credibility .....	89
3.8.2 Transferability .....	90
3.8.3 Dependability .....	90
3.8.4 Confirmability .....	91
<b>3.9 Summary .....</b>	<b>91</b>
<b>Chapter 4: Educational preparation for nursing practice .....</b>	<b>93</b>
<b>4.1 Introduction .....</b>	<b>93</b>
<b>4.2 Knowledge acquisition, learning and preparation for practice .....</b>	<b>94</b>
4.2.1 Professional practice, reflection and graduate skills .....	97
4.2.2 Interpersonal skills .....	102
4.2.3 Simulation and role play .....	108
<b>4.3 Summary .....</b>	<b>110</b>
<b>Chapter 5: Learning to Practise .....</b>	<b>112</b>
<b>5.1 Introduction .....</b>	<b>112</b>
<b>5.2 Student Placement Learning .....</b>	<b>112</b>
5.2.1 Perspectives on Mentorship .....	118
<b>5.3 Preceptorship and the Newly Qualified Nurse .....</b>	<b>123</b>
5.3.1 Perspectives on preceptorship .....	123
5.3.2 Supportive preceptorship .....	128
5.3.3 Well-intentioned preceptorship .....	130

5.3.4 Problematic preceptorship.....	134
<b>5.4 Working with others and workplace cultures .....</b>	<b>137</b>
<b>5.5 Summary .....</b>	<b>139</b>
<b>Chapter 6: Student to RN Transition.....</b>	<b>141</b>
6.1 Introduction .....	141
6.2 Perspectives on becoming an NQN.....	141
6.2.1 Recognising the reality of accountability .....	145
<b>6.3 Confidence, judgement and decision-making .....</b>	<b>147</b>
6.3.1 Confidence and advocacy .....	150
6.3.2 Confidence and significant experiences .....	154
<b>6.4 Summary.....</b>	<b>157</b>
<b>Chapter 7: Discussion.....</b>	<b>159</b>
7.1 Introduction .....	159
7.1.1 Step1: Two interacting activity systems.....	160
7.1.2 Step 2: Integration of research questions.....	161
7.1.3 Step 3: Matrix analysis using CHAT .....	162
<b>7.2 Step 4: Analysis, contradictions and expansive learning .....</b>	<b>165</b>
7.2.1 Who are the subjects of learning? .....	166
7.2.2 Why do they learn? .....	168
7.2.3 What do they learn? .....	171
7.2.4 How do they learn? .....	174
<b>7.3 Conclusion .....</b>	<b>177</b>
<b>Chapter 8: Research Questions: Final Review .....</b>	<b>179</b>
<b>8.1 Research aim.....</b>	<b>179</b>
<b>8.2 Originality and contribution to knowledge .....</b>	<b>180</b>

<b>8.3 Limitations .....</b>	<b>180</b>
<b>8.4 Research questions .....</b>	<b>181</b>
8.4.1 How well-prepared are a group of newly qualified, graduate nurses for the realities of autonomous professional practice? .....	182
8.4.2 What experiences appear to shape professional competence and identity during the first 6-12 months of qualified practice? .....	183
8.4.3 Are there any identifiable tensions in relation to higher education theoretical preparation for the role and the real world of work? .....	184
<b>8.5 Implications for practice and policy .....</b>	<b>187</b>
<b>8.6 Implications for further research .....</b>	<b>189</b>
<b>References .....</b>	<b>190</b>
<b>Appendices .....</b>	<b>206</b>
Appendix 1: Online Survey .....	206
Appendix 2: Consent Form.....	215
Appendix 3: Initial Codes aligned to sub-themes .....	216



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## List of abbreviations

AHP	Allied Health Professional
AS1	Activity System 1
AS2	Activity System 2
AT	Activity Theory
CHAT	Cultural-Historical Activity Theory
CoP	Community of Practice
CQC	Care Quality Commission
CSW	Clinical or Care Support Worker
DH	Department of Health
GP	General Practitioner
HCSW	Health Care Support Worker
HE	Higher Education
HEE	Health Education England
HEI	Higher Education Institution
HEFCE	Higher Education Funding Council, England
LD	Learning Disabilities
MDT	Multidisciplinary Team
MH	Mental Health
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NMC	Nursing and Midwifery Council
NHS	National Health Service
NQN	Newly Qualified Nurse

PIVO	Private Independent Voluntary Organisation
RDO	Research and Development Officer
RN	Registered Nurse
UK	United Kingdom

## List of Figures and Tables

### Figures

Figure 2.1 - Summary of Dreyfus and Dreyfus model of skill acquisition .....	18
Figure 2.2 - The structure of a human activity system (Engeström, 1987; 2001) .....	53
Figure 2.3 - Two interacting activity systems (based on Engeström 2001)....	54
Figure 3.1 - A Framework for Research (2014, p. 5) .....	60
Figure 3.2 - Research Design adapted from Creswell (2014, p. 5).....	60
Figure 3.3 - Basic designs for case studies (Yin 2014, p. 50).....	66
Figure 3.4 - Case study: summary and timeline of methods.....	67
Figure 3.5 - Focus Group During Final Clinical Placement. ....	76
Figure 3.6 - List of Individual Interview Questions Post Qualifying .....	78
Figure 3.7 - Mixed methods case study design adapted from Creswell and Plano Clark (2018).....	82
Figure 3.8 - Example of analytic coding.....	85
Figure 3.9 - Memo written following analytical coding with early links to AT..	86
Figure 3.10 - Nexus based on coding and developing sub-themes .....	87
Figure 4.1 - Two interacting activity systems (based on Engeström 2001)....	93
Figure 4.2 - Overall preparedness for final placement.....	95
Figure 4.3 - Overall preparedness for working as an RN.....	95
Figure 4.4 - Knowledge base for practice .....	96
Figure 4.5 - Theoretical preparation for practice.....	96
Figure 4.6 - Self-assessment of staff delegation.....	100
Figure 4.7 - Self-assessment of managing a team .....	101

Figure 4.8 - Communication with patients or service users .....	102
Figure 4.9 - Communication with health professionals .....	103
Figure 4.10 - Communication with relatives/significant others .....	103
Figure 4.11 - Breaking bad news.....	105
Figure 4.12 - Practice simulation and preparation to work as an RN.....	108
Figure 5.1 - Clinical practice and self-assessment of competent, independent working .....	113
Figure 5.2 - Practice placements and preparation to work as an RN.....	113
Figure 5.3 - Self-assessment of managing complex care .....	117
Figure 6.1 - Self-assessment of clinical decision making.....	148
Figure 6.2 - Self-assessment of dealing with emergency situations .....	148
Figure 7.1 - Two interacting activity systems based on personal knowledge of the nurse education system (adapted from Engeström, 2001) .....	159
Figure 7.2 – Steps to intersect data analysis with CHAT as a theoretical framework.....	160
Figure 7.3 – Contradictions in preparation of NQNs for autonomous practice .....	163

## Tables

Table 3.1 - Respondents According to Field of Nursing .....	75
Table 3.2 - Participants According to Nursing Field and Methods .....	79
Table 3.3 - Employment context of individual interview participants.....	81
Table 3.4 Phases of thematic analysis (Braun and Clarke, 2012) .....	85
Table 3.5 - Final themes and sub-themes .....	88

Table 5.1 First destination posts in relation to student placement experiences. .....	124
Table 5.2 Varied experiences of preceptorship provision .....	125
Table 7.1 - Alignment of research questions to Engeström's 4 key questions .....	162
Table 7.2 - Matrix analysis tool (based on Engeström, 2001).....	163
Table 7.3 - Matrix analysis of expansive learning .....	165

# **Chapter 1: Introduction and Context**

## **1.1 Introduction**

Since the 1980s nurse education has made various transitions from hospital-based schools of nursing into higher education institutions (HEIs) alongside developments in nursing research and evidence-based practice (Traynor, 2013). The Nursing and Midwifery Council (NMC) regulation requires a bachelor's degree level qualification as mandatory for registration as a nurse (NMC 2010; 2018c) and has been defended as the best level of education and preparation for practice (Willis, 2012). In recent years there has been increased media attention regarding the preparation and education of nurses during the transition of nurse education from the work-based model to an all graduate profession (Beer, 2013). Phrases such as “too clever to care” have been bandied in the media to conceptualise scholarship versus practical skills (Aubeeluck et al., 2016).

‘Too posh to wash’ is a common accusation, as though well-educated nurses are not willing to deliver the intimate personal care at the heart of good nursing. Research suggests the opposite – that graduate nurses are highly committed to clinical work. (Salvage 2007)

The purpose of this thesis is to present the findings of a mixed methods case study of undergraduate nurses as they completed their educational preparation and embarked on their careers as Registered Nurses (RNs). The focus is on how far higher education (HE) prepares a group of newly qualified nurses (NQNs) for their roles. This includes identification of factors influencing professional identity transition and the NQNs' fitness for practice and purpose.

This introductory chapter will begin by outlining my professional experience and personal motivation for this thesis. The professional and policy contexts of the proposed research in relation to nurse education will be explored. This will be followed by discussion of graduate employability as it aligns to concepts of mentorship and preceptorship in facilitating practice experience for nursing students and NQNs. The chapter will conclude by outlining the structure of the thesis in relation to reviewed literature; methodology and theoretical framework; findings, conclusion and recommendations.

## **1.2 Professional Experience and Personal Motivation**

At the beginning of this research I had completed 37 years full-time professional experience as an RN with the latter thirty years as a nurse-educator. Starting my teaching career in 1987 in a hospital-based school of nursing, I experienced the various transitions from a work-based vocational training model to the graduate preparation now required. At each stage this has required me to study for higher level qualifications having qualified as a non-graduate RN. More recently in my career, I have been responsible for quality assurance and monitoring of nursing programmes, and for curriculum development aligned to NMC standards. I believe that my 'lived experience' of the many aspects and changes to nurse education during my career affords an in-depth understanding of the subject area and allows me to make knowledgeable and reflexive commentary.

My motivation and interest for embarking on this research was originally based on curiosity arising from anecdotal comments made by students and work-based employers over the years. Students on programme when studying a



research module would grumble about content “what has this got to do with nursing?” or “why are we studying communication again?” “we have already covered it!”. A district nurse post-qualification said, “I am so glad you made us study community profiling, I didn’t know why at the time but now two years later I get it”. Senior nurse employers have also complained to me “we need them to hit the ground running and they aren’t ready!” and “why don’t you teach them X?” when actually we did, implying a lack of awareness of curricula. Students taught ‘correct’ procedures in university have sometimes been told that in the “real world” they need to work differently.

I believe that for nursing students, HE is not just about awarding them with a degree, but it is also about equipping nurses to be compassionate, caring and resilient with the ability to make difficult, evidence-based clinical decisions. Specific specialities and skills which might be included in a taught programme could be endless. Therefore, providing a curriculum that meets the needs of all NQNs is a fine balance between NMC requirements, what NQNs must know and what would be nice to know. In my experience, the consequence of this situation is that some NQNs may begin their first employment in an unfamiliar speciality. However, they should have been equipped with the ability to at least deliver essential evidence-based nursing care, communicate effectively, and to recognise their code of conduct and limitations of practice (NMC, 2018b).

I was aware that there was a plethora of research and literature about the transition of NQNs into practice since the 1970s, and that it was a stressful period, but this strengthened my desire to research this with reference to a

curriculum I was familiar with. I wanted to use a 'case study' approach across a pre-qualifying and post-qualifying timeframe to try and establish new insights into the transition period and what aspects of their nurse education had been helpful or otherwise. This is 'small scale research with meaning' of one case studied in its own context (Tight, 2017, p.8). I also intended to utilise any insights to influence content of a nursing curriculum rewrite at the time. Since embarking on this research, I have become part of a national team to implement findings from the Health Education England RePAIR<sup>1</sup> project (HEE, 2018). I am hoping that my findings will help to inform the development of support processes for NQNs under review by HEE in 2020.

### **1.3 Contextualising the Research Field**

The regulation of nurses and midwives in the United Kingdom is governed by the NMC, a professional organisation whose overarching role is public protection carried out by the setting of standards of education, training, conduct and performance (NMC 2018a; 2018b). This public safeguarding function is delegated to RN academics in higher education institutions (HEIs) in relation to undergraduate (pre-registration) student nurses and midwives. At the beginning of this research, HEIs needed to align curricula theory and practice to the NMC education standards (NMC, 2010). The most recent education standards were published in May 2018 allowing a period of transition to allow HEIs to rewrite pre-registration nursing curricula by implementing the new framework for

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<sup>1</sup> Reducing Pre-registration Attrition and Improving Retention (HEE, 2018)

education; requirements for the assessment of practice; and standards of proficiency by September 2020 (NMC, 2018c). As a point of clarification, the research in this thesis was carried out with nursing students completing to the NMC (2010) standards but the findings and recommendations will be discussed in light of the latest standards (NMC, 2018c).

Nursing is essentially a practice-based profession which has undergone several key changes to the required type of educational preparation programmes since the 1980s. Prior to 1989, nurse education was primarily based on an apprenticeship style model of training in schools of nursing based within hospitals, although a few degree preparation programmes had begun to slowly emerge (Willis, 2012). From the mid-1990s, nurse education was required to be at 'diploma level' and moved from National Health Service (NHS) management into HEIs (Traynor, 2013) accompanied by major developments in research, publication, and the appointment of deans of nursing into universities (Willis, 2012). Until 2010 NQNs were admitted to the register as a first level nurse with either a diploma or degree (Traynor, 2013). From September 2013 a bachelor's degree level qualification became mandatory for registration as a nurse (NMC, 2010) with a more recent proposed change announced in December 2016 when the Department of Health (DH) stated that degree (higher level) *apprenticeships* in nursing were to be introduced from September 2017 operating alongside, and as well as, university based undergraduate programmes (DH, 2016). At the time of writing these apprenticeships have been slow to take off as they are costly for employers who must find finances for both wages and cover for their work when the nurse

apprentices are away on placement and study days (House of Commons Education Committee; 2018, HC 1017).

The Willis review of nurse education recommended 'step on – step off' routes into nursing as a way forward (Willis, 2015). This approach advocates opening career pathways which include widening participation entry to nursing with opportunities to exit educational programmes with qualifications such as care certificates and foundation degrees (HEE, 2016). In addition, a new Nursing Associate role has been introduced in response to national nursing shortages (DH, 2016). This programme of study normally takes 2 years at Foundation Degree level and became regulated by the NMC in September 2018 (NMC, 2019a).

The more recent proposals for nurse education were originally fueled by scandals such as failures in patient care at the Stafford Hospital as well as other stories being told of poor care and mismanagement (Francis, 2013; Willis, 2012; 2015). Lord Willis was commissioned to investigate and report on nurse education as many critics blamed system failures explicitly on the move to degree-level education, but the findings were to the contrary, suggesting that degree level nurse education was the most appropriate and safest (Willis, 2012). Findings from an extensive European study implied that patients in hospitals in which 60% of nurses with bachelor's degrees would have almost 30% lower mortality than patients in hospitals in which only 30% of nurses had bachelor's degrees (Aiken et al., 2014). Willis (2012) argued the need for graduate nurses because the nature of nursing has changed considerably in

recent years; the division of labour has altered and is more complex; reduction in junior doctors working hours opened up new roles for nurses as assistant practitioners and advanced specialist nurses who can treat and prescribe independently. From September 2017 a policy change was introduced affecting new students on nursing pre-registration courses in England who need to take out maintenance and tuition loans, rather than continuing with the provision of an NHS Bursary including the funding of course tuition fees (Hubble et al., 2016). Until September 2016 there was a cap on local health authority commissioned and funded places. Concerns were expressed by members of the professions that applications would fall as a result (Hubble et al., 2016). These concerns have come to fruition as applications to nursing programmes dropped considerably by a third between 2016 and 2018 (House of Commons Education Committee; 2018) leading to concerns regarding the future workforce. Following the 2019 General Election a non-repayable annual bursary of £5000 has been instigated for September 2020 (Prime Minister's Office, 2019) although full tuition fees will still be via student loans.

The policy context outlined above illustrates that nurse education has been quite 'unsettled' for several years. In summary, there have been variety of nursing apprenticeship routes and qualification levels recently introduced; at the time of writing new NMC Education Standards (NMC, 2018c) are being implemented gradually; and NHS bursaries and tuition fees have been withdrawn leading to a fall in applications.

#### **1.4 Employability, Mentorship and Preceptorship**

Graduate employability has been subject to debate in recent years with government expectations for HE to contribute to developing complex skills which 'enhances the stock of human capital and makes for national economic well-being' (Knight and Yorke, 2003, p. 3). Four identified ways of enhancing employability of students are: work experience; modules on entrepreneurship; careers advice and usage of portfolios or records of achievement which may be transient and not always integral to the programme (Knight and Yorke, 2003). These criticisms may not apply to more vocationally relevant HE programmes (Knight and Yorke, 2003) such as nursing degrees which include 2300 hours of assessed practice experience with academic modules designed and mapped against NMC competence standards. Yorke (2006, p. 7) argues that experience itself or the 'curricular process' does not ensure the student develops the prerequisites for successful employment but 'employability derives from the ways in which the student learns from his or her experience'. Dray et al. (2011) suggest that historically, sufficient vacancies are available for assured employment as an NQN, but taught employability skills can help with writing personal statements and improve interview technique to succeed with applications.

It is interesting to note the NMC (2010) perspective on NQNs in terms of the role stated that they were not expected to have extensive specialist expertise or leadership skills. The quote below demonstrates a potential mismatch between employers' expectations of HE preparation, the NQNs' own anticipation of autonomous practice versus the NMC's perspective.

Nurses must be able to meet all NMC requirements when they qualify and then maintain their knowledge and skills. Newly qualified nurses cannot be expected to have extensive clinical experience, specialist expertise, or highly developed supervision and leadership skills. Opportunities will be needed to develop these through preceptorship and ongoing professional development. (NMC, 2010, p. 5)

In nursing there are two key supportive processes which are expected to enhance learning in the employability and vocational development of NQNs namely 'mentorship' for student nurses and 'preceptorship' once qualified. It is useful to explore the meanings of both terms in context as they are referred to by the respondents in this research in Chapters 4,5 and 6.

#### **1.4.1 Mentorship**

The NMC standards for learning and assessment of practice (NMC, 2008) required competence to be judged by a sign-off mentor in clinical practice who is on the same part of the professional register as the student. The role of mentor is more than just an advisor and is defined as 'a registrant who facilitates learning and supervises and assesses students in a practice setting' (p. 56) and needed to complete an NMC approved mentor preparation programme (NMC, 2008)<sup>2</sup>. As well as making the final assessment of competence, the mentor needed to ensure 40% of placement time is spent with the student and that the student always had supernumerary status (NMC, 2008). This status is to protect the student from being used in the workforce numbers and to ensure that time

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<sup>2</sup> New standards for student supervision and assessment (NMC 2018) use 'practice assessor' rather than mentor although not referred to in this thesis as the respondents were assessed in practice to the NMC (2008) standards.

in practice is for learning to nurse rather than providing unpaid labour. One might argue that the downside of this is over-protection and not being allowed to work autonomously as expected of NQNs therefore needing extra support when commencing first employment as an RN.

### **1.4.2 Preceptorship**

The period of transition and support for NQNs, midwives and allied health professionals (AHPs) is called preceptorship and defined as:

A period of structured transition for the newly registered practitioner during which he or she will be supported by a preceptor, to develop their confidence as an autonomous professional, refine skills, values and behaviours and to continue on their journey of life-long learning. (DH, 2010, p. 11)

The NMC website refers to preceptorship in relation to employers' responsibilities but with no detail of what it entails, probably because the NMC is not a regulator of preceptorship although a guide to preceptorship principles has been recently published (NMC, 2020).

Preceptorship is a period of support for people who have joined the register to help their transition from student to qualified nurse or midwife (NMC, 2019b).

The word 'preceptor' derives from the Latin '*praeceptor*' meaning a 'person who gives instruction; a teacher, a tutor' (Oxford English Dictionary, 2020). Preceptor is the term used for a person nominated to support NQNs and other AHPs, as opposed to mentors (for student nurses) and practice educators (student AHPs). Whilst the NMC dictates required standards of supervision and assessment of practice for student nurses (NMC2008, NMC 2018d), there is



not the same regulation for preceptorship for NQNs. The NMC (2006; 2008; 2019b, 2020) recommends that preceptorship be made available to nurses and midwives following initial registration, but it is not mandatory. However, the NMC sets out unregulated, employers' *responsibilities* for the provision of safe care which includes access to support via: a thorough induction; training and supervision where necessary; access to professional development; clinical supervision; and preceptorship (NMC, 2019b). A guidance document recommending *principles* for preceptorship was also published very recently by the NMC (NMC, 2020).

Retention of students and staff have become of national interest due to the current and worsening nursing workforce shortage. A national report on Reducing Pre-registration Attrition and Improving Retention (RePAIR) focused on nursing, midwifery and therapeutic radiography was published by Health Education England (HEE, 2018). The report highlighted the importance of the preceptorship model for staff support and retention and includes examples of best practice such as the 'CapitalNurse' programme which provides a clear framework for London-based health care providers (HEE, 2017). This example contains guidance for preceptors and preceptees such as: definition of a supernumerary induction period; clinical practice workshops; leadership and management development; protected time for meetings and support and expectations for portfolios of evidence of professional development.

## **1.5 Research questions**

At this time of complex changes to nurse education coupled with workforce shortages, I propose that it would be an important study to explore what might be learned from student experiences as they qualify and transition as RNs: to inform and help to shape curricula; influence the reduction of potential theory-practice gaps at the point of qualification; insights for employers and strategies to support NQNs and maintain the workforce. Much of the previous research in this area has been carried out on post qualification experiences or evaluation of preceptor programmes of support. Various studies suggest that there is a theory/practice gap and that content of education programmes does not prepare students for the 'real world'. The research literature will be explored in Chapter 2. The research questions are as follows:

- a) How well-prepared are a group of newly qualified, graduate nurses for the realities of autonomous professional practice?
- b) What experiences appear to shape professional competence and identity during the first 6-12 months of qualified practice?
- c) Are there any identifiable tensions in relation to higher education theoretical preparation for the role and the real world of work?

## **1.6 Original Contribution to Knowledge**

This research takes a different approach to NQN transition by using a case study approach intersected with cultural historical activity theory (CHAT) as a theoretical framework (Engeström, 2001) to explore two activity systems; a university nursing degree programme and first NQN employment. This approach is unique to researching nurse education with the intention of

uncovering any new insights into systemic problems or 'disturbances' in either or both of the systems preparing NQNs for professional practice.

### **1.7 Outline of Thesis and Structure**

Having set out the background to the study and the research context an outline of the thesis follows. Chapter 2 provides an overview of literature and previous studies pertaining to professional requirements of nurse education, transition shock and the support mechanisms such as preceptorship for NQNs. Chapter 2 also presents literature on professional and workplace learning and concludes with an introduction to practice theories and CHAT. Chapter 3 presents the methodology as aligned to my ontological and epistemological position with justification for the case study research design and the mixed methods employed for data collection. Intersection of CHAT with the data analysis is explained. Chapters 4, 5 and 6 present the integrated findings of the mixed methods in relation to the major themes: Educational Preparation for Nursing Practice; Learning to Practise; Student to Registered Nurse Transition. Chapter 7 explains how the data has been analysed using two interacting activity systems and integration of the research questions with a matrix analysis to explore: who are the subjects of learning? why do they learn in this way? what do they learn? and how do they learn? (Engeström, 2001). Chapter 8 concludes by addressing the original research questions, contribution to knowledge, limitations, and implications for policy and practice.

## **Chapter 2: Literature Review**

### **2.1 Introduction**

Educational preparation for RNs in the United Kingdom (UK) has been delivered by the HE sectors and based in universities since 1995 (Burke, 2006). The educational programmes are approved, regulated and monitored by the NMC and delivered by RN academics. Additional support in the form of a period of preceptorship is strongly recommended for NQNs in their new employment role and responsibilities (Whitehead et al., 2013; 2016; Owen et al., 2020). Research interest in transitioning from student to NQN has grown since the 1990s with many of the findings suggesting that it can be stressful (Holland, 1999; Whitehead, 2001; Ross and Clifford, 2002; Duchscher, 2009; Deasey et al, 2011). The need for a period of preceptorship has led to questions about the adequacy of HE degree-based preparation for nursing and drawn attention to theory-practice integration.

This chapter concentrates on three key areas of literature and previous research as follows:

- Section 2.2 focuses on NMC requirements for professional practice, including the competence and confidence required to work independently as an NQN.
- Section 2.3 examines transition from student nurse to NQN, the issue of transition-shock, and the need for support such as preceptorship (see 1.4).
- Section 2.4 discusses the theoretical frameworks pertinent to this thesis which include: workplace learning and professional knowledge; the

relevance of practice theories to this study; and the applicability of activity theory as a framework of interpretation (Engeström, 2001) for investigating nurse education as preparation for transition to newly-qualified practice.

## **2.2 Preparation for Professional Practice in Nursing**

The NMC is the regulator of nursing and midwifery practice. It protects the public by setting standards of education, training, conduct and performance so that nurses and midwives can deliver high quality healthcare throughout their careers (NMC, 2018a; 2018b). Employing organizations and the public want to know that nurses are safe to practise and are also 'fit for purpose' at the point of registration. RNs are educated to bachelor's degree level (NMC, 2010; 2018c) with the recent addition of Nursing Associates studying for a foundation degree (NMC, 2018e).

The Nursing and Midwifery Council (NMC) regulates all HE provisions of nurse education. Universities design their own nursing curricula but must provide extensive evidence of how they conform to the standards and framework for pre-registration nursing education (NMC, 2010; 2018c). These standards provide regulation and guidance on the knowledge, skills and attitudes required for the undergraduate programme design, and for RNs to be able to practise safely and effectively on registration as an NQN. A key regulation is that the programme must consist of 4600 hours of learning of which 2300 hours should take place in clinical practice (NMC, 2010; 2018c). New NMC education standards were published in 2018 including more advanced skills to better

prepare for 'role of the nurse in the 21<sup>st</sup> century' (NMC, 2018f). However, this research took place alongside a curriculum based on the NMC (2010) standards which therefore form the basis for discussion in the next section.

### **2.2.1 Nurse Education Standards for Competence and Education**

The NMC (2010) set out their standards for undergraduate, pre-registration nurse education into two component parts: standards for competence and standards for education. The standards for competence identified the knowledge, skills and attitudes the student needed to demonstrate by the end of the programme whereas the standards for education set out requirements for university programme approval and delivery. The NMC (2010, p. 11) promoted a holistic definition of competence advising that:

Competence is a requirement for entry to the NMC register. It is a holistic concept that may be defined as the combination of skills, knowledge and attitudes, values and technical abilities that underpin safe and effective nursing practice and interventions.

Nursing practice requires a complex mixture of 'knowledge, performance, skills, values and attitudes' (Cowan et al., 2005 p. 361). Freshwater and Stickley (2004) suggest that the holistic assessment of competence attempts to bring these complexities together by trying to identify how emotionally intelligent students interpret and learn from care episodes. Cassidy (2009) posits that a student/mentor relationship is more about 'the process of enquiry than the product of what is taught, investing in a learning relationship that is reciprocal rather than expert led' (p. 41).

The standards framework (NMC, 2010) required *competencies* to be achieved across both theory and practice. There were four sets of competencies for the four fields of practice (adult, mental health, learning disabilities and children's nursing). Each set included generic competencies for all fields as well as those specific to the specialist field of practice. At the time of writing, there is no requirement to use a universal competency practice assessment document for RN programmes, although, from my own experience and networking, many universities are beginning to collaborate on shared designs. Universities use the NMC standards to devise curricula and competency practice assessment documents which are then approved, and quality assured annually (NMC, 2019c).

In his extensive work on professional knowledge and competence, Eraut (1994; 2004) proposed that, on the one hand, competence has an individual-centred definition and can refer to a personal characteristic or quality, while elsewhere it has a social-centred definition and refers to meeting public expectations of competence. Eraut prefers the latter definition in that he says it identifies with the everyday role of the notion of 'competence' in the workplace and helps to mediate between roles of professionals and their technicians; and between their clients and the general public with an expectation that a 'qualified professional will be competent in the discharge of normal professional tasks and duties' (Eraut, 1994, p159).

Eraut (1994) also debates the dualistic nature of being 'competent' or 'not competent' which may be recognised here and suggests 'spelling out minimum

requirements for qualification is essential' (p118). This is done to a great extent in the NMC (2010) standards but these are interpreted by universities to create practice assessment documents, which are then further subject to interpretation by mentors (Watson et al., 2002). Eraut (1994) is sympathetic to definitions of competence being set in a wider context of lifelong learning such as the five-stage model (Dreyfus and Dreyfus, 1986; Benner, 1984) incorporating stages of competence: novice, advanced beginner, competent, proficient and expert, as this can extend the assessment of professional performance into the post-qualification period (Figure 2,1).

<i>Level 1</i>	<i>Novice</i> Rigid adherence to taught rules or plans Little situational perception No discretionary judgement
<i>Level 2</i>	<i>Advanced Beginner</i> Guidelines for action based on attributes or aspects (aspects are global characteristics of situations recognisable only after some prior experience) Situational perception still limited
<i>Level 3</i>	<i>Competent</i> Coping with crowdedness Now sees actions at least partially in terms of longer-term goals Conscious deliberate planning Standardised and routine procedures
<i>Level 4</i>	<i>Proficient</i> See situations holistically rather than in terms of aspects See what is most important in a situation Perceives deviations from normal patterns Decision-making less laboured Uses maxims for guidance, whose meaning varies according to the situation
<i>Level 5</i>	<i>Expert</i> No longer relies on rules, guidelines or maxims Intuitive grasp of situations based on deep tacit understanding Analytic approaches used only in novel situations, when problems occur or when justifying conclusions Vision of what is possible

Figure 2.1 - Summary of Dreyfus and Dreyfus model of skill acquisition

However, Benner (1984) suggested that it actually takes an NQN two or three years in a job to acquire competence and become proficient. In the latest education standards (NMC 2018c; 2018d; 2018f) the NMC have returned to



using the term of 'proficiency' as a measure rather than competence, neither of which have been clearly defined by them.

Finding a universal definition of competence to apply to the nursing profession is problematic as definitions in the literature lack consensus (Cowan et al., 2005). Garside and Nhemachena (2013) undertook a concept analysis to identify key influences informing professional understanding of competence to enlighten practical application within present-day nursing practice. They suggested that leading academics and professional bodies have tried extensively to define the concept of competence and concluded that it may be unlikely to ever reach a universally accepted definition and that it could be the presence of so many definitions which has 'compounded the conundrum of what competence really is' (p541).

### **2.2.2 Nursing curricula and preparation for autonomous practice**

Previous research has suggested that nurse education programmes do not always adequately prepare students for the transition to NQN (Ross and Clifford, 2002; Clark and Holmes, 2007; Newton and McKenna, 2007; O'Shea and Kelly, 2007; Horsburgh and Ross, 2013). O'Shea and Kelly (2007) explored the 'lived experiences' of ten NQNs in the first six months of qualifying who found it stressful in relation to multifactorial managerial responsibilities, deficits in skills and dealing with unexpected situations. However, there is recognition that certain graduate skills can make up for a perceived lack of specific preparation which include: taking a questioning approach in practice (Maben and Clark, 1998); possessing an active learning style (Gerrish, 2000); ability to

reflect on practice (Delaney, 2003; Hatlevik, 2012); recognition of own limitations (O'Shea and Kelly, 2007); and an ability to learn and adapt (Parker et al., 2014).

Some authors advocate that more attention should be given to developing management skills and preparing for transition in the latter part of pre-registration courses (Gerrish, 2000; Ross and Clifford, 2002; O'Shea and Kelly, 2007; Hartigan et al., 2010; Hasson et al., 2013; Allan et al., 2016). Ross and Clifford (2002) researched a period of transition between pre-qualification and post-qualification to compare the expectations and reality of the transition. One of the key issues raised was that theory in the final year did not address the demands of being an NQN from a clinical or professional perspective suggesting simulations of prioritisation of care, and dealing with incidents such as accidents, deaths, and perceived need for more pharmacology and science. It was suggested that careful planning of experiences in students' final year as well as dealing with inconsistencies in preceptorship programmes for NQNs was needed (Ross and Clifford, 2002).

Variations in types of placement experiences (Bisholt et al., 2014) and in curriculum content (Hartigan et al., 2010) can lead to some students being less prepared than others. Hartigan et al's (2010) research focused on NQNs' ability to deal with acute and more challenging nursing episodes and key aspects of competence required to deal with them. Thematic analysis identified 41 acute nursing scenarios and four key facets of competence required: patient assessment; technical/clinical skills; interactions and communications and

clinical decision making. The findings provided evidence that curricula need to be developed with more congruence to nursing practice realities (Hartigan et al., 2010). Clinical placement planning needs to provide students with meaningful experiences which allow them to achieve their required learning outcomes (Bisholt et al., 2014).

Management of care and staff delegation are complex skills needed as an NQN when responsible for patient care, requiring sophisticated clinical judgement (Weydt, 2010). Hasson et al's (2013) research suggested that nurse education does not adequately prepare students for the practicalities of delegation. Allan et al's (2016) research used participant observation and interviews aiming to understand how NQNs recontextualise knowledge in delegation and supervision of ward-based nursing care suggest that 'on-the-job' learning in clinical practice is a hidden method of knowledge construction which can be illustrated by their ability to delegate appropriately. The researchers noticed several examples of 'invisible learning' in practice, alongside more visible, formal learning taking four main forms: learning through mistakes; learning from difficult experiences; informal learning from colleagues; and 'muddling through' (p. 380). A better understanding of this 'invisible learning' is needed to adequately prepare NQNs to supervise and delegate (Allan et al., 2016).

### **2.2.3 Competence and Confidence**

This section explores previous research on aspects of competence of NQNs including attention to a seemingly symbiotic relationship between confidence and competence. The competence of NQNs has been widely debated (Holland

et al, 2010) with a general expectation that NQNs should be competent and able to practise independently (Clark and Holmes, 2007; Hartigan et al., 2010). There have been conflicting views expressed in previous research: some research suggests that most training has not provided NQNs with adequate knowledge, skills or confidence for the realities of practice (Clark and Holmes, 2007; Hartigan et al., 2010); other studies argue that NQNs are competent and 'fit to practice' at the point of registration (O'Connor et al., 2001; Holland et al., 2010). These differing views might be interpreted as NQNs being competent as a qualifying student but may not yet be competent as autonomous RN practitioners. In other words, they have gained registration to practise but have yet to develop expertise.

The clinical expertise of NQNs or their 'fitness for purpose' became a concern in the late 1990s leading to reforms suggested by the Peach report which included the development of competence-based curricula (UKCC, 1999; Lauder et al., 2008). Using a validated instrument to measure competence, a prospective study (O'Connor et al., 2001) attempted to compare the expected competency between 139 senior nurses and the actual competency of 36 NQNs after 8 weeks in post. The study found that NQNs performed consistently at a higher level than expected by senior nurses (O'Connor, 2001). Clark and Holmes' (2007) qualitative study explored factors which influence the development of competence over time having suggested that previous studies had focused on competence levels on qualification. The study found that ward managers appeared to have low expectations of the NQN while NQNs themselves believed they were expected carry out tasks they felt ill-prepared

for; and advised that expectations of NQNs need to be made clearer as not all NQNs are ready for autonomous practice on registration (Clark and Holmes, 2007).

Concerns that NQNs are not 'fit for practice' has concentrated on an apparent lack of clinical skills rather than overall competence to practice on registration which is an important distinction according to Holland et al., (2010). Holland et al. (2010) undertook a major, mixed methods study with students, mentors and stakeholders to evaluate whether pre-registration programmes enabled students to achieve 'fitness for practice'. A predominant finding was that stakeholders felt that NQNs were perceived to be competent overall and fit for practice at the point of registration leading to suggestions that life-long learning as well as support to develop confidence during a period of preceptorship should be accommodated (Holland et al., 2010).

Confidence development has been highlighted as a principal factor in preparation to be an NQN (Spouse, 2003; Calman, 2006; Roberts 2009; Monaghan, 2015) and there have been claims that NQNs may lack confidence but assessed by managers, mentors and students to appear to possess the expected competencies needed on qualification (Lauder et al., 2008). Roberts (2009) explains that lack of confidence can be misinterpreted as lack of competence and suggests that contemporary nurse education in relation to ethics, legal and professional accountability leads to better insight. However, this illuminates potential dangers for NQNs of autonomous practice thereby potentially affecting confidence (Roberts. 2009).

#### **2.2.4 Confidence and Clinical Judgement**

The ability to make clinical judgements is viewed as an essential skill for virtually every health professional' (Tanner 2006, p. 204). Clinical judgments often determine how quickly nurses detect a life-threatening complication, how soon patients leave the hospital, or how quickly patients learn to take care of themselves (Etheridge, 2007). A systematic review by Tanner (2006) of 200 studies on clinical judgment in nursing produced five main conclusions: clinical judgements are influenced more by nurse's knowledge and experience than facts about the situation itself; sound clinical judgment is influenced by knowledge about the patients, their normal responses and engagement with their concerns; clinical judgments are affected by the nursing culture in the setting and the context of the situation; nurses utilise differing patterns of reasoning; 'reflection on practice' can be prompted by a failure with clinical judgment which is necessary for developing and improving clinical knowledge and reasoning (p. 204). Reflective thinking is not a generic skill, but is based on relevant theoretical instruction, professional knowledge and experience with the development of reflective skills being key to making theory-practice links (Hatlevik, 2012).

NQNs can lack confidence in their abilities in making clinical judgements (Etheridge, 2007) from their own perceived lack of knowledge (Whitehead, 2001) and paucity of time spent on clinical skills training (Monaghan, 2015), NQNs are often unaware of levels of responsibility required of NQNs in the process of 'learning to think like a nurse' (Etheridge, 2007 p. 29) which is

shaped by confidence-building, thinking more critically, accepting responsibility and adapting to relationships with others. Helpful strategies suggested as critical in the transition period were identified as: varying clinical experiences; support from educators; support from experienced nurses and peer support (Etheridge, 2007). Monaghan's (2015) systematic review of the literature explored factors and theoretical perspectives contributing to the theory–practice gap for NQNs and indicated that NQNs do not feel prepared for practice with not enough time spent on clinical skills training which affected confidence levels. More research is needed on outcomes of preceptorship and simulation training to demonstrate enough evidence to make them mandatory (Monaghan, 2015).

Simulation of clinical scenarios using high-fidelity mannequins in HE nursing programmes has grown and been shown to enhance clinical skills and helps increase confidence in clinical decision-making (Stirling et al., 2012). Simulation provides a less threatening environment to practice decision making without harming patients (Gaba, 2007) and normally includes debriefing and critical reflection to aid learning (Abelsson and Bisholt, 2017). Bliss and Aitken's (2018) research into simulation with RNs identified that assessment skills and decision-making in caring for the acutely ill patient improved, and that knowledge was then applied in clinical practice.

## **2.3 Transition from Student to RN**

Transition from student to graduate nurse marks the end of pre-registration education and the commencement of a 'professional journey as a nurse' (Deasy et al., 2011, p. 109) and concerns those working in organisations that prepare, recruit and retain NQNs (Darvill et al., 2014). The transition period can be stressful leading to early workforce attrition (Kramer, 1974; Duchscher, 2009, Draper et al., 2010; Whitehead et al., 2016). Preceptorship (see section 1.4) is the recommended process for supporting NQNs in the UK (NMC, 2006; 2008; 2019b; DH, 2010). This section will begin with an exploration of the concept of transition including 'reality-shock', 'transition-shock' and previous studies on transition that highlight coming to terms with being wholly accountable for practice. This will be followed by discussion of research and evaluation of preceptorship programmes.

Schlossberg's (1981) theory of transition postulates that there are three sets of factors which interact to influence the outcome of an adaptation to transition: firstly, the characteristic of the transition itself; secondly, characteristics of the pre-and post-transition environments; and finally, individual characteristics of the individual undergoing transition.

A transition can be said to occur if an event or non-event results in a change in assumptions about oneself and the world and thus requires a corresponding change in one's behaviour and relationships. (Schlossberg, 1981, p. 5).

In relation to the characteristics of pre- and post-transition environments, Schlossberg (1981) recognises the importance of internal support systems, institutional support, and physical settings. Applying Schlossberg's three



factors to NQNs, the first key characteristic of the transition for the NQN is the move from an educational setting as a student into an employment role as an RN. Student nurses are normally in a protected supernumerary role with practice mentors who provide supervision, support and advice for practice and decision making. As an NQN, the individual becomes accountable for their own practice under their code of professional conduct (NMC, 2018b) as is the case for the participants in this thesis. Secondly, characteristics of the pre- and post-transition environments (Schlossberg,1981) relate to the nature of the undergraduate nursing curriculum with placement experiences followed by the environment of the first-post destination. These characteristics could depend on the type of nursing and the formal support and training in place. Finally, the individual characteristics of the NQN that may impact on adaptation (Schlossberg,1981) could be related to their knowledge base, competence, confidence and resilience.

### **2.3.1 Stress and transition shock**

Stress during transition can lead to nurses leaving the profession early on in their careers (Whitehead et al., 2016). The wider impact is problematic in relation to workforce planning and is a contemporary issue in relation to recent and predicted nursing shortages (Kings Fund and Nuffield Trust, 2018; National Health Executive, 2018; National Audit Office, 2020). There have been several studies carried out demonstrating that NQNs find the period of transition very stressful (Holland, 1999; Whitehead, 2001; Ross and Clifford, 2002; Duchscher, 2009; Deasey et al, 2011; Whitehead et al., 2016) for reasons such as poor definition of the transition process; a change in culture from educational

to employment settings, mismatched expectation regarding competence in clinical skills and lack of formal support structures (Ross & Clifford, 2002; Clark & Holmes, 2007; O'Shea & Kelly, 2007, Horsburgh and Ross, 2013; Kumaran and Carney, 2014).

Darvill et al. (2014) explain that current understanding of experiences for NQNs beginning employment are founded on concepts of transition put forward by Kramer (1974), Chick & Meleis (1986) and Duchscher (2009). Whilst somewhat dated now, Kramer's work is still cited as seminal work which highlighted the 'reality shock' and explored incongruence between role expectations and reality of practice. Reality shock is described by Kramer (1974, p. viii) as:

...the reactions of new workers when they find themselves in a work situation for which they have spent several years preparing, for which they thought they were going to be prepared, and then suddenly find they are not.

Melia's research on 'learning and working' (1984; 1987) found that student nurses learn to 'fit in' to whichever version of nursing is needed as they move between education and different clinical settings. Students caught between the theoretical, idealised educational preparation and the practical work in placements to 'get the work done' meant that students remained uncertain about what the job really is (Melia, 1987). Although the level of academic qualification has changed since the 1980s, the requirement for practical work and fitting in to new placements remains a feature of nurse education. As an NQN, the practice environment may not be such a transient one (unless he or

she moves employment at an early stage) and will likely become their first 'community of practice' (Wenger, 1998).

A concept analysis by Chick and Meleis (1986) defines transition as 'a period of change between two relatively stable states that comes to be associated with some degree of self-redefinition' (p. 253). They likened transitions in nursing to important life phases suggesting that 'defining characteristics of transition include process, disconnectedness, perception, and patterns of response' (p.240). Duchscher (2009) expanded on Kramer's earlier work to theorise on 'transition shock' and how NQNs nurses were confronted with a plethora of 'physical, intellectual, emotional and sociocultural changes that are expressions of, and mitigating factors within the experience of transition' (p. 1103). 'Transition shock' theory provided perspectives on facets of the NQN roles, responsibilities, relationships and knowledge that can influence the intensity and length of transition experiences for the professional role (Duchscher, 2009). Duchscher concluded that senior nursing students needed better preparation for transition in recognition of the 'critical importance of bridging undergraduate educational curricula with escalating workplace expectations' (2009, p. 1103).

A systematic literature review of the experiences and perceptions of NQNs in the UK during the transition from student to staff nurse was undertaken by Higgins et al. (2010). They concluded that the transition process continued to be a stressful time for NQNs and was generally ill-defined and lacking transparency. The review raised some implications for nursing practice in relation to the structure of pre-registration education, preparation for practice

and post qualification support. Higgins et al. (2010) highlighted gaps in research suggesting a need for more research to be undertaken which determines the effects of the practice environment on the transition process. Halpin et al., (2017) investigating causes of NQNs' stress experiences during transition found that workload was the most reported stressor as well as NQNs workplace incivility, but good teams and previous care experience supported transition and reduced stressors. Employers need to be managing workload of NQNs proactively and better address workplace incivility (Halpin et al, 2017).

### **2.3.2 Transition and Support**

Studies which have focused on the post-registration period for NQNs have consistently found that support is crucial (Deasy et al., 2011; Horsburgh and Ross, 2013; Kumaran and Carney, 2014; Parker et al., 2014; Phillips et al., 2014). Deasy et al. (2011) explored perceptions and expectations of role transition in a group of final year nursing students and again as NQNs following a period of rostered internship. Respondents felt very confident in some areas before and after qualifying such as clinical abilities, managing workloads, prioritising care, interpersonal skills, time management and multidisciplinary team (MDT) working but stated a need for constructive feedback on performance and ongoing support to help with stress. Horsburgh and Ross (2013) used focus groups to explore NQNs' perceptions of compassionate care and factors that facilitate and inhibit its delivery. They argued that there are certain expectations regarding competence of NQNs, as well as staffing shortages and differing support structures, that make transition a challenging time. Some of the participants were felt to be 'flung in at the deep end' and 'left

to sink or swim' (p.1127) and the study found generally that there was a tension between agency and structure with the more supportive environments also facilitating delivery of compassionate care which would seem to suggest a cultural aspect in respect of supportive behaviours. Phillips et al. (2014) suggested that a lack of respect and feedback from senior nurses for 'a job well done' (p109) can undermine the confidence of NQNs.

NQNs can have mixed emotions during the transition period, a complex and multi-faceted process, quickly realising several differences between nursing school and work (Delaney, 2003). Arrowsmith et al's (2016) systematic review of nurses' perceptions and experiences of work role transitions found that novice nurses are more likely to experience extremes of emotional upheaval than experienced nurses who undergo role transitions. There may be initial excitement but at the same time be overwhelmed with the thought of professional accountability and frustrated that not enough support is available during transition (Kumaran and Carney, 2014).

Successful transition results more from post-registration employment factors and workplace environment than pre-registration factors according to Phillips et al. (2014) including the need for good teamwork and staff support while NQNs incorporate their knowledge into clinical practice (Kumaran and Carney, 2014). Parker et al., (2014) also found that the workplace environment and the type of available support impacted on the NQNs' transition experience adding key factors comprising the NQNs' own abilities to learn, to adapt to the culture of the workplace accommodating own and others' expectations and their

amount of previous experience. Phillips et al's study (2014) revealed the NQNs thought their skills on qualification were at a basic level, and that this level of competency should be recognised when being allocated to patient care as many were presented with complex patients which heightened anxieties. NQNs stated that support was crucial in the transition process, but some received none, short or poor orientation and this could influence the desire to continue in nursing (Phillips et al., 2014).

The main strategies used to support NQNs during the transition into the clinical workplace was the focus of a systematic review of the literature (Edwards, 2015). Structured support strategies combining clinical development and didactic approaches seemed to successfully facilitate transition. However, several reviewed studies highlighted that structured support from both colleagues and the organization was important, in this case preceptors should be properly prepared to provide support with the combined approach of clinical and didactic periods of teaching (Edwards et al., 2015). Monaghan (2015) suggested that preceptorship programmes reduce the stress of transition associated with being an NQN and that more research is needed into the effects of preceptorship and clinical simulation to provide evidence for professional bodies to require preceptorship to become mandatory.

### **2.3.3 Preceptorship and Post-Registration Support**

Preceptorship was introduced into nursing in the UK in 1991 with a view to improving support for NQNs' development of confidence and competence during transition from student to NQN (Irwin et al., 2018). Employers are

encouraged to provide preceptorship for NQNs (NMC, 2006; 2008; 2019b; 2020; DH, 2010; NHS Employers, 2020) although it is not mandatory (see discussion in 1.4). Bain (1996) suggested that preceptorship 'offers a period of support and attempts to ease transition into professional practice or socialization into a new role' (p. 105). Several studies and systematic reviews have examined the concept of preceptorship and evaluated preceptorship programmes some of which will be explored below. These studies relate to preceptorship as support; the nature and effectiveness of preceptorship; and associations between pre-registration and preceptorship programmes. Some international research studies use the term 'transition programme' rather than preceptorship and therefore the terms are used interchangeably here.

Research and evaluations of preceptorships are generally very positive in the NQNs' development (Gerrish, 2000; Marks-Maran et al., 2013; Muir et al., 2013; Whitehead et al., 2013; Edwards et al., 2015; Monaghan, 2015). A mixed methods study to evaluate a preceptorship programme for NQNs found that the NQNs' engagement with the programme was very positive, with preceptors being valued as positive contributors in helping to develop clinical skills, communication skills, aiding professional development and alleviation of stress (Marks-Maran et al., 2013). Several issues are clearly summarised in Whitehead et al's (2013) systematic literature review of published research related to the development of preceptorship to support NQNs in the UK concluding that the evidence is strong that NQNs benefit from a structured, supported preceptorship which leads to improved recruitment and retention of the workforce. More investment is needed to properly resource this (Robinson

and Griffiths, 2009). In some cases, preceptorship did not happen even when the NQN was allocated a preceptor (Robinson and Griffiths, 2009; Higgins et al., 2010) and was often described as a 'paper exercise' (Robinson and Griffiths, 2009, p.17). Organisational culture should include managerial support frameworks for preceptorship, trained preceptors and supported supernumerary time (Whitehead et al., 2016; Owen et al., 2020). With respect to recruitment and retention, Whitehead et al. (2013) suggests that NQNs felt that it was necessary and therefore likely to seek out employers who provide it although Robinson and Griffith's (2009) scoping of preceptorship had found no direct link between preceptorship and retention.

Although Muir et al's (2013) evaluative research also found that preceptors mainly had a positive impact on the preceptee's development, they identified difficulties in finding time to meet. Levett-Jones and FitzGerald (2005, p. 43) challenged the efficacy of transition programmes arguing that despite over twenty years of delivering in Australia, there was little evidence on the effectiveness of them and what might constitute best practice for NQNs. It was acknowledged that preceptorship and transition programmes can 'smooth' the transition process and reduce 'reality shock' but, staff shortages and increasing use of casual staff mitigate against the sustainability of supportive relationships. Managers of care settings should ensure that a formalised supportive framework is in place for RNs throughout their first year of practice (Horsburgh and Ross, 2013). Kumaran and Carney (2014) identified the need for strong, supportive preceptorship from experienced staff to facilitate the transition. Westwood (2019) advocates the need to nurture NQNs as early experiences



can be challenging and influential on career development; and she called for the NMC to consider standardising periods of 'preceptorship' as the recommended process for supporting NQNs, midwives and AHPs in the UK. If preceptorship is provided by employers as an organisational, cultural norm there is evidence of improved staff recruitment, retention and engagement (Westwood, 2019; NHS Employers, 2020). These suggestions entail added resource implications; at the time of writing, nursing workforce shortages are problematic and could interfere with the supportive relationships advocated in the literature.

Returning to concepts of NQNs' competence and confidence, Irwin et al. (2018) undertook a systematic literature review published between 1996 and 2013 to assess whether preceptorship improves confidence and competence in NQNs concluding that preceptorship programmes have a greater impact than individual preceptors. There are few empirical studies to provide unmistakable evidence that confidence or competence is directly impacted by preceptorship (Irwin et al., 2018).

#### **2.3.4 Summary of Literature**

The literature has highlighted that educational preparation of NQNs is complex and multifactorial. The NMC sets professional and educational benchmarks requiring standards for competence to be met to become an RN. These are visible as NMC approved curricula with competencies to be assessed by mentors in practice. A consensus definition of the concept of competence is

elusive and may be confused with confidence in NQNs. Developing confidence to make clinical judgements and decisions is essential and requires knowledge and experience as well as the ability to critically reflect on practice. Support in the form of preceptorship has been advocated as necessary to assist the transition of students to NQNs which can be stressful and lead to reality or transition shock as they are confronted with challenges of autonomous practice. Preceptorship programmes rely on supportive organisations and preceptors which can be problematic when there are staff shortages and workforce pressures.

Much of the literature on transition has focused on the post-qualifying period, transition and preceptorship provision. The literature review identified that recent UK research had not been presented with a specific focus on exploring two activity systems beginning with educational preparation pre-qualification, through to post-qualification and transition from student to RN. Recent research and systematic reviews continue to suggest NQN transition is stressful despite recognition of the value of preceptorships and suggestions to strengthen curriculum content. I propose that using a theoretical framework which explores practice across two activity systems (Engeström, 2001), HE and first workplace destination, will provide further insights into the NQN transition period. This approach would appear to provide a unique contribution to knowledge in that use of CHAT as an analytical tool to explore NQN transition does not appear to have been published previously. The resultant research questions are:

- a) How well-prepared are a group of newly qualified, graduate nurses for the realities of autonomous professional practice?
- b) What experiences appear to shape professional competence and identity during the first 6-12 months of qualified practice?
- c) Are there any identifiable tensions in relation to higher education theoretical preparation for the role and the real world of work?

The inclusion of CHAT will be discussed in more depth in the methodology section (Chapter 3) but it is useful to now 'set the scene' and include a literature review of theoretical frameworks which provide 'practice' focused perspectives which I would argue are the most relevant to investigate a work-based learning profession such as nursing.

## **2.4 Theoretical Frameworks.**

RN education in the UK is a university-based, graduate-level preparation but is essentially practice-based requiring fifty per cent of the learning to take place in placement settings (NMC 2010, 2018c). On completion of the programme, following formal registration with the NMC, the NQN can begin to practice as an RN. The previous sections highlighted issues in relation to preparation for autonomous practice including required competence and confidence during a potentially stressful time for NQNs. The research informing this thesis asks how well prepared the NQNs are for practice and elucidates factors affecting the transition period.

The discipline of nursing practice includes social activity governed by procedures, rules and traditions as illustrated by Trowler's definition of a discipline using a social practice perspective which appears to capture the student nurse's journey in terms of both a learning and then an eventual working environment as an RN:

Reservoirs of knowledge resources shaping regularised behavioural practices, sets of discourses, ways of thinking, procedures, emotional responses and motivations. These provide structured dispositions for disciplinary practitioners who reshape them in different practice clusters into localised repertoires...Disciplines take organisational form, have internal hierarchies and bestow power differentially, conferring advantage and disadvantage. (Trowler, 2012a, p. 9)

In my experience (see 1.2), nursing as a discipline is a very structured one including routines, procedures, rules and regulations which must be learnt and adhered to. Many of these are a 'given' as they support public protection and patient safety. Student nurses must learn to behave appropriately in many differing assessed placement settings which gives them the 'structured disposition' for the overall role at the point of qualification. However, there will then be a new set of learning to take place on qualification, which is, learning how to work as an autonomous practitioner and how to fit in to one particular 'community of practice' where they take up employment. It is my intention here to argue that a social practice theoretical perspective is the most relevant to inform analysis of nursing's practice-based learning, this will be explored in 2.4.3 following discussion below on workplace learning and knowledge for professional practice.

### **2.4.1 Workplace Learning**

Workplace learning theories have advanced since the 1990s. Previous emphasis on individual formal learning has grown to include informal learning and diverse, multi-layered types of learning such as group, organisational as well as individual learning surpassing the 'standard concepts' of vocational 'on-the-job' training (Hager, 2011, p. 17). Alongside these developments, and the gradual absorption of professional education into universities, has been concerns that preparation for successful occupational performance cannot be fully realised in advance in formal course delivery and therefore there has been a growing interest in better aligning formal education with more vocational, graduate occupations (Hager, 2011).

Behaviourist approaches to learning were the most prevalent before the emergence of interest in workplace learning and premised on learning being linked to directly observable behaviours which could be set up and tested in training rooms before joining the workplace (Hager, 2011). However, the acceleration of social, economic and technological changes in recent years creates problems here because much work is 'not minutely codifiable or predictable as required by the theory' (p18). The revival of cognitive theories of learning followed the premise that behaviourism, was limited as an explanatory concept for learning (Hager, 2011). Reflective practice is one such cognitive theory which has become influential in nurse education (Ruth -Sahd, 2003):

In the broadest sense, reflective practice is a means of self-examination that involves looking back over what has happened in practice in an effort to improve or encourage professional growth. (p. 488).

Dewey had introduced the idea of reflection in 1933, defining it as 'the turning over of a subject in the mind and giving it serious and consecutive consideration' (Ruth-Saad, 2003, p. 489). Schön's (1983; 1987) work on the 'reflective practitioner' has been influential in the advancement of using reflection for critical thinking and decision-making in nursing (Ruth-Sahd, 2003; Tanner, 2006). Schön (1983; 1987) contended that practising professionals faced complex, unique situations, which cannot be solved just by technical-rational approaches and suggested an approach in which professional learning could be enhanced by reflection, of which he put forward three models: reflection-in-action; reflection-on-action; and reflection-for-action. Schön (1987) stated that reflection-in-action is spontaneous reflection at the time and in the midst of an action itself. This 'knowing' is intuitive, conscious and critical and results in the action that shapes what is being done when it is being done (Schön, 1987). In contrast, reflection-on-action involves working through an event after it has happened. Reflection-for-action is a desired result from the other two reflection methods to develop a guide for future action. Reflective practice is advocated several times in the NMC (2010) education standards, and reflective writing has certainly been included as a key skill in undergraduate curricula I have worked with since the late 1980s. Examples of two directives are illustrated below:

On entry to the register...through reflection and evaluation demonstrates commitment to personal and professional development and lifelong learning (p109)

On entry to the register...reflects on and learns from safety incidents as an autonomous individual and as a team member (p121)

Hager (2011) posits that general learning theorists, such as Dewey (1916) and Vygotsky (1978), have been significant influences on much of the early work on socio-cultural theories of workplace learning. This work stresses the importance of the contextuality of the work setting as well as performance standards in relation to the shape of the learning that takes place which can account for differences in learning required to be a proficient practitioner in different sites. Social aspects of learning are elevated as prominent and become the focus of analysis rather than on the individual learner, with an emphasis on learning as participation in suitable activities so that learning is about active engagement in workplace processes rather than acquiring learning as a product (ibid.). Additionally, the context of performance and workplace learning is shaped by social, organisational and cultural factors (ibid.).

#### **2.4.2 Knowledge for Professional Practice**

Earlier sections have highlighted the importance of knowledge and experience of NQNs in relation to clinical judgement and decision-making, so it seems appropriate to explore the concept of knowledge for professional practice with particular reference to Eraut (1994; 2000) and Illeris (2011). A distinction has been made between 'technical knowledge' and 'practical knowledge'.

Technical knowledge is capable of written codification; but practical knowledge is expressed only in practice and learned only through experience with practice. Some kinds of practical knowledge are uncodifiable in principle. For example, knowledge which is essentially non-verbal: the tone of a voice or musical instrument, the feel of a muscle or a piece of sculpture, the expression on a face cannot be fully described in writing. (Oakeshott, 1962 in Eraut, 1994 p. 42)

Eraut (2000) identifies two parallel definitions of knowledge as 'codified' and 'personal'. Codified knowledge, also known as public or propositional knowledge, is given status because it is included in educational programmes and is 'subject to quality control, peer review and debate' (p. 114). The NMC expects universities to develop and manage content (codified knowledge) of nursing programmes to specific educational standards (NMC 2010; 2018c). Eraut (2000) defines personal knowledge as the 'cognitive resource' of a person that can help them to think and perform when brought to a situation.

This incorporates codified knowledge in its personalised form, together with procedural knowledge and process knowledge, experiential knowledge, and impressions in episodic memory. Skills are part of this knowledge, thus allowing representation of competence, capability or expertise in which the use of skills and propositional knowledge are closely integrated. Codified knowledge is identified by its source and epistemological status, personal knowledge by the context and manner of its use. Codified knowledge is explicit by definition. Personal knowledge may be either explicit or tacit (Eraut, 2000, p. 114).

Tacit knowledge is that which is embedded in practice as knowing something that allows awareness of it to attend to a secondary activity but can be difficult to fully articulate to others (Polyani, 1967; Meerabeau, 1992). Benner (1984) argues that experienced or 'expert' practitioners draw on previous experiences, viewing situations holistically without always being able to articulate their knowledge, whereas the NQN as 'competent' or 'proficient' needs to use specific problem-solving strategies.

Developing professional expertise is contingent on acquiring practical experience and skills (Benner, 1984; Eraut, 2004; Benner et al., 2009) and the



level of tacit knowledge has been found to be higher in NQNs who had been successful in dealing with a critical situation. (Herbig et al., 2001). In respect of 'personal' or 'tacit' knowledge both nurse education and preceptorship programmes require application of theory to practice, experience of different settings, and competence in procedural skills, decision-making and professional behaviours. The teaching and development of critical reflection skills (see 2.1.1) is useful to bridge the theory-practice gap and facilitates articulation of tacit knowledge (Clarke, 1986; Benner et al., 2009; Hatlevik, 2012). It seems evident that the tacit knowledge required to practise with 'expert' clinical decision making would be unlikely in NQNs unless they had experience of an adequate range of critical situations on which to reflect. It is likely that NQNs will have had differing placement experiences meaning they will not all be as ready for autonomous practice at the point of registration. This affects levels of confidence in the transition period as previously discussed in 2.2 and 2.3.

Illeris (2011, p.12) provides perspectives on learning recognising it includes 'both social interaction and individual psychological processing and acquisition'.

Human learning also involves complicated patterns of motivation, understanding, meaning, emotions, blockings, defence, resistance, consciousness and subconsciousness. (Illeris, 2011, p.12).

Human learning includes three dimensions described as content or factual knowledge, incentive and interaction (Illeris, 2011). Content is needed because without it there is no learning, and an incentive to acquire knowledge is required to make the process work (Illeris, 2011). Interaction between the individual and

the learning environment allows the individual to absorb the impulses required to trigger 'inner psychological elaboration and acquisition processes' (p.12). Adequate preparation for practice as an NQN is reliant on the content of the degree programme being appropriate so that the individuals, given the motivation to acquire the knowledge, are afforded suitable clinical environments in which to interact and experience the impulses needed to relate theory and practice. The character of feelings attached to experiences can influence cognitive learning, especially if there is a story attached to what is learned and becomes easier to recall in similar situations (Illeris, 2011). In my experience, students acquire deeper learning from clinical incidents or simulation when they link nursing theory with hands-on practice and decision-making.

#### **2.4.3 Practice theories and situated learning**

Nursing is a practice-based profession therefore a practice theory perspective seemed the most useful lens to employ when researching nurse education and preparation to be an RN. There are a few theoretical frameworks that could be utilised for the analysis of practice which can be applied individually or combined to form a 'toolkit' approach (Nicolini, 2012). As my own research is exploring preparation for NQN practice across two roles (student nurse; NQN) in more than one setting (HEI, placement and first post destination) the central analytical framework for interpretation of the data will be cultural historical activity theory (CHAT) according to Engeström's work (2001, 2008) as this allows exploration of two or more activity systems. Situated learning theory and perspectives on communities of practice (Lave and Wenger, 1991; Wenger, 1998) may also be usefully incorporated into discussions to follow.

Literature regarding situated learning (Lave and Wenger, 1991) and communities of practice (Wenger, 1998) can be helpful when exploring one activity system such as a clinical placement and was considered as one option as a theoretical framework for analysis in this thesis. To a great extent situated learning theory helps to understand individual learning within the 'communities' that nurses join during each clinical placement and in their employment destination.

Mentors, preceptors and other health professionals can provide support for students and NQNs. Lave and Wenger (1991 p. 91) refer to 'sponsors' in communities of practice who are experienced members of the community who provide support and guidance. Wenger (2000, p. 9) discusses the concept of 'boundaries' as important learning systems connecting communities that offer 'learning opportunities in their own right'. For nursing students, boundary crossing may relate to working with medics and AHPs. According to Wenger (2000) learning from others across boundaries is maximised for both individuals and communities when: there is something to interact about; there are differences as well as common ground; suspension of judgement in order to see the competence of the other community; and a way of translating between 'repertoires' so interaction of experience and competence can interact. The common ground here is patient care, each needs to learn and understand something of the others' practices in order to reach the goal of holistic, patient-centred care as Wenger (2000, p. 234) suggests that 'learning and innovation

potential of a social learning system lies in its configuration of strong core practices and active boundary processes’.

With regard to functions of mentorship and preceptorship, Wenger (1998) describes this facilitation of learning as ‘brokering’ or bringing ‘core’ social learning systems together across ‘boundaries’

Inside organizations, people in charge of special projects across functional units often find themselves brokering...brokers are able to make new connections across communities of practice, enable co-ordination, and – if they are good brokers – open new possibilities for meaning.

(Wenger, 1998 p 109)

Wenger (1998) suggests that a broker needs to be able to translate, co-ordinate, and align perspectives and interests, and possess legitimacy to influence development of a practice. Although situated learning theory is helpful for analysing work-based learning, NQNs result from at least two activity systems, the university and first employment destination, it seemed more appropriate to explore the outcomes of both activity systems together in the analysis using CHAT. This justification will be further explored in 2.4.4. following a general introduction to practice theories below.

According to Nicolini (2012) the concept of practice has become increasingly popular in organization and work studies since the 1970s and has been referred to as the ‘practice turn’ (Schatzki, 2001). Nicolini (2012, p.1) argues that there is not just one single unified theory of practice:

Practice theories constitute, in fact, a rather broad family of theoretical approaches connected by a web of historical and conceptual similarities.

A 'toolkit' approach is advocated, approaching studies of organizational and social phenomena as a 'plurality' to explore and analyse practices (Nicolini, 2012, p. 1). Nicolini (2012) cites authors such as Schatzki (2002) and Reckwitz (2002) arguing that they offer an alternative to problems of other analytical perspectives which create irreducible dualisms in the structure versus agency debate, and that the explanatory power of a practice approach such as AT has a propensity to dissipate rather than resolve them. Reckwitz (2002) provides a definition of practice which demonstrates its complexity:

A 'practice' (Praktik) is a routinized type of behaviour which consists of several elements, interconnected to one other: forms of bodily activities, forms of mental activities, 'things' and their use, a background knowledge in the form of understanding, know-how, states of emotion and motivational knowledge. A practice – a way of cooking, of consuming, of working, of investigating, of taking care of oneself or of others, etc. – forms so to speak a 'block' whose existence necessarily depends on the existence and specific interconnectedness of these elements, and which cannot be reduced to any one of these single elements. (p. 249).

Schatzki's (2012) definition of practice seems simplistic in comparison but is underpinned by explanatory discourse.

A practice, on my understanding, is an open-ended, spatially-temporally dispersed nexus of doings and sayings. (p.14)

Doings and sayings are nearly always made up of further actions in the circumstances in which they are executed in that a set of actions that compose a practice is wider than its doings and sayings alone so 'task' and 'project' is used to present order on the wider set (Schatzki, 2002). Nicolini (2012) points

out that the emphasis on 'doings' or emphasis on bodily actions is what distinguishes it from other perspectives such as hermeneutics and post-structuralism which focus on language over activities and although language cannot fully capture the cognition that underpins practice, the two cannot be separated. This would imply that practice does not happen as an isolated event, rather it entails interactions and dialogue. Schatzki (2002) explains practice being 'open-ended' means that it is not composed of or limited to a particular number of activities and takes place somewhere in objective space (spatially) at some point in or over time (temporally), hanging together in an organised nexus of actions, and are connected through relations such as causality and intentional directedness. Using the concept of a 'nexus' became helpful in my thematic analysis in this thesis illustrated in Figure 3.10. This is because my contention is that learning to practise nursing happens whilst partaking in a complex web of education, dexterities and interpersonal encounters taking place in multidisciplinary settings.

Organization of a practice is formed by four elements identified by Schatzki as: practical understandings; rules; a teleoaffective structure and general understandings (2012, p. 16). Using my own nursing examples to illustrate Schatzki's definitions: 'practical understanding' relates to an individual knowing how to perform actions through basic 'doings and sayings' such as understanding how to sort patients' records and file them appropriately; 'rule' refers to an explicit formulated directive or instruction such as following clinical procedural techniques such as medicine administration; 'teleoaffective

structure,' relates to a 'set of teleological hierarchies (end-project-activity combinations) that are enjoined or acceptable in a given practice' such as how to communicate sensitively with patients when delivering physical care; 'general understandings' are more abstract relating to a sense of value or worth for what is being striven for such as belief in, and delivery of truly holistic nursing care (Schatzki, 2012, p. 16). To summarise and apply Schatzki's theory here, organisation of nursing practice is knowing how to do something holistically, following procedural rules, with the knowledge and belief it is the correct way to do it whilst recognising its sense of worth. My assumption and expectations is that the NQNs would have met these elements of practice at the point of qualification when this research commenced.

Contemporary practice theories can assist making in making sense of work in organizations and other social phenomena (Nicolini, 2012). As a nurse educationalist, my view is that practice perspectives as outlined above (Reckwitz, 2002; Schatzki, 2012) sit neatly with the concept of nursing as a practice-based profession. Organised clinical procedures and routines need to be completed by knowledgeable practitioners following policies or 'rules', MDT working, using specialised equipment in complex and challenging environments. Shove et al, (2012) suggests that these complex practice 'performances' are reproduced by both beginners and the more experienced:

At any one moment, 'a practice' consists of a composite patchwork of variously skilled, variously committed performances enacted and reproduced by beginners and by old-hands alike. (p.70)

Nursing students and NQNs join various communities of practice in HEIs, placements and employment settings where these 'beginners' and 'old hands' work together.

Situated learning theory proposes that learning is a process of participation in a community of practice (CoP) beginning on the periphery but eventually increasing in complexity and engagement (Lave and Wenger's, 1991; Wenger, 1998). NMC guidance on mentorship for students was clear that mentors needed to spend the minimum of 40% of the student hours supervising the learning of practice (NMC, 2008: 2010). Student nurses are required to work across several placement settings in order to get the breadth of experience needed to achieve the required competence and will therefore join a number of different communities of practice. As discussed in 1.4.2 and 2.3.3, NQNs are normally expected to be paired with a preceptor as they begin their career as an RN. As one of the concepts sitting within social practice theory (SPT), Trowler (2012b) describe situated learning theory as one of a number of related traditions lying in a 'broad category of cultural theory' (p 30). This recognises the importance of 'symbolic structures of meaning in the social world, both their construction and their enactment by people' (p30). SPT is concerned with relationships between people and objects (humans and artefacts) and how the two use each other when enacting practice (Trowler, 2012b). Nursing work concerns human interactions using a variety of artefacts such as protocols, medical equipment and assessment tools in the provision of care.

With respect to competence development in a CoP, Wenger (1998) suggests:



...it is by its very practice – not by any other criteria – that a community establishes what it is to be a competent participant, an outsider or somewhere in between...a community of practice acts as a locally negotiated regime of competence. (p137)

This focus on competence as a participation in a community aligns with the nature of students' practice experiences as they move from one placement (or community of practice) to another; or the transition from student to the NQN employment setting. Wenger's view of competence is that it is 'not merely the ability to perform certain actions, the possession of certain pieces of information, or the mastery of certain skills in the abstract' (p136) but that it relates closely with three dimensions of practice. Firstly, a *mutuality of engagement* which is the ability to establish relationships and engage with other members of the community. Secondly, must show *accountability to the joint enterprise* which includes an ability to understand the community enterprise enough to take some responsibility for it and to contribute to its purpose. Finally, to be able to negotiate with the *joint repertoire* of the practice in order to engage in it meaningfully. Lave and Wenger (1991) use the term 'legitimate peripheral participation' for those learning from experience in a community of practice. To become even a peripheral member of a CoP, one must do some learning along the three dimensions of competence in practice.

In summary, practice theories derive from a broad family of theoretical approaches which set out to interpret and explain practices rather than resolve them. They are interrelated in recognising the complex web and interconnectedness of physical and mental activities needed for practice such

as nursing, including use of tools or artefacts, skills, knowledge, understanding, motivation and values. CHAT can be used to analyse practice across two or more activity systems such as a university nursing programme and first employment experience as an NQN. I would argue that this approach is therefore the most appropriate to employ in this thesis and will be justified in the following section.

#### **2.4.4 Cultural Historical Activity Theory as a Framework for Interpretation**

From the 1990s various researchers focused on CHAT introducing the concept that social practices and activities ‘can be studied in terms of a small number of basic interrelated analytical elements and the fundamental forms of mediation between them’ (Nicolini, 2012, p. 109). Edwards (2009) posits that in CHAT, action is object orientated and when we work on an object, or try to transform it, interpretations are shaped by the historical practices of the system; are constrained by the system in which it is located; and an object may motivate certain reactions that are allowed in a certain sets of social practices. Activity theory (AT) provides a three-point analytical structure portraying activity ‘as a collective, systemic formation that has a complex mediational structure’ (Engeström, 2008, p. 26). In this instance, activity is seen as long-lived events that do not have a defined beginning or end. Activities are systems that develop over periods of time and they *produce* various actions and events. Engeström (2001) explains that CHAT is rooted in Lev Vygotsky’s work (1978). Engeström’s own work has evolved through three generations of research towards a version of activity theory which advocates the minimum unit of analysis as two interacting activity systems with a focus on researching

challenges and opportunities of inter-organisational learning (Engeström, 2001). With reference to nurse education and this thesis, the 'object' undergoing transformation or transition, is the nursing student becoming a practising RN. As highlighted in Chapter 1, nurse education's history has been beset with political influence and professional body requirements in recent years with NQN transformation taking place across multiple interrelated, mediated settings. I would therefore argue that AT is a useful framework for exploring these complexities.

Engeström (2008, p.26) explains the model of AT as representing 'multiple mediations in activity'. The sub-triangle at the top of Figure 2.2 represents both group and individual actions as possible subjects within a collective activity (Engeström, 2001). The relationship between a 'subject' and an 'object' is mediated by 'instruments' or tools which could include symbols or representations (Engeström, 2008). The object is represented as an oval indicating that 'object-oriented actions are explicitly or implicitly, characterized by ambiguity, surprise, interpretation, sense making, and potential for change' (Engeström, 2001, p. 134).

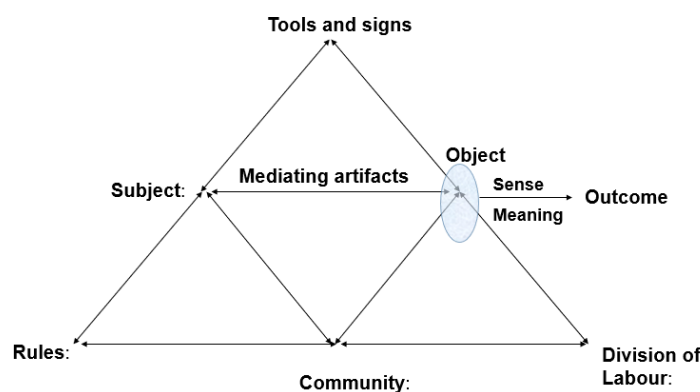


Figure 2.2 - The structure of a human activity system (Engeström, 1987; 2001)

The example in Figure. 2.3 shows two activity systems which incorporates my own interpretation of a student nurse (activity system 1) and of an NQN (activity system 2) as learners of different facets of nursing practice (object 2) with the expected shared resultant outcome being a confident, autonomous practitioner (object 3). The interplay between them is mediated by tools or instruments, such as practice-assessment documents to assess competence in care delivery and work-readiness of the student/NQN.

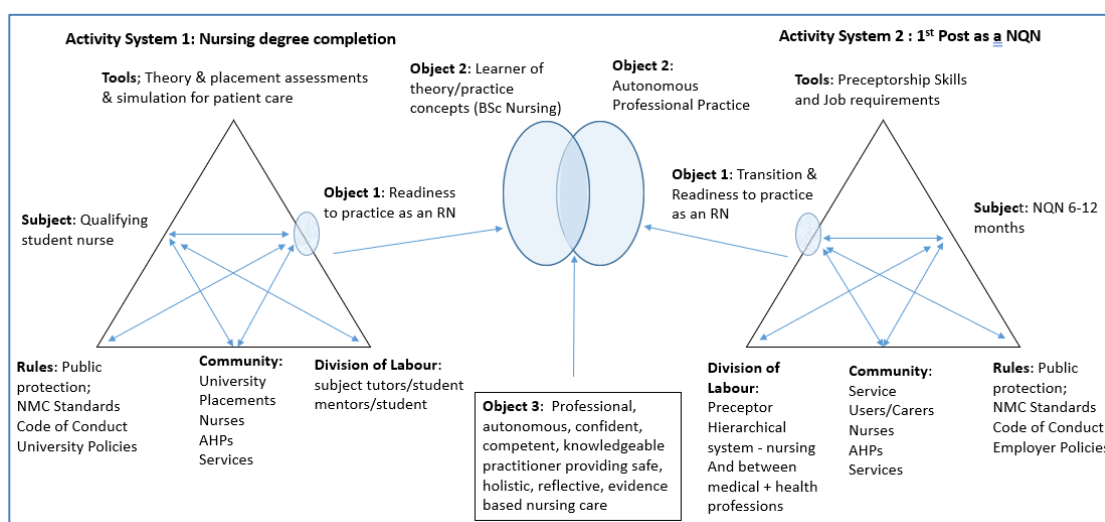


Figure 2.3 - Two interacting activity systems (based on Engeström 2001)

The outcome expected is that learning will take place about management of patient care and nursing practice with mediations taking place between the mentor/preceptor, student nurse, AHPs and the persons receiving nursing care. Engeström (2008, p. 27) elaborates that the 'uppermost subtriangle....is but the tip of an iceberg' and that the less visible mediators (rules, community and division of labour) are transforming continuously meaning that the activity system constantly reconstructs itself. Continuing with application of the model

to the example (Figure 2.3), the 'community' might be a placement or employment in a hospital ward or a primary health care centre including patients and stakeholders. The overarching rule of the NMC is 'public protection' therefore 'rules' regarding nurses' code of conduct and patient safety policies dictate behaviour related to all patient care and related nurses' learning activities. The division of labour in patient care delivery is often hierarchical, complex and multi-faceted including mentors, preceptors, specialist nurses, doctors, social workers and various AHPs. This framework (Figure 2.3) will be further expounded during application and analysis of data in Chapters 4-6).

An activity system can contain several viewpoints or 'voices' and layers of different rules and divisions of labour accumulated over time which can provide a vehicle for communal achievements; however, it can also be source of conflicts (Engeström 2008). A conceptual model of the activity system is particularly useful when one wants to make sense of systemic factors behind seemingly individual and accidental disturbances, deviations, and innovations occurring in the daily practice of workplaces (Engeström, 2008). Engeström (2008, p. 27) explains that disturbances are actions that deviate from the expected outcomes and can be interpreted as manifestations of 'inner contradictions' in the activity system which may have developed over time. For example, new procedures implemented in clinical practice may cause tensions when a student is placed there or an NQN perceived to not have been adequately prepared leading to criticism of the education system. These contradictions can be crucial in understanding sources of both troubles and innovative developments. Contradictions can be recognised as 'tensions

between two or more components of the system' (p. 27) and can emerge when one of the components changes in such a way that it cannot logically operate with the other components. This may be due to influences and interfaces with other activity systems. These inner contradictions may be analysed in relation to any current disturbances along with historical evolution of the activity system which may help the researcher to understand and pinpoint the disturbances.

Engeström (2001) explains that AT and its expansive learning concept should be explored incorporating four key questions: who are the subjects of learning? why do they learn? what do they learn? and how do they learn. For expansive learning to take place, recognition is needed that an activity system is multi-voiced and can include many points of view, interests, traditions, rules and divisions of labour, including the history of the activity system and its transformation over time; any issues and developments can only be appreciated against its own history (Engeström, 2001). Contradictions in the systems are central to change and development:

Contradictions are not the same as problems or conflicts. Contradictions are historically accumulating structural tensions within and between activity systems. (Engeström, 2001 p. 137)

However, an *identified* disturbance or conflict could eventually lead to innovations in developing nursing practice in the university 'activity system' or in the preceptorship period as contradictions in an activity system can lead to innovative collaborative changes; an expansive transformation is accomplished when the object and motive of the activity are reconceptualized to embrace a

radically wider horizon of possibilities than in the previous mode of the activity (Engeström, 2001, p.137).

## **2.5 Summary**

Educational preparation of NQNs is complex and multifactorial with literature focused on preparation re theory-practice alignment, competence and confidence, and on transition in the post-qualifying period and preceptorship support. CHAT was identified as a useful practice theory framework to explore two or more activity systems such as a university nursing programme and first employment experience as an NQN. This will be further justified in the following Chapter.

## **Chapter 3: Methodology**

### **3.1 Introduction**

This chapter discusses the methodological underpinnings of this thesis which essentially takes a pragmatic approach to exploring the research questions. A case study was designed using mixed methods to gather data and investigate the educational preparation of NQNs for practice and their transition from student to RN. The previous discussion highlighted that there are theory/practice gaps and that content of education programmes do not always prepare students for the 'real world' leading to 'transition shock'.

The aims of the research questions outlined in 1.5 were to discover how well NQNs perceive that they have been educationally prepared in relation to professional competence; and to explore how their professional identity has transitioned from being a student nurse to that of an autonomous practitioner. The research aimed to identify which aspects of HE preparation for the NQN role are beneficial using the NQNs' experiences to inform future, local curriculum development and to add insights to the body of knowledge on transition to RN.

### **3.2 Choosing a Methodology**

Methodology can be described as the research design which influences the choice of particular methods linked to desired outcomes (Crotty, 1998) and is 'a broad approach to scientific inquiry specifying how research questions should be asked or answered' (Teddlie & Tashakkori, 2009, p21). Blaxter et al. (2010)



suggest that methodology is a philosophical concept referring to the underpinning paradigm or approach. Cohen et al. (2011, p. 3) summarises the view of Hitchcock and Hughes (1995) that:

...ontological assumptions (assumptions about the nature of reality and the nature of things) give rise to epistemological assumptions (ways of researching and enquiring into the nature of things); these, in turn give rise to methodological considerations; and these in turn, give rise to issues of instrumentation and data collection. Indeed, added to ontology and epistemology is axiology (the values and beliefs that we hold).

This view implies that research is not just a ‘technical exercise’ but is about how we view and understand the world and what is seen to be of value. Thinking about my own ontological and epistemological assumptions allowed me to reflect on the approach I wanted to take to explore the NQNs’ experiences and educational preparation. Although I had knowledge of the programme, I was not involved in their previous educational provision, nor had any jurisdiction over the diverse employment settings of the participants. However, I needed a design that would explore and explain the participants’ perceptions of their educational preparation and readiness to practise as NQNs. I also needed to consider the methodology that would be best suited for the research and would complement the proposed analytical framework proposed as CHAT in 2.4.4. Given the complexity of nursing practice discussed in 2.3 and 2.4, I also considered how the findings might be shared as credible, trustworthy and transferable rather than trying to generalise which may then challenge validity and reliability of the findings. This will be discussed towards the end of this chapter, but it was certainly a consideration in choosing the methodology of a case study approach using mixed methods as justified in this section.

Creswell (2014) suggests the researcher needs to think through the paradigm or philosophical ‘worldview’ assumptions that they bring to the research design and translate it into practice in designing research methods. Creswell provided a framework in Figure 3.1 below to reflect on and used to inform my own research design (see Figure 3.2). The final design was that of a pragmatic approach to a descriptive case study using multiphase, embedded mixed methods inclusive of an online survey, focus groups and individual interviews. The design is explored further in 3.3.

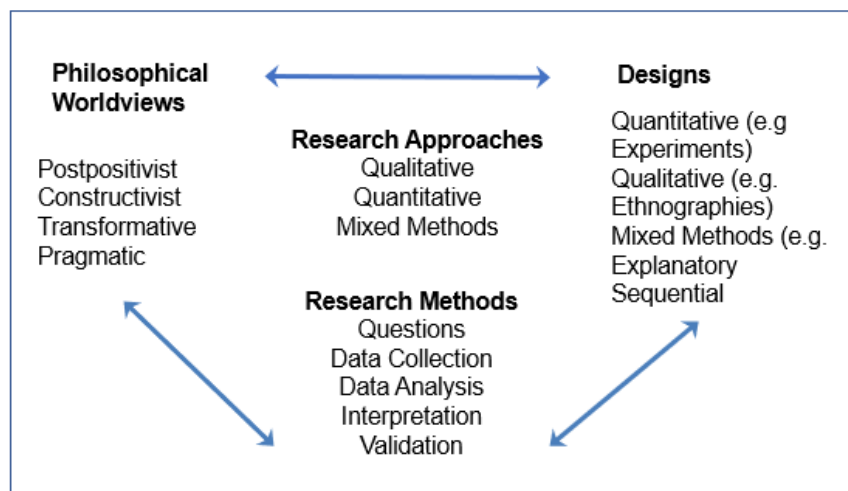


Figure 3.1 - A Framework for Research (2014, p. 5)

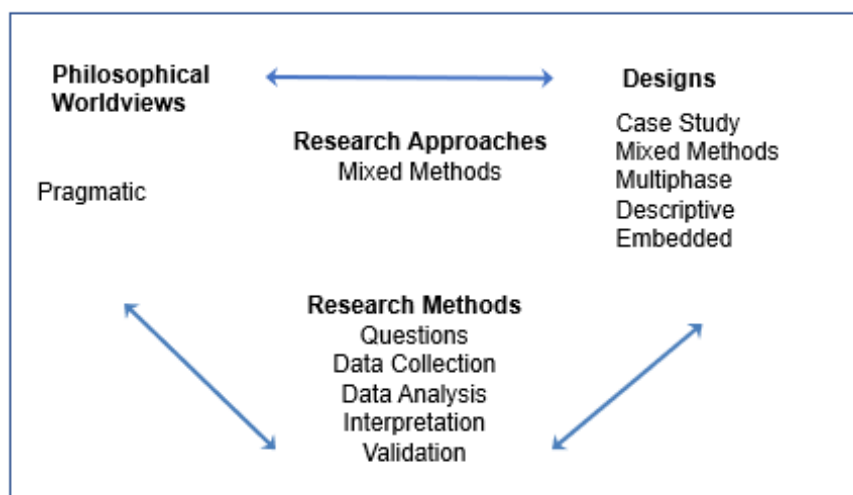


Figure 3.2 - Research Design adapted from Creswell (2014, p. 5).

### **3.2.1 Ontological and Epistemological Position**

Pragmatism 'as a world view arises out of actions, situations, and consequences rather than antecedent conditions' (Creswell, 2014, p.10). A pragmatic approach advocates that the research question itself is more important than the methods used (Creswell and Plano Clark, 2011; 2018) with the research question determining the research framework as opposed to beginning with a particular ontological and epistemological stance (Wahyuni, 2012). At the heart of the research was a genuine wish to provide insights from the NQNs' experiences and to inform future improvements to the educational programme, and ease transition into what continues to be a stressful period. To this end, my research questions were the primary focus leading me to favour a mixed methods case study design as the chosen methodology. Nursing is a practice-based 'real world' profession and given my experience and professional interests outlined in 1.2, it was no surprise to me that I would be drawn to a more practical and pragmatic approach to carrying out my research. Pragmatism is practice-driven and practical rather than just being idealistic (Denscombe, 2008).

Regarding my experience in nurse education, my ontological assumptions are that: nursing is a practice-based profession; nurse education and NQN practice takes place in a complex nexus of inter-organisational learning communities; it entails communication and learning with a multi-voiced network of people; it is governed by multiple procedural and professional rules. I consider these assumptions are closely aligned with a philosophical world view of pragmatism which believes that:

...objectivist and subjectivist perspectives are not mutually exclusive. Hence, a mixture of ontology, epistemology and axiology is acceptable to approach and understand social phenomena. Here, the emphasis is on what works best to address the research problem at hand. Pragmatist researchers favour working with both quantitative and qualitative data because it enables them to better understand social reality.

(Wahyuni, 2012, p. 71)

Following on from my ontological position, my epistemological assumption is that research into such complexity of practices requires a practice theory focused methodology which assists in making sense of them. CHAT was justified in 2.4.4 as an appropriate theoretical lens which I would argue aligns appropriately with my ontological assumptions as I believe the framework addresses the aforesaid complexities across more than one activity system, including exploration of cultural and historical influences. Creswell and Plano Clark (2018) supports this belief and suggest that intersecting mixed methods with a theoretical framework 'advances an abstract and formalised set of assumptions to guide the design and the conduct of the research' (p, 104).

### **3.3 Research Design and Methods**

On reflection of the research questions and aims to investigate the educational preparation of NQNs (see 1.5 and 2.5), I needed to consider the research design and methods for appropriate alignment with the pragmatic approach. A case study approach was chosen incorporating mixed methods. The suggestion by Tight (2017, p. 21) to 'view case study as a research design so that other, particular methods can be used to progress the research' helped to clarify the methodology. The research design is a case study, using mixed methods approaches which 'are premised on pragmatism ontologies and

epistemologies' (Cohen et al., 2011, p.23). Although mixed methods research incorporates elements of both quantitative and qualitative research, this study uses a 'qualitative dominant' approach (Johnson et al., 2007, p. 124).

The study may utilize a qualitative priority where a greater emphasis is placed on the qualitative methods and the quantitative methods are used in a secondary role. (Creswell and Plano Clark, 2011, p. 65)

To summarise, a case-study approach situated in a pragmatic paradigm aimed to investigate a real-world, practice-oriented issue with the adoption of a multiphase, qualitative dominant, embedded mixed methods design (Creswell and Plano Clark, 2011). Pragmatism is generally associated with the mixed methods approach (Denscombe, 2008; Creswell and Plano Clark, 2011; 2018). The focus is on the research question and outcomes of research, rather than the methods, and focused on the use of mixed methods of data collection to inform issues being researched, 'thus, it is pluralistic and oriented to what works and practice' (Creswell and Plano Clark, 2011, p. 41).

### **3.3.1 Mixed Methods Approach**

Johnson and Onwuegbuzie (2004, p. 17) describe mixed methods as 'the class of research where the researcher mixes or combines quantitative and qualitative research techniques, methods, approaches, concepts or language into a single study'. The philosophical position most usually associated with mixed methods research is pragmatism (Teddlie & Tashakkori, 2009, p. 7) with advocates of mixed methods research supporting integration of quantitative and qualitative research suggesting that the approach does not fall within the positivist or humanist worldviews (Feilzer, 2010). The underlying assumption is

that combining quantitative and qualitative methods provides a clearer understanding of a problem and a research question than a singular method might provide (Creswell and Plano Clark, 2011). A mixed methods approach can collect and analyse complementary data whilst sharing the same research questions (Yin, 2006) and address more complex research questions, collecting a 'richer and stronger array of evidence than can be accomplished by any single method alone' (Yin, 2014, p. 66). It will be seen in the methods section that the different data collection methods shared similar questions albeit at different points in the timeline.

### **3.3.2 Case Study Design**

Case study research can be viewed as a research *design* so that various other methods can be used to implement the research and is a useful approach in trying to appreciate contexts of social behaviour in a particular social context as opposed to making generalisations. (Tight, 2017). Stake (1995) suggests that the emphasis is on uniqueness in a case study and that there should be a focus on what is particular to that case; and to come to know it well rather than generalise, aiming to thoroughly understand the case and to try and see how the respondents see things (Stake, 1995). One might question what is unique about this cohort of students that makes it a 'case study' when the curriculum is delivered year on year and was based on a set of national standards (NMC, 2010). My argument here is that the demographics of this particular cohort, the classroom learning environment, different placement experiences and new employment positions are unique to this cohort. The intention here is not to generalise but to aim to understand the experiences of a cohort of qualifying

nurses. Some transferability of the inferences may be possible from case study research from one research setting to another similar setting (Teddle and Tashakkori, 2009) and will be addressed in section 3.8.

The case study design outlined here is that of a single context of a cohort of qualifying nurses using embedded, multiple units of study and analysis (Yin, 2014). Creswell (2014) suggests that case studies are a design of inquiry found in many fields, especially evaluation, in which the researcher develops an in-depth analysis of a case, often a program, event, activity, process, or one or more individuals. Cases are bounded by time and activity, and researchers collect detailed information using a variety of data collection procedures over a sustained period of time (Stake, 1995; Yin, 2012, 2014). Yin (2014, p 50) discusses case study design with reference to data collection and 'units of analysis' and suggests that a case study design structure can strengthen the methodology and advocates four types: firstly, a single case design with a single case as a unit of analysis; secondly, a single case with multiple embedded units of analysis; thirdly, multiple case designs each with single units of analysis; fourthly, multiple case designs with multiple embedded units of analysis (Figure 3.3). The design utilised for this research is the second type of design which is a single case design with multiple embedded units of analysis. Figure 3.4 provides a summary of the embedded mixed methods for this study.

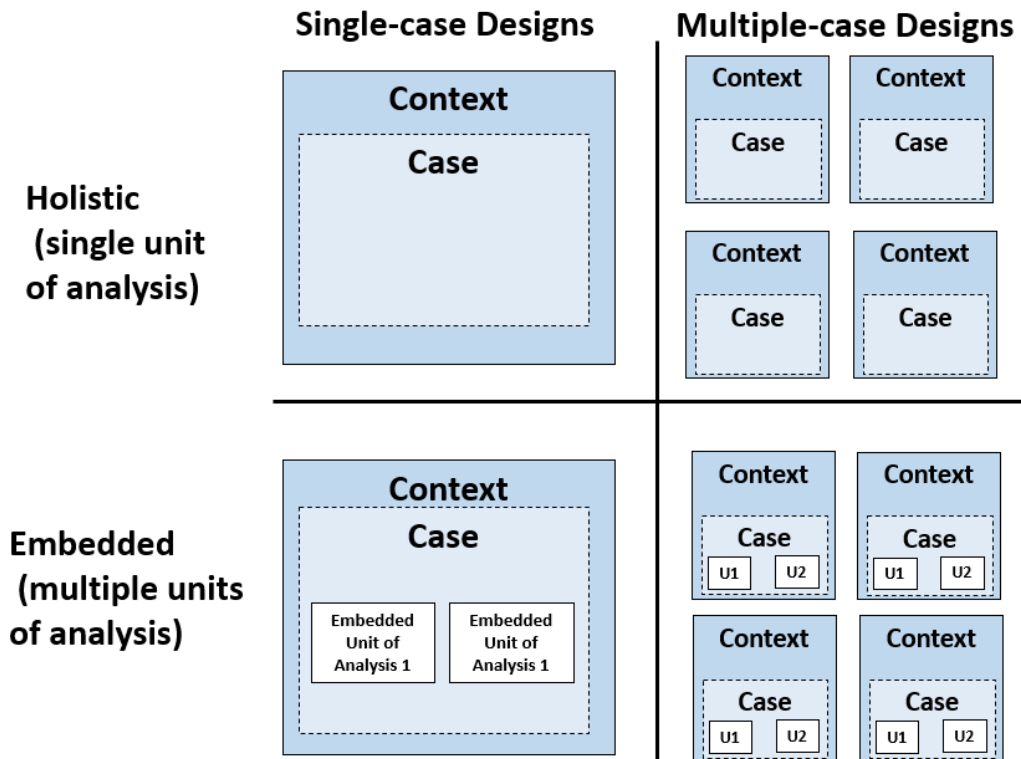


Figure 3.3 - Basic designs for case studies (Yin 2014, p. 50)

### 3.3.3 Application of Case Study Design: Exploration of Transition from Student to NQN

The case study utilised a multiphase approach to the collection of data using mixed methods (Figure 3.4).

Multiphase combination timing occurs when the researcher implements multiple phases that include sequential and/or concurrent timing over a program of study. (Creswell and Plano Clark, 2011, p. 66)

Creswell and Plano Clark (2011) postulate that researchers need to consider approaches for mixing quantitative and qualitative methods within their design. The case study was designed with the intention of using CHAT (Engeström, 2001) as a theoretical framework (see 2.4.4) to combine and interpret the data



sets following the final phase (Creswell and Plano Clark, 2011). However, intention to incorporate CHAT did not influence the specifics of the research questions which were posed from my own experiences in nurse education encompassing the pragmatic perspective discussed in 3.2.1.

Case study mixed methods as applied to a cohort of undergraduate students during 12-18 month transition from student nurse to NQN

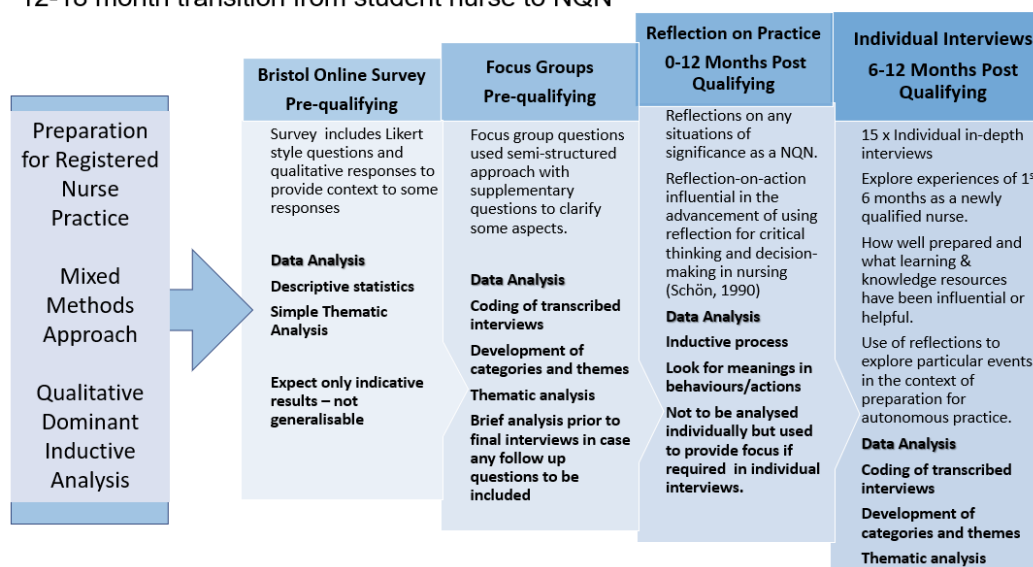


Figure 3.4 - Case study: summary and timeline of methods

Detailed discussion on the different phases and methods is situated later in section 3.5. The ‘case’ relates to a cohort of undergraduate nursing students who were due to complete their studies and become NQNs in September 2017. All cohort members (n=185) were invited to complete an online survey *prior* to final placements in May to July 2017 which aimed to discover how well prepared they felt for both these as well as their readiness to practice as NQNs. Also, in the pre-qualifying period as the survey closed, cohort members were invited to volunteer to attend focus groups (FGs) during July 2017. Participants were also sought for individual interviews 6-12 months post qualification. The first few

interview volunteers (n=9) were asked to reflect on any significant learning situations during this time that might contribute to the individual interview follow-up. Individual interviews (n=15) took place between April-August 2018.

### **3.4 Participants in the Study**

The participant cohort of nursing students was identified using a purposive sampling strategy which can be used in qualitative research to select 'units' with a particular purpose to answer a research study question (Teddlie and Tashakkori, 2009). Maxwell (1997 cited in Teddlie and Tashakkori, 2009) adds to the definition, 'particular settings, persons, or events are deliberately selected for the important information they can provide that cannot be gotten as well from the other choices' (p. 170). In this respect, what was desirable here was respondents to represent all four fields of nursing.

The invited participants were drawn from a cohort (n=185) of undergraduate nursing students undertaking the final six months of a BSc (Hons) Nursing programme. The cohort consisted of four fields of nursing across two geographical sites of programme delivery in the North of England. The four nursing fields included adult, child, learning disabilities and mental health specialities. Whilst these students are on different qualifying pathways, they studied what is essentially one programme, with students sharing some preparatory academic modules and interprofessional learning experiences as required by the nursing and midwifery council (NMC, 2010). In the latter part of the research, the NQNs were working in a variety of clinical settings with a wide geographical spread. Participation was entirely optional. A total of 63 students

(34.1%) responded to an initial online survey. Volunteers to participate in FGs (3) and individual interviews (15) were recruited via student email addresses and via the online survey. These phases are detailed further in 3.5.

### **3.5 Data Collection**

This section will provide an overview of the data collection methods followed by more detailed individual sections for each method. Ethical considerations will also be discussed. The case study of the preparation and transition of a group of NQNs for professional practice took place during a 12-18-month period through collection of a variety of data. The data was collected using mixed methods which included an online survey, FGs, reflection on practice and individual interviews. The research began with an online, Likert-style questionnaire which was sent to the whole cohort of students asking them to self-assess their perceived level of readiness and competence at the start of their final assessed placement (Appendix1). In my experience as a nurse educator, I have seen that some students develop more confidence in their final placement; anecdotally, some students have said they felt ready for autonomous practice at this stage, whilst others expressed anxiety about it. It seemed appropriate to capture a snapshot of how prepared the students were feeling prior to qualification to help identify what influenced their competence and readiness at which stage in their journey. Although the main focus of this study was the NQN stage, my belief was that the participants may forget aspects of their HEI preparation having 'moved on' and that having some evidence of pre-qualifying perspectives could help in the analysis stage. Some evaluation of theoretical preparation for the required level of professional

practice was also included in the survey. Questionnaires are a useful tool for collecting survey information from larger samples and can be quite straightforward to analyse if developed appropriately (Cohen et al., 2011). This survey contained both five-point and four-point Likert-style rating scales with closed questions (Appendix 1), as these methods are user friendly and can be quickly coded and analysed easily (Parahoo, 2006). Clarificatory descriptive responses were requested for some of the questions to provide context (Blaxter et al., 2010).

Concurrently, three FGs were convened using a small sample of 10 volunteers divided into three groups: one group of 4 participants and two groups of 3. FGs are a type of group interview used to bring together a group of individuals to discuss a topic or theme with the data being derived from the interaction of the group (Cohen et al., 2011) but are not as appropriate for generating individual narratives (Mason, 2018). These occurred towards the end of a final twelve-week placement. The original request for volunteers yielded 33 students who stated they would potentially take part in the FGs. This appeared to be a very positive response initially. Following invitations to attend, with some declines and several 'non-attenders', the participating number reduced to 10. On reflection the timing of the FGs during clinical placements probably contributed to non-participation. However, a positive outcome was that all 10 participants from the FGs were very keen to participate in the individual interviews post qualification. In addition, 2 students who could not attend the FG expressed a willingness to take part in the post-qualifying stage of the research.

Fifteen, individual, semi-structured interviews were carried out between 6-12 months post qualifying to explore with individuals how well prepared they had been for working as an NQN and any key moments of importance during the transition from student to NQN. A semi-structured interview is one in which the researcher sets the questions in relation to the subject matter, but the interviewee can determine the information provided in the responses in relation to the relative importance (Green and Thorogood, 2014). The early volunteers were asked to record any reflections of significance during their first 6 months of newly qualified status although many chose not to do this and instead recalled significant events during interviews. As highlighted in Chapter 2, critical reflection skills are useful in facilitating articulation of tacit knowledge (Clarke, 1986; Benner et al., 2009; Hatlevik, 2012).

The reader may notice similarities of questions in the data collection tools. This was purposeful in order to retain focus and alignment to the research questions in the pre and post qualifying periods, to collect and analyse complementary data whilst sharing the same research questions (Yin, 2006).

### **3.5.1 Researcher Positioning**

The term 'insider' research is used when carrying out research in a university where one is working, although 'insiderness' is not a fixed entity if the researcher studies unfamiliar facets within the employing university (Trowler, 2012c). Researchers need to understand themselves and their part in the research rather than trying to fully eliminate researcher influences as this may not be fully possible (Cohen et al., 2011). My position is such that I was aware

of the programme learning outcomes and individual units of study of the curriculum having facilitated the writing of the curriculum between 2010 and 2012. However, I had not worked in a face-to-face capacity with the cohort and had only one thirty-minute contact with the students prior to their first placement in 2014.

Prior to starting each focus group or interview, I explained my professional position as an RN academic and potential change agent, and also that I understood the programme and nursing education in general so that the participants did not feel the need to explain the modules or nursing procedures. One benefit of explaining my position in relation to insider research is that it can make for an implicit understanding of the participants' meanings therefore allowing the researcher to produce emic or meaningful accounts on their behalf (Trowler, 2012c). I stated my intentions honestly with the intentions of avoiding any deceptive practice and used a friendly, informal style with the intention of minimising potential power influence during the interviews (Mason, 2018). I am unable to state categorically that my position in the university did or did not influence narratives, although the honesty in responses and critiques would suggest that this was minimal.

### **3.5.2 Ethical Considerations**

This research required collection of data from human subjects therefore ethical approval according to the British Educational Research Association (BERA, 2011) guidelines was agreed by the University Ethics Committee prior to starting the data collection. The research proposal was also shared and agreed

by the Research and Development Officer (RDO) in a partner NHS Trust. The RDO was approached in March 2017 to discuss any permissions required because the student nurses would be qualified RNs in the latter part of the study. As interviews and FGs were planned to take place in the University, and because patients and clinical settings were not accessed and were not deemed to be 'at risk', NHS ethics approval was not required following confirmation from the RDO.

Using the Lancaster University standard templates, participants for the FGs and interviews were provided with an information sheet detailing the proposed research and a consent form as well as being assured of confidentiality and anonymity of the data (Appendix 2). Informed, signed consent was sought before recording and transcribing of FGs and interviews. The anonymous online survey explained that completion and submission of the survey implied agreement and consent for the data to be used.

Participants in interviews were allocated gender-neutral pseudonyms. The key reason for this was there was only one male in the fifteen respondents. Due to the sensitive nature of some of their experiences the use of these pseudonyms helps to preserve anonymity and it can be seen that the narrative does not refer to 'he' or 'she' which sometimes makes the narrative a little clumsy. All participant information and data were stored electronically in a password protected data file.

### **3.5.3 Online Survey**

An online semi-structured questionnaire was emailed to all students in an undergraduate nursing cohort (n=185) in the form of a hyperlink to the survey site (Appendix 1). The survey collected primarily quantitative data, with additional qualitative responses being sought to provide context and reasoning for some of the more structured quantitative responses (Blaxter et al., 2010). The questionnaire consisted of 26 questions of which three were demographic, 18 questions required Likert-style responses, with five questions allowing for more open comments to provide some context or clarification of a preceding question. Questions were centred around two key areas: firstly, how well prepared the respondents felt in relation to their final assessed placements and for working as an RN; secondly, some self-assessment of theoretical knowledge and clinical practice competence. The initial invitation to participate in the survey was followed up by three reminders over a six-week period to those who had not responded. These reminders were built into the design of the survey so that those who had completed did not receive unnecessary reminders. 63 responses were received out of a possible 185, a response rate of 34.1%.

Table 3.1 shows the number of survey respondents for each field of nursing. The highest number of respondents in number (33) were from adult nurses which represented 27.7% of their Field. The other three nursing fields show less respondents in number, but they do represent a higher proportion of their total numbers. There were only 6 children's nursing responses, but this represents



37.5% of their field; 13 learning disability nurses represents 48.1% of their field and 11 mental health nurses represented 47.8% of their field.

<b>Nursing Field</b>	<b>Total No Respondents</b>	<b>No in Cohort</b>	<b>% Field response</b>
Adult	33 (52.4%)	119	27.7%
Child	6 (9.5%)	16	37.5%
Learning Disabilities	13 (20.6%)	27	48.1%
Mental Health	11 (17.5%)	23	47.8%
Total	63 (34.1%)	185	

Table 3.1 - Respondents According to Field of Nursing

### 3.5.4 Focus Groups

Three FGs were convened after the survey closed and during a period of two weeks towards the end of the final clinical placement. The FGs were with 10 undergraduate student nurses during their final clinical placement prior to qualification as RNs (RNs). The FGs took place in University classroom and not in the placement setting. The groups were made up of students from adult and mental health nursing: Group 1 (n=4); Group 2 (n=3); Group 3 (n=3). There were no volunteers at that time to represent the learning disability or children's fields although there is representation from them later in the study in the post-qualifying individual interviews. All the FG participants agreed to take part in individual interviews six months post qualifying although one participant did not respond to invitations for an individual interview. The FG questions are listed in Figure 3.5. using semi-structured open questions (see section 3.5.6 for rationale and discussion on qualitative interviewing). Group interaction was

encouraged during questioning to stimulate discussion and sharing of views (Mason, 2018).

1. How was your final placement? Please tell me a little bit about how it went generally.
2. How did you feel going into the final placement? Did you feel differently about it in any way?
3. How well prepared do you think you are for registration and working as a qualified nurse?
4. What theory or practice teaching/learning do you think has been helpful or supportive in your development?
5. What aspects of preparation do you think you needed that has not been included or covered?
6. Do you have any particular concerns at this stage in relation to working as an RN?
7. The survey results provided some interesting results in relation to dealing with emergencies, adverse incidents, breaking bad news and managing staff and teams. Can you give any examples of these from experience and how you might have been prepared for these?
8. Do you have anything to add that you think may be important to the research topic in relation to support for your learning and development of autonomous practice.

Figure 3.5 - Focus Group During Final Clinical Placement.

### **3.5.5 Reflections on practice**

The participants agreeing to be interviewed at six months post-qualifying were asked to consider using reflection-on-action to be used as a prompt for discussion in individual interviews, In relation to this research, I wanted the participants to concentrate on experiences in practice that may have had an impact on their development or transition as an RN. I was particularly interested in discovering if the degree programme had prepared them to deal with them, or if some other factors were influential such as employment induction and preceptorship. Five of the participants had written some personal reflections but

these were not included in the data analysis although some aspects were included as prompts in the individual interview. This turned out to be unproblematic as most of the participants were able to recall memorable significant learning experiences during the individual interviews.

### **3.5.6 Qualitative Interviews**

Qualitative interviews can be utilised to obtain in-depth information from participants, establishing trust and rapport for ease of communication whilst exploring 'thoughts, beliefs, knowledge, reasoning, motivations and feelings about a topic' (Johnson and Christenson, 2014, p. 233). Interviews can be a powerful strategy for data collection when there is a one-to-one interface between the researcher and participant, providing opportunity for clarification of responses (Teddlie and Tashakkori, 2009). Three types of qualitative interview have been put forward by Patton (1987). The first is an informal conversational interview where there is no predetermined wording of questions or topics. Second is the interview guide approach in which topics and issues are in outline form but the sequence and wording of questions is decided by the interviewer during the interview. Third is the standardized open-ended interview in which the precise wording and sequence of questions are pre-determined and asked in the same order (Patton 1987; Johnson and Christenson, 2014). Figure 3.6 lists the interview questions used in this stage of the study which appear to be fixed and to fit into the 'standardized open-ended interview' category. However, in practice, a combined approach was taken as suggested by Teddlie and Tashakkori (2009), starting and finishing with an unstructured conversational style. Questions 2 – 7 utilised an 'interview guide approach'

using structured ‘standardized’ questions but also incorporated a probing conversational style when more context and detail was required. This style could be described as a semi-structured interview; one in which the researcher sets the questions in relation to the subject matter, but the interviewee can determine the information provided in the responses in relation to the relative importance (Green and Thorogood, 2014).

1. How has the last 6 months been for you working as an RN? Please tell me a little bit about how it has gone generally.
2. How well prepared do you think you have been for your registration and working as a qualified nurse?
3. What theory or practice learning do you think has been particularly helpful or supportive in preparing you for your new role?
4. What aspects of preparation do you now think you needed that was not included or covered in your degree studies?
5. Do you have any particular concerns at this stage in relation to your role as an RN?
6. Is there anything you or the University (or other) could have done to help with any concerns or development needs?
7. Can you explain how you think you have developed or changed between qualifying and now at 6 months on?
8. Any comments on your transition that have not been captured by the previous questions?

Figure 3.6 - List of Individual Interview Questions Post Qualifying

Semi-structured interviews were carried out with fifteen participants between 6-12 months post qualifying, to explore with individuals, how well prepared they had been for working as a newly qualified nurse (NQN) and any key moments of importance during the transition from student to NQN. Some of the participants had been interviewed previously in the FGs, others had not. Table

3.2 shows a list of participants (names changed to protect confidentiality). There were nine participants out of the ten from the FGs who were interviewed after six months of being qualified. There were five participants who agreed to be interviewed who had been unable to attend FGs. It was important to add further participants to interview to incorporate views from all four fields of nursing in terms of their general preparation for practice. The length of interviews ranged between forty-five and sixty minutes long and were all recorded and transcribed. Table 3.3 outlines a brief summary of their NQN employment context collected at the time of the individual interviews.

Participants	Nursing Field	Interview	Focus Group
Drew	Adult	✓	✓
Kit	Adult	✓	✓
Linden	Adult	✓	✓
Brook	Adult	✓	✓
Rowan	Adult	✓	X
Taylor	Adult	✓	✓
Wynne	Adult	✓	✓
Ash	Child	✓	X
Darryl	Child	✓	X
Jules	LD	✓	X
Casey	LD	✓	X
Jamie	LD	✓	X
Alex	MH	x	✓
Bailey	MH	✓	✓
Chris	MH	✓	✓
Eden	MH	✓	✓

Table 3.2 - Participants According to Nursing Field and Methods

<b>Pseudonym (gender neutral to preserve anonymity)</b>	<b>Age Group</b>	<b>Employment context of interview participant</b>
Ash	21-30	Children's nurse working in an acute care ward.
Bailey	31-40	Mental Health nurse working in a private nursing home. Bailey had previously worked there having been seconded and supported to undertake nurse training.
Brook	21-30	Adult nurse working in an orthopaedic trauma ward.
Casey	41-50	Learning Disability nurse worked in a community LD team for seven months before moving to a nursing home for people with learning disabilities. Had many years of experience in LD prior to nurse training.
Chris	31-40	Mental Health nurse who moved to a different country for first nursing post in a dementia acute care unit. Chris had previously worked as a care support worker.
Darryl	21-30	Children's nurse worked in an acute surgical/medical ward for three months in a different NHS Trust before returning to the home Trust of nurse training.
Drew	21-30	Adult nurse working in an acute medical unit.
Eden	31-40	Mental Health nurse based in the community providing intensive home-based treatment. Eden had previous experience of working as a care support worker (home care and LD work).
Jamie	21-30	Learning Disability nurse working in an adult nursing ward (elective orthopaedics). Had previous work experience in nursing homes and a special needs school.

<b>Pseudonym (gender neutral to preserve anonymity)</b>	<b>Age Group</b>	<b>Employment context of interview participant</b>
Jules		Learning Disability (LD) nurse who moved away to work in an adult nursing setting caring for older people. After four weeks moved to a nursing home and moved again to work on a neurosurgical ward.
Kit	31-40	Adult nurse working as a practice nurse in a General Practice. Had previous care experience before commencing nurse education
Linden	31-40	Adult nurse working on a general surgery and gynaecology ward.
Rowan	21-30	Adult nurse working in a cardiology ward with cardiac care unit.
Taylor	21-30	Adult nurse working in elective orthopaedic ward.
Wynne	41-50	Adult nurse working in an acute stroke unit. Previous career as a teacher.

Table 3.3 - Employment context of individual interview participants

### 3.6 Data Analysis

A mixed methods case study design allows for convergent or intersecting data analysis of quantitative and qualitative results using a theoretical framework (Creswell and Plano Clark 2011; 2018). Figure 3.7 summarises how the methods discussed in 3.5 were aligned to the data analysis process. This section will now outline the order and processes with theoretical rationale in support of the approach.

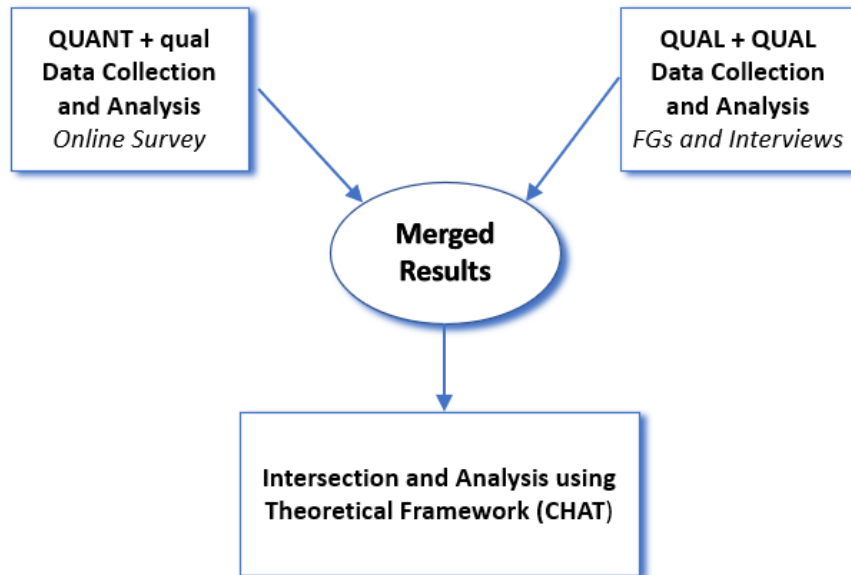


Figure 3.7 - Mixed methods case study design adapted from Creswell and Plano Clark (2018)

Data analysis took place mostly on completion of the data collection and was intersected with a theoretical framework aligning the research questions with expansive learning elements of CHAT (Engeström, 2001; Creswell and Plano Clark, 2018). However, brief and partial analysis of the survey results was undertaken as the survey closed in order to determine if any follow-up clarification was needed in the FG questions in July 2017. As an illustration of this, ‘breaking bad news’ appeared more problematic for a higher percentage of students, so a clarificatory question was added to the FG questions (see Figure 3.5; Q7).

Qualitative data from the survey, FGs and interviews were thematically analysed together following completion of all interviews. As themes began to emerge regarding preparedness as an NQN, the more quantitative survey



results were consulted to compare how the cohort participants had self-assessed readiness pre-qualifying. An alternative option might have been to analyse the data on a person-by-person basis but on commencement of this time-limited study, and as a novice researcher, I was unable to rely on the same participants being available to follow through. In hindsight this may have been possible but decided that commitment to my proposed plan was the appropriate option as I began the analysis.

In the early stages I listened to recordings and read survey results and transcripts to 'get a feel' for the data as a whole. A number of authors suggest a strategy of firstly looking at the different types of data as a whole to get a sense of any overall meanings and impressions of what the participants are saying (Creswell, 2014; Friese, 2014; Teddlie and Tashakkori, 2009). Yin (2014) suggests that a starting point for analysis would be to begin 'playing with the data and searching for promising patterns, insights or concepts', and to consider four strategies which include 'theoretical propositions, working data from the 'ground up', develop a case description, and examine rival explanations' (p.122).

The main strategy for analysing the qualitative data from all stages of the research was by thematic analysis incorporating the coding and categorising data to develop themes (Braun and Clarke, 2012). Thematic analysis across the data set as described by Braun and Clarke (2012) was used to 'see and make sense of collective or shared meanings and experiences' (p. 57). This process is described and applied in section 3.7. Creswell (2014, p. 195)

recommends that qualitative data analysis should go ‘hand in hand’ with data collection and writing up of findings, using a process of writing memos as the research and data unfolds that could be incorporated into the final narrative.

Quantitative analysis for the online survey employed a descriptive statistical analysis method exploring the interrelationships between pairs of variables using cross-tabulation (Blaxter et al., 2010) along with a simple thematic analysis of the qualitative findings exploring what is being said rather than how it is being said (Howitt, 2010). Quantitative findings are presented with explanatory descriptive quotes to support them. These will be included as relevant to the wider narrative discussion rather than summarised in isolation with the intent of converging results for enhanced understanding and addressing of research questions (Creswell and Plano Clark, 2018). Qualitative responses were examined for basic categories related to the type of responses given to the Likert-style questions. For example, elucidation of reasons why a respondent may or may not have felt prepared for their final placement or autonomous professional practice. Quotes from the categories are used to illustrate the findings where appropriate.

### **3.7 Development of the themes**

Thematic analysis as described in Table 3.4 was used to systematically identify and organise the data and offer insight into patterns of meaning or themes (Braun and Clarke, 2012, p. 57). After familiarising myself with the data by reading transcripts and listening to recorded interviews, initial codes were generated. An example of coding method is provided in Figure 3.8).

Phase
1. Familiarizing yourself with your data
2. Generating initial codes
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Producing the report

Table 3.4 Phases of thematic analysis (Braun and Clarke, 2012)

Analytic coding of FG and interview transcripts generated several codes which are listed in Appendix 3 along with sub-themes developed from memo writing. Figure 3.8 provides an example of analytic coding. Figure 3.9 then provides a memo generated from the coding in Figure 3.8.

Participant	Individual Interview Data	Coding
Wynne	<p>We had to do a big fat essay on pharmacology – it was a pharmacological intervention and I think it was a psychological intervention or a patient-centred intervention in Year 2 - and we had to base that around a real person we were looking after and I based mine on somebody in intensive care which was where I was on placement at the time, and that was really useful especially because with the encouragement of my mentor I actually went and spent a long time talking to the pharmacist on intensive care who of course was able to teach me loads.</p> <p>...bringing practice into that concept as well has been a brilliant experience and getting the input from the pharmacist on ITU was really helpful. And just the fact that my mentor was like, "oh you need to talk to the pharmacist about this". Well it wouldn't have occurred to me because I thought I was too lowly as a student nurse for the pharmacist to be bothered with me.</p>	<p>Assessment linked to practice</p> <p>Case study from placement</p> <p>Mentor mediating MDT work</p> <p>Learning from pharmacist</p> <p>Mentor important mediator</p>

Figure 3.8 - Example of analytic coding

Analytic coding was used to inform and develop memos which I perceived to be important concepts in searching for initial sub-themes (Figure 3.9). As I 'played around' with potential sub-themes, I started to incorporate early links to activity theory providing some reassurance that it aligned to the unfolding narrative.

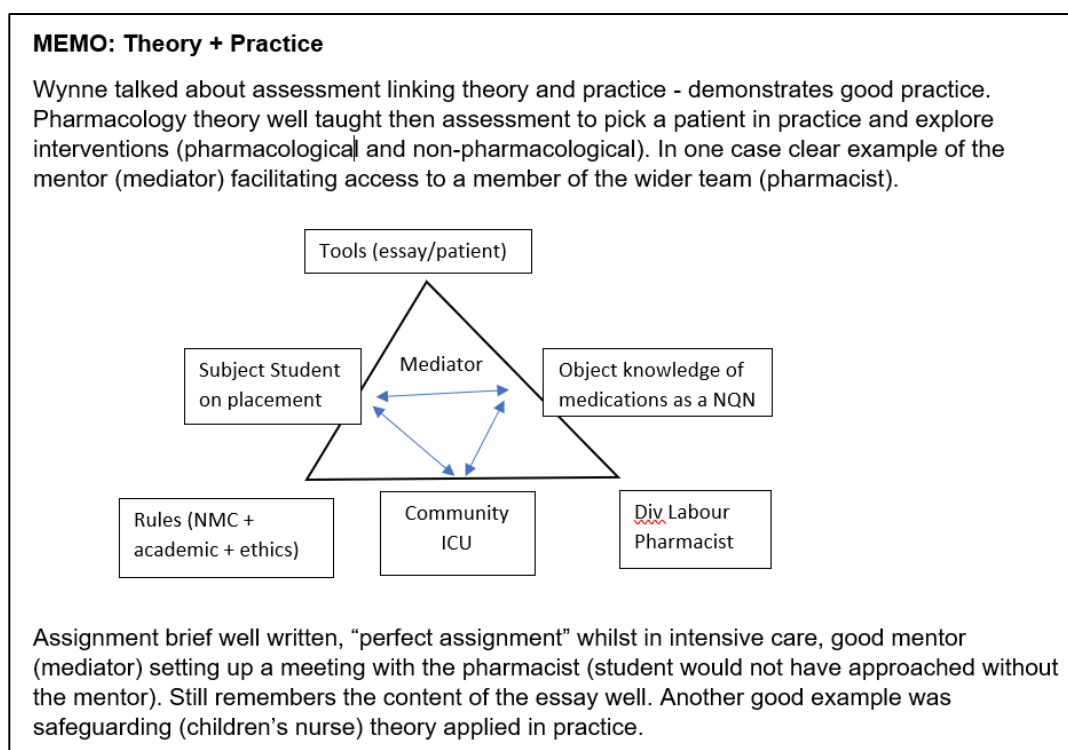


Figure 3.9 - Memo written following analytical coding with early links to AT

Several sub-themes were generated which initially proved difficult to make sense of and reduce to fewer meaningful themes. This led to the construction of a 'mind map' (Figure 3.10) based loosely on key elements of social practice theory (SPT) which I found helpful to visualise as a 'nexus of doings and saying' as described by Schatzki (2002). The research questions were also central to the nexus development: how well prepared are NQNs for autonomous practice

and what experiences shape the development of professional identity, competence and confidence during the transition period?

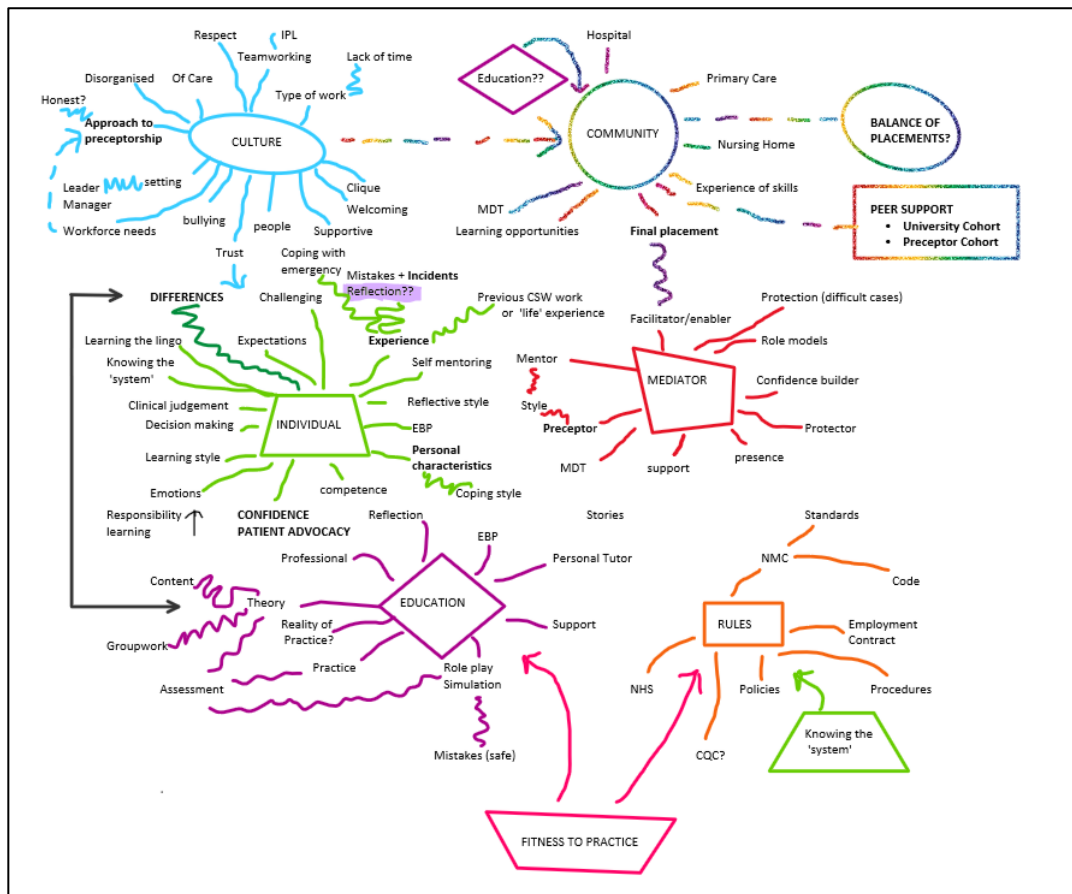


Figure 3.10 - Nexus based on coding and developing sub-themes

Initial analysis indicated existence of broad concepts such as: specific individual experiences; cultures of placements and work settings; the personal nature and attributes of participants and the other 'actors' involved; and the formal organisational aspects such as the educational provision and the formal rules and regulations for practice (Figure 3.10). These broad concepts or larger sub-themes were then explored and revisited several times until they were refined to three main themes (Table 3.5) which inform the basis of the presentation of the data in chapters 4, 5 and 6.

Aspects of inquiry based on research questions	Themes	Sub themes From analytical coding to inform the themes	
Preparedness and competence of student nurses at the point of qualification and 6 months post qualifying.	Educational preparation for nursing practice	<b>Theoretical Learning and Teaching</b> <ul style="list-style-type: none"> <li>Professional practice theory</li> <li>Evidence based practice/care</li> <li>Reflective practice</li> </ul> <b>Practice Based Learning</b> <ul style="list-style-type: none"> <li>Skills Practice</li> <li>Simulation &amp; Role Play</li> <li>Safe place for mistakes</li> </ul>	<b>Assessments/Support for Learning</b> <ul style="list-style-type: none"> <li>Lecturers</li> <li>Personal support</li> <li>Assessment linked to practice</li> </ul>
Shaping of professional competence and identity during the first 6 months of qualified practice?	Learning to Practise:  <i>In Placement and Workplace Communities</i>   <i>With Facilitators of Learning</i>	<b>Student Placement</b> <ul style="list-style-type: none"> <li>Placement allocation</li> <li>Balance of placements</li> <li>Final placement</li> </ul> <b>Culture</b> <ul style="list-style-type: none"> <li>Placement/workplace type</li> <li>Placement/workplace culture</li> <li>Learning opportunities/MDT</li> <li>Learning experiences.</li> <li>Supportive or unsupportive?</li> </ul> <b>Types of facilitator</b> <ul style="list-style-type: none"> <li>Mentor/Assessor</li> <li>Preceptor support</li> <li>Allied Health Professionals</li> </ul>	<b>Preceptorship (employer approach)</b> <ul style="list-style-type: none"> <li>Programme/Induction/Preceptor</li> <li>Programme/Induction/preceptor but no time</li> <li>Programme/Induction no preceptor</li> <li>Little or no preceptorship</li> </ul> <b>Style of facilitator</b> <ul style="list-style-type: none"> <li>Role models</li> <li>Enablers/mediator</li> <li>Protectors</li> <li>Confidence builders</li> </ul>
Possible tensions in relation to education preparation for the NQN role and actual practice (world of work)?	Student to Registered Nurse transition	<b>Personal attributes</b> <ul style="list-style-type: none"> <li>Emotions/resilience/guilt</li> <li>Reality of accountability/fear</li> <li>Reflective skills</li> </ul> <b>Support – old and new</b> <ul style="list-style-type: none"> <li>Mentors</li> <li>Peers</li> <li>Lecturers</li> </ul>	<b>Personal Learning</b> <ul style="list-style-type: none"> <li>Knowledge -Transferable skills</li> <li>Experiences</li> <li>Mistakes and errors</li> <li>Clinical judgement &amp; decision making</li> <li>Personal values/Advocacy</li> <li>Learning the lingo</li> <li>Knowing the system</li> </ul> <b>Influence of personal attributes and learning</b> <ul style="list-style-type: none"> <li>Competence</li> <li>Confidence</li> </ul>

Table 3.5 - Final themes and sub-themes

The three main themes developed are: (1) educational preparation for nursing practice; (2) placement and workplace communities including facilitators of learning; and (3) student to RN transition. The aspects of inquiry are aligned to the research questions and the emergent themes in Table 3.5. Where appropriate main themes will be aligned with CHAT in Chapters 4, 5 and 6 (Engeström, 2001), although there will be a stronger, overall synthesis in Chapter 7.

### **3.8 Trustworthiness**

Lincoln and Guba (1985) provided four criteria of trustworthiness as an alternative approach to reliability and validity relative to the nature of qualitative research which are: credibility; transferability; dependability; and confirmability. Validity, reliability, replicability and generalisability in research are usually associated with the positivist or quantitative traditions with these concepts not being well aligned with qualitative research (Wahyuni, 2012). I propose that this research is acknowledged as 'authentic' rather than judged against more scientific measures of reliability and validity. Ontological authenticity focuses on research that is worthwhile, and its impact on the community being researched, and should support development of a better understanding of the environmental context of the study (James, 2008). In this respect, an exploration and understanding NQNs' preparation for autonomous practice across two activity systems to which they belong.

#### **3.8.1 Credibility**

Credibility relates to confidence in the truth of research findings (Lincoln and Guba, 1985). There should be clarity in reasons for choice of research model and reasons why participants were selected as well as clear alignment of emerging codes and themes with participant data (Jenson, 2008a). The choice of using a mixed methods case study approach with a purposive sample from a cohort of student nurses has been discussed previously in this chapter containing rationale for the pragmatic approach to researching a particular experience with the students in a defined period of time. The methods of analytic coding and emerging themes have been described.

### **3.8.2 Transferability**

Transferability in qualitative research involves signifying that findings may have applicability in different settings or contexts (Lincoln and Guba, 1985). Jenson (2008) suggests that transferability can be increased by considering two questions. Firstly, how close are the participants linked to the context and community of study? Secondly, what are the boundaries of the context of study? Providing a full and focused account of the research design, the participants and context as well as the use of purposeful sampling to best represent the design of the study will enhance the potential for readers to assess transferability to their particular context (Jenson, 2008b). In this research, the participants are NQNs and they are directly linked to the context and community of study in respect of their nursing degree and how it prepares them to work as RNs. The boundaries of study are limited to only one university but several employment settings. Whilst the results will not be fully transferable, there will be findings of interest that may be helpful for other universities and employers to consider.

### **3.8.3 Dependability**

Dependability denotes the extent to which a study would produce the same results if it were to be replicated (Lincoln and Guba, 1985). Wahyuni (2012) suggests that dependability 'corresponds to the notion of reliability which promotes replicability or repeatability' (p. 77) and means recognising all the changes that occur in a setting and how they might influence how the research is conducted. By providing a detailed explanation of the steps in my research process, future researchers would be able to replicate the research framework,



but they would not necessarily achieve all the same results because of the unique nature of each cohort of students commencing work as NQNs in several different settings.

#### **3.8.4 Confirmability**

Lincoln and Guba (1985) define confirmability as “the degree of neutrality, or the extent to which the findings of the study are shaped by the respondents and not researcher bias, motivation, or interest” (p. 299). Confirmability includes provision of evidence that the researcher's interpretations of the participants' narratives are representative of the participants' constructions and research purpose rather than reflective of the researcher's bias (Jenson, 2008c). I have explicitly stated my role and experience as a nurse educator so that any readers will understand my position and interest. The quotations used in Chapters 4, 5 and 6 represent as many of the participants as possible in each part in order to represent their views. My own interpretations are clearly set out in the section on data analysis and the participant quotes have been used to illustrate them with a view to readers being able to recognise and understand my assumptions.

#### **3.9 Summary**

This chapter has outlined my researcher positioning and provides rationale for the methodology employed in this thesis. In particular, the reasons for choosing a case study design using mixed methods to approach the data gathering form a specific cohort of students has been discussed and justified. As a pragmatic researcher I have chosen to employ a practical approach to answering research questions relating to the work-based learning, preparation for practice and

transition of NQNs. In my view this approach aligns with the research questions linked to social practice theory through the use of CHAT as a theoretical framework to aid analysis. Ethical considerations and trustworthiness of the approach has also been considered.

## Chapter 4: Educational preparation for nursing practice

### 4.1 Introduction

Chapters 4-6 are written and organised around the themes and subthemes emerging from the mixed methods data of the case study. The emergent themes provide a framework to organise and present a diverse set of data in a structured way. Cultural-historical activity theory (CHAT) according to Engeström (2001) will be used as the preliminary unit for analysis and discussion of the themes. The two interacting activity systems introduced in 2.4.4 provides a focus for discussion of the findings (Figure 4.1). Engeström's (2001) adaptation of CHAT seeks to aid the discovery of perceived contradictions or disturbances in the systems. These will be highlighted in each chapter summary alongside any positively evaluated aspects of preparation and then revisited in a wider discussion in Chapter 7.

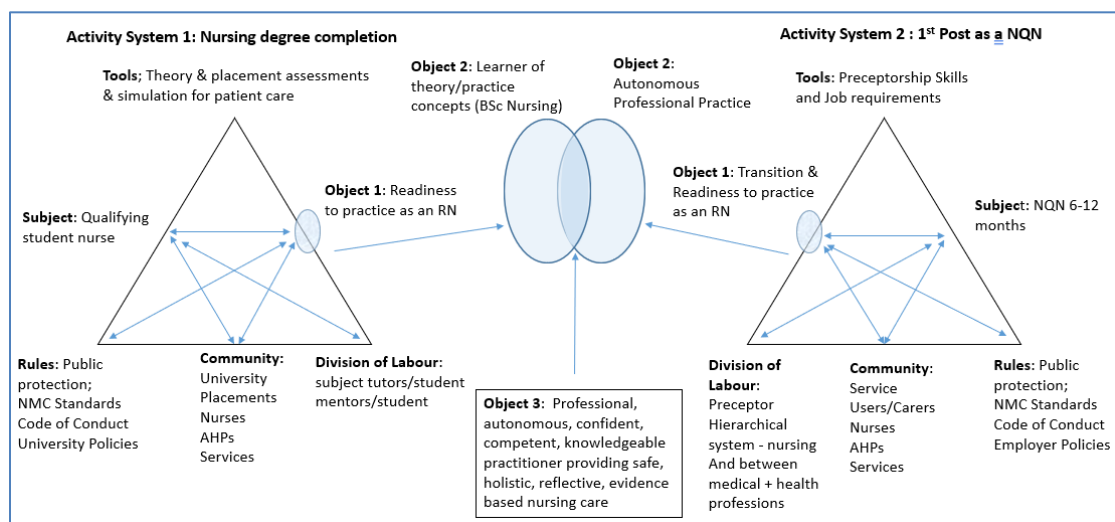


Figure 4.1 - Two interacting activity systems (based on Engeström 2001)

This chapter is the first of three which aim to discuss the findings in relation to educational preparation for NQNs, learning in practice settings, and factors which appear to influence the transition period. This chapter focuses on the university educational preparation for practice for a final assessed placement, and for practising as an NQN. Chapter 5 explores cultural and social aspects of the practice setting as an environment for learning and support. Chapter 6 concentrates on the period of change and the various factors, practical and emotional, which appear to influence transition for the NQNs. Qualitative findings are presented as they pertain to the resultant theme rather than presenting discrete findings for each 'method'. Quotations from qualitative data are included to illustrate salient experiences or feelings. Demographic and descriptive statistical data from the early online survey are incorporated at pertinent points to provide some context, indications and perceptions of the cohort at the beginning of the research.

#### **4.2 Knowledge acquisition, learning and preparation for practice**

This section will discuss how some of the educational programme content helped to prepare the NQNs for practice. Graduate skills such as evidence-based practice and reflection skills were recognised as valuable as problem-solving transferable skills. Professional practice theory, interpersonal skills training and simulation or role-play were also recognised as helpful preparation.

The online survey with the pre-qualifying students indicated mainly positive feelings regarding preparedness for the final placement and working as an NQN (Figures 4.2 and 4.3). Figure 4.2 shows that overall, 73% (n=46) students felt

well prepared for the final placement and Figure 4.3 that 68.3% (n=43) were ready to work as an NQN. Whilst this appears to be positive, it also indicates that 27% were unsure or disagreed regarding readiness for final placement and 27.8% were unsure or disagree they were prepared to be an NQN which is more than a quarter of the respondents in both cases.

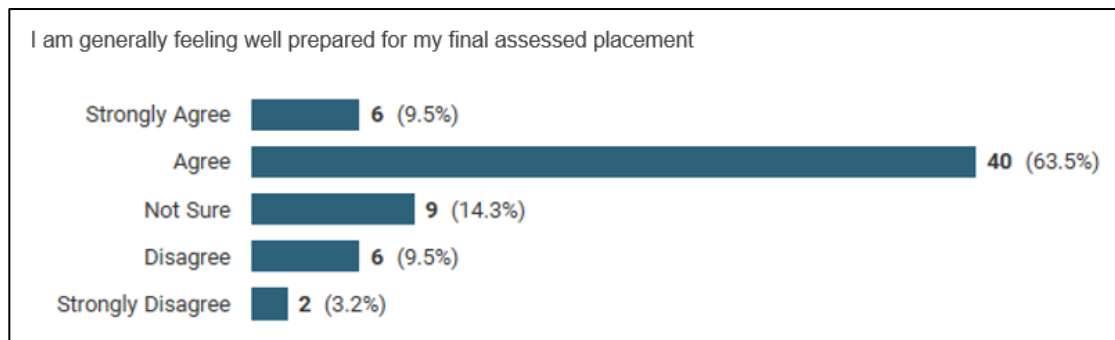


Figure 4.2 - Overall preparedness for final placement

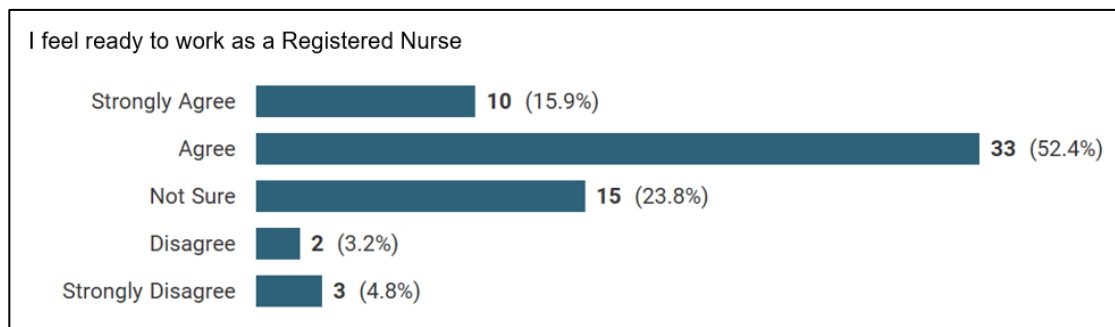


Figure 4.3 - Overall preparedness for working as an RN

Figures 4.4 and 4.5 also indicate generally positive responses in relation to perceptions of theoretical knowledge needed for NQN practice. 81% (n=51) felt their knowledge base was good although only 63.5% (n=40) attributed this to University study. This indicates that 19.1% (n=12) in Figure.4.4 and 36.6% (n=23) in Figure.4.5 were unsure or in disagreement that their knowledge base was good or that University study had prepared them.

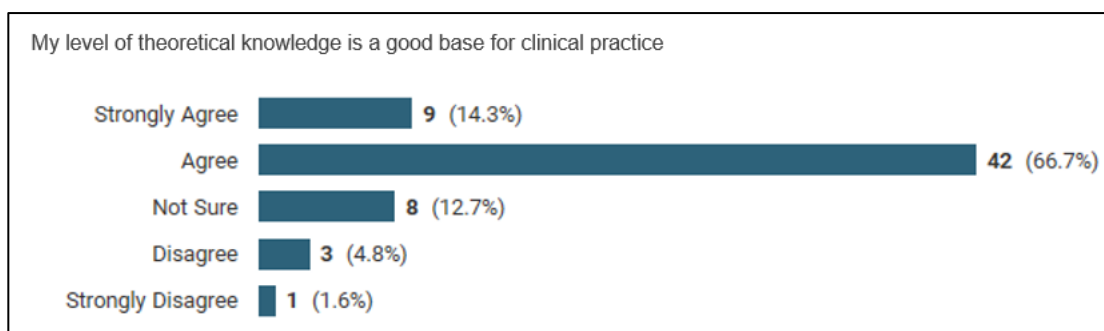


Figure 4.4 - Knowledge base for practice

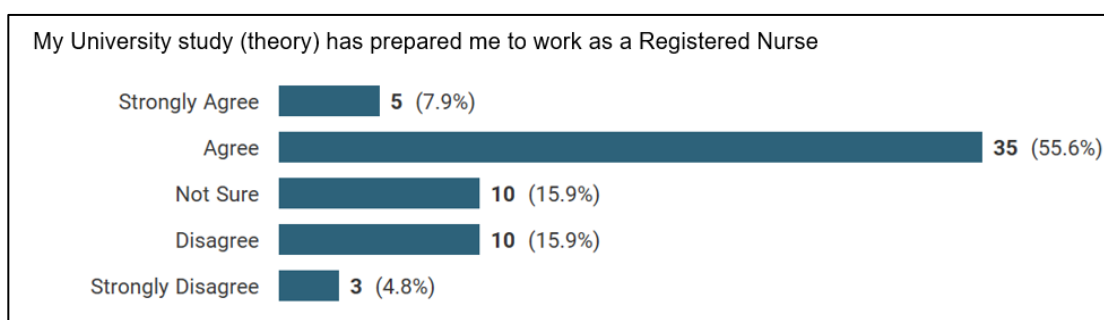


Figure 4.5 - Theoretical preparation for practice

The individual interviews with NQNs helped to contextualise these results. For example, Brook stressed the importance of placement experience but felt that skills initially learnt in university had led to application in practice.

The assessment skills that I'm talking about came from all the things that I was learning at university so my A and P<sup>3</sup>, you know, learning about the anatomy and learning about when things go wrong in the body and having that on top of using my clinical skills, I understood what was going on whilst I was using those clinical skills...things like patients with oxygen therapy and people with COPD<sup>4</sup> and understanding that they don't need a high amount of oxygen to be able to fully function...I wouldn't be the nurse that I am without my university experience and without the clinical knowledge. (Brook)

<sup>3</sup> A & P commonly used colloquialism for 'anatomy and physiology'.

<sup>4</sup> Chronic Obstructive Pulmonary Disease.

Taylor recognised that not every specialism could be taught, and that independent study was necessary. Learning about broader topics such as recognition of signs of physical deterioration and being able to carry out observations were well covered in University.

Every ward's different so you can't learn everything in university like orthopaedics for example, so I did have to read some more stuff on my own but in terms of recognising signs of deterioration and your observations...I feel like I learnt that well in university to be able to go out and take it onto practice. But you can't know everything, can you? You can't learn everything at uni. (Taylor)

It was difficult to isolate commonly agreed useful theoretical preparation in University as the NQNs were working in diverse employment settings, in different fields of nursing. There was some commonality in respect of broader concepts which the NQNs had helped to prepare them. Concepts such as professional practice, reflection and graduate skills, simulation and role play, interpersonal skills and communication had been useful preparation. These will be explored next.

#### **4.2.1 Professional practice, reflection and graduate skills**

Jules reflected on the usefulness of foundational study in relation to accountability and professional practice as an NQN.

The main thing was the sudden responsibility of, "Oh now if I do anything, I'm actually responsible for this patient". But I've realised now they prepared me well for that...about accountability, you've written essays upon essays...so I've realised that over the past three years I have thought a lot about accountability and responsibility. (Jules)

One respondent recognised that more attention could have been paid in lectures as a student but as an NQN appreciated in hindsight that there had been good preparation for understanding evidence-based, legal and professional aspects of work. The pressure of autonomous practice led to appreciation of better preparation than had initially realised.

There was a lot of stuff that I did that I know has been very beneficial...the accountability and understanding...the evidence-base behind it and knowing that...that's important, the legal side and the law. It feels once I've qualified and I've started working I understand that and appreciate that more rather than at the time I didn't really think I was learning anything, or I didn't really understand it. Whether it's just the pressure of working on my own and knowing that there's litigation possibilities. (Kit)

Brook became more objective and resilient about things, learned to keep emotions in check to deal with work colleagues better. Brook had delayed voicing an opinion would then get very emotive about it but has had to do some self-reflection in relation to own personality and reactions within a team. Learning to reflect as a student was identified as useful as this helped with resilience and coping as an NQN.

Reflection I think is a really important element because had I not learned how to properly reflect; I think I would have been a nervous wreck by now. All my experiences whenever things go wrong, or I make a mistake now I've learned to reflect on it rather than to beat myself up about it.

(Brook)

Jamie also found that reflection skills developed in University were useful in developing self-awareness and to improve practice.

I hated reflection...but it is a very, very useful tool and I do it all the time now and I find myself going home reflecting...I'm thinking about what's



happened that day, like an incident that day, so I'm thinking "how could that have gone better"? (Jamie)

Development of graduate skills using evidence-based practice was identified as important to inform practice and to be able to provide information for patients and relatives.

Evidence-based practice...everything that I do at the forefront of my mind is, "what is my evidence for doing this"? or "what is the evidence for doing that"?...because of Uni and exploring different areas I know where to go to get that evidence and what's reliable and what's not and sources and things like that. (Kit)

The assignments that we did, at some points you were "what's the relevance of this?"...until you're actually in the situation where parents were asking "how can we bond better with our baby"? and you think..."at Uni we researched this"...it helps you to have the underlying theory to back up what you're saying...When you're doing your degree, you don't think everything fits together until you're qualified. (Darryl)

Casey talked about being an enquiring learner and enjoyed independent exploration of topics, why things are done, and is helpful for knowing signs and symptoms of conditions and when to refer to other health professionals. Research skills and independent study were important for keeping practice evidence-based and current.

I've been qualified just a year now...I don't want to be that nurse that becomes stagnant and stale...because that's what people have always done and, you know, that fear has not left me...it doesn't plague me every day...but I'm always mindful and like "why am I doing this"? (Casey)

Summative assessment linking theory and practice was identified as particularly useful. A module and assessment on pharmacology theory required students to choose a patient in practice and explore interventions

(pharmacological and non-pharmacological). In one case a clear example was provided of the mentor (nurse) facilitating Wynne's access to a member of the wider team (pharmacist). This was illustrated in the coding and memo-writing in Section 3.6 (Figures 3.8 and 3.9). Jamie also referred to this helpful form of assessment linked to practice.

You had to pick a medication and then write what it does chemically, not just what it treats, in-depth about the side effects and then the contraindications...is there another medication that does the same without that effect that you could give? So that prepared me...a lot of the medications I was administering when I first started, I didn't know, I knew how to research them effectively rather than just look them up and see what they do. (Jamie)

Theory on leadership models had helped some NQNs with understanding of how to lead and delegate recognising that just having good 'people skills' may not be enough. The pre-qualifying survey had indicated that some expected to need support for management and delegation skills (Figures 4.6; 4.7). 34.9 % (n=22) felt competent to delegate but with support whilst 23.8% (15) assessed themselves as unsure or not competent (Figure. 4.6).

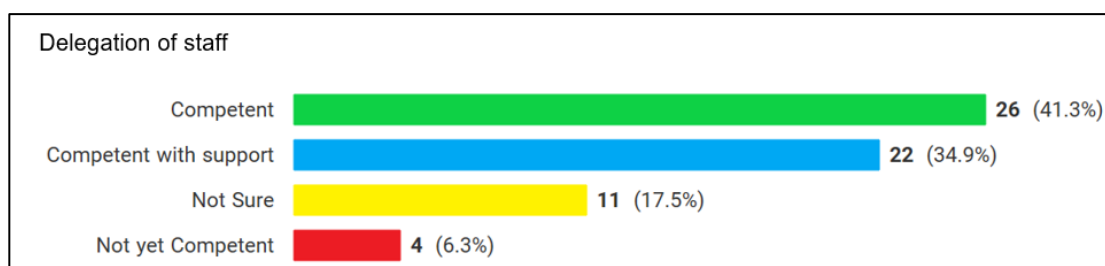


Figure 4.6 - Self-assessment of staff delegation

More respondents (57.1%, n=36) felt they needed more support for managing a team and 27% (n=17) were unsure or not competent on self-assessment (Figure.4.7).

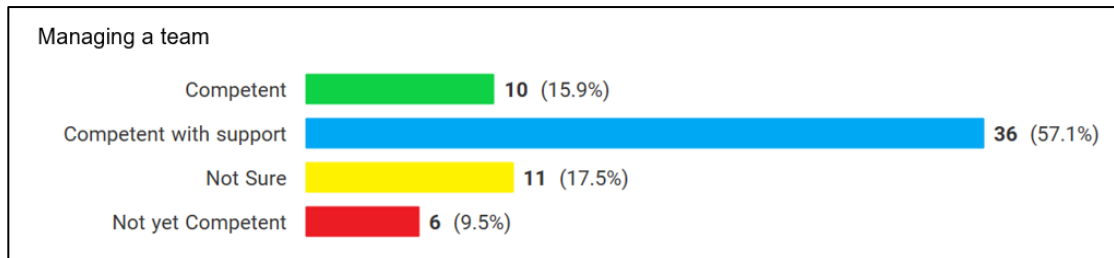


Figure 4.7 - Self-assessment of managing a team

As an NQN, studying leadership theory had helped Bailey in dealing with a 'fractured team' applying what had been learnt in relation to raising team morale.

Leadership stuff, that was really beneficial cos I'd like to think that I've got quite good people skills, but it doesn't always translate over into leadership skills, does it?...the unit that I went on when I first qualified it was quite fractured and about three months after my senior nurse...she said, "but everything seems to have kind of clicked together since you came"...the morale wasn't great for example and I made a conscious effort to raise that by making the staff know that we understand that they're important and just communicating that sort of thing and it lifted morale. (Bailey)

Jamie agreed and talked about still going back to the leadership module assignment to recap on leadership styles combined with reflection skills when things were not working.

You find yourself thinking about the words that you've heard at university at the time or the things that you've read. "OK well this approach didn't work; maybe I should take this approach" and I still go back to my assignment in leadership. (Jamie)

### 4.2.2 Interpersonal skills

This section explores perceptions of preparation for communication with co-workers, patients, service users<sup>5</sup> and their significant others. The tables below indicate that preparation for communication seemed well-covered in university. Prior to qualifying, the results from the cohort were very optimistic in self-assessments of competence. However, interviews with the NQNs highlighted difficult situations in which they felt not as well prepared as they thought. Figure 4.8 indicates that most of the pre-qualifying cohort (92%) felt competent in communication with patients/service users with a small number needing some support (6.3%). Only one respondent was unsure, and none deemed themselves to lack competence.

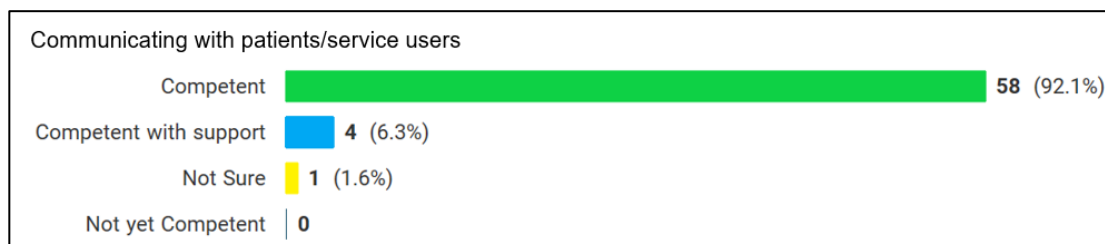


Figure 4.8 - Communication with patients or service users

Self-assessments of competence for communication with other health professionals and relatives/significant others were also very positive generating identical numbers (Figures 4.9; 4.10). 84.1% felt competent in both cases

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<sup>5</sup> Service user is a generic term for people accessing health and care services.

although 14.3% wanted some support. Again, only one student was unsure and none self-assessed as not competent.

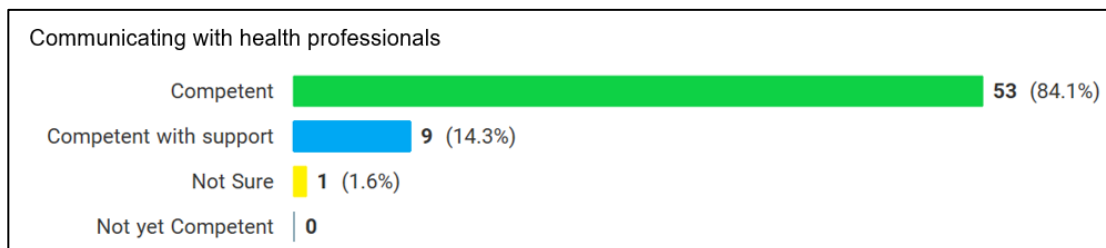


Figure 4.9 - Communication with health professionals

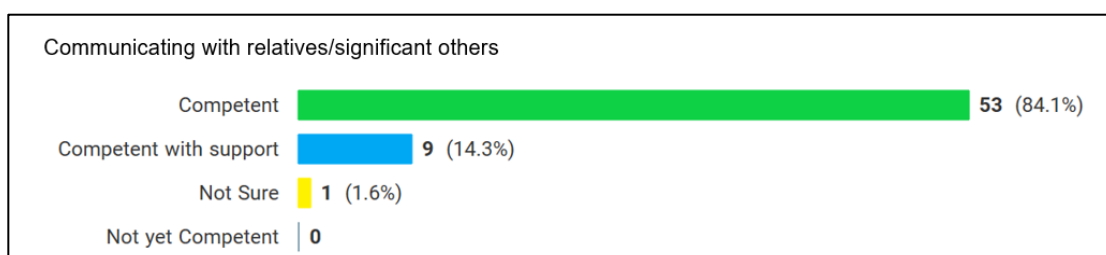


Figure 4.10 - Communication with relatives/significant others

As a student, Jamie remembered feeling irritated regarding the number of times communication had been included in the programme; but as an NQN, Jamie could see how well this had prepared them for practice.

I remember sitting in Uni thinking “oh we’re doing communication again. This is like the 6<sup>th</sup> time. I know how to communicate!” and at the time I didn’t feel like it was relevant to concentrate on it so many times but now I do recognise it and the importance of that. Even with patients with dementia that can’t communicate their needs...I pick up on what’s wrong without being told...So that skill was definitely taught at Uni with the intense communication modules and lectures that we had and then being able to do that in my placement as well. (Jamie)

Brook's interview as an NQN suggested that therapeutic relationships and communication were covered well in university but in hindsight did not feel there had been enough emphasis on difficult family situations and on the assessment of communications practice by mentors.

I've learned that there's a massive amount of communication that nurses need and need to understand. Like understanding family dynamics and that side of things, you're brought into the middle of massive domestic issues and you're having to deal with that, and I don't think that's reflected in the practice assessment documents sometimes. (Brook)

Learning about the person-centred approach in an interactive way to promote empathy was valued by Chris as it helped in a difficult situation with a mental health patient who was refusing medication. Other staff wanted the patient 'sectioned'<sup>6</sup>, but Chris had used interpersonal skills to approach the situation in a more person-centred way.

Person-centred care, you know, trying to listen to that person, trying to understand their needs...it's not a case of "they're just refusing their medication let's section them", it's a case of understanding why you're doing that...It could be a case where they don't know that particular medication, so you spend that time, a few more minutes explaining that medication in a way they understand it... then they're making a more informed decision. (Chris)

Similarly, family centred care was seen to be important by a children's nurse who was able to put it into practice as an NQN.

Well one of the biggest things they do teach in children's nursing is... basing your care around the child including the family in that care so not excluding them...keeping them up to date with all the information...family-centred care really is the core of children's nursing.

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<sup>6</sup> Sectioned: a person can be detained under the Mental Health Act (1983) and treated without their agreement (Legislation.gov.uk, 2019).

If you don't understand that you wouldn't be able to care for that child effectively...also to be able to apply it in your practice and that's another thing that my university really focussed on. (Ash)

One aspect of self-assessment in the pre-qualifying survey was that students felt less sure of their competence in relation to breaking bad news<sup>7</sup> (Figure.4.11). Only 19% (n=12) of the cohort felt competent in this area of practice with 38.1% (n=24) self-assessing as competent with support. This leaves several students (42.9%; n=27) feeling unsure or not competent in this aspect as they qualified.

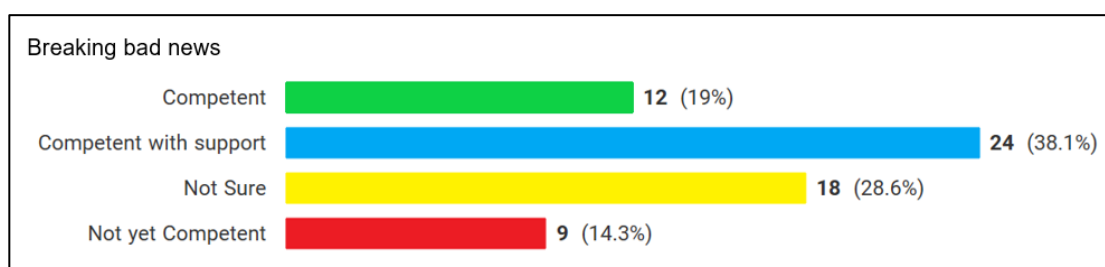


Figure 4.11 - Breaking bad news

The FGs with pre-qualifying students gave some examples which illustrated some of the difficulties, the first being fear of triggering own emotions.

I think breaking bad news is something that I'll always struggle with. I've been around dealing with people that have received bad news but I've never been obviously there to say "this is what it is" or to tell people that their family member has died or whatever it might be so I think that's something that I'll struggle with because I'm quite an emotional person anyway so I think it's hard for me to hold back my emotions. (FG2)

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<sup>7</sup> Bad news in medical terms is 'any information likely to alter drastically a patient's view of his or her future' Buckman (1984, p. 1597).

The next example is a fear of getting things wrong and causing further upset. One student was with a patient who died but as a student was not allowed to verify death. The situation also affected the student's emotional health for some time.

I was quite aware that it was probably time...so I just said "I'm just going to go and get my mentor and then we'll come in together and we can make the assessment" but as I was going out, one of them grabbed me and said "did you feel anything"? because they saw me doing the pulse and I couldn't lie...so I said "there was something, but I want to make sure"...so I went to get my mentor and then she confirmed when we were in the room... I didn't sleep for days after because I thought "have I said the totally wrong thing and upset them? have I given them false hope in saying that I felt something"? And it really sat on me and my mentor was really good with it actually. (FG1)

Breaking bad news is an aspect of communication that students in this study were not encouraged to practice. This creates a tension in relation to linking theory and practice in preparation for having to do this as an NQN.

I've never had to break bad news. I've been there, I've witnessed things being told. A lot of the time they don't like a student nurse hovering around when they're telling somebody some bad news. (FG3)

Darryl provided perspective on this as an NQN recognising that even observation of difficult communications had been denied as a student.

I think that would be beneficial if you...went with the nurse, I feel that would be more helpful, or being in situations where you've got child protection cases. I think students are steered away from that quite a lot because it can be quite emotional or when you suspect a family of a non-accidental injury. The students are sort of protected...whereas as a newly qualified nurse you're expected to deal with that and you feel like "oh my gosh, what do I do"? I think, even if you didn't do anything as a student, apart from watched, I feel like that would be helpful. (Darryl)



Communication in relation to mental health issues, attempted suicide and drug misuse was raised as something which could have been enhanced in the adult nursing programme.

I think in particular mental health...I didn't realise from the placements how apparent drug use was, you know like suicidal patients...that surprised me how much mental health is an issue with my speciality being cardiology. I hadn't realised naively how much other stuff there would be, and we do get a lot of cardiac arrests or whatever after drug use...the communication and knowing what support could be on offer and I think being a bit more aware of the different avenues would have helped. (Rowan)

A mental health nurse working in a community crisis team suggested more was needed on suicide (threat) and how to respond to someone who says they are going to kill themselves.

I think personally from a mental health perspective we didn't get that much suicide training and that's a massive part of my role and a lot of my friends as well who are staff nurses on a ward and things like that. (Eden)

Interprofessional group learning at University was mentioned by some as useful for understanding other professions and how they work together to benefit the patient and could help to avoid inappropriate referral.

Inter-professional ones, I liked them. It's interesting, you think you know what other professions do when you've got no idea actually...I was completely wrong with what I thought an occupational therapist did. I liked that cos you got to understand each other's roles and how it all works to help the patient...It's helped me in my practice after qualifying just knowing what their role is cos sometimes you can make an inappropriate referral...but if you know what they're doing you can refer correctly and get the patient the help. (Drew)

Jules recognised the value of groupwork in university sessions where there was no choice of which group one was allocated to and the value of this in preparing for team-working in the workplace as well as dealing with difficult people.

I think Uni prepared me very well...we had class discussions where we would get put into groups that we didn't choose and the lecturers would tell us "there's no point complaining because the whole point of putting you with people you don't know is that it causes conflict, you just have to learn to deal with it, cos when you go into work you're not going to like everyone"...so that really prepared me for the real world, cos there's some characters out there! (Jules)

#### 4.2.3 Simulation and role play

The use of simulation and role play was valued by some, but others had mixed feelings. The interviews highlighted that some appreciated the use of simulation in hindsight, recognising that it was a safe way to 'make mistakes' Figure 4.12 indicates that prior to qualifying, 79.3% of the cohort agreed or strongly agreed that simulation had prepared them for working as an RN (n=50). A small percentage were unsure (11.1%) and 9.5% disagreed that simulation had been useful.

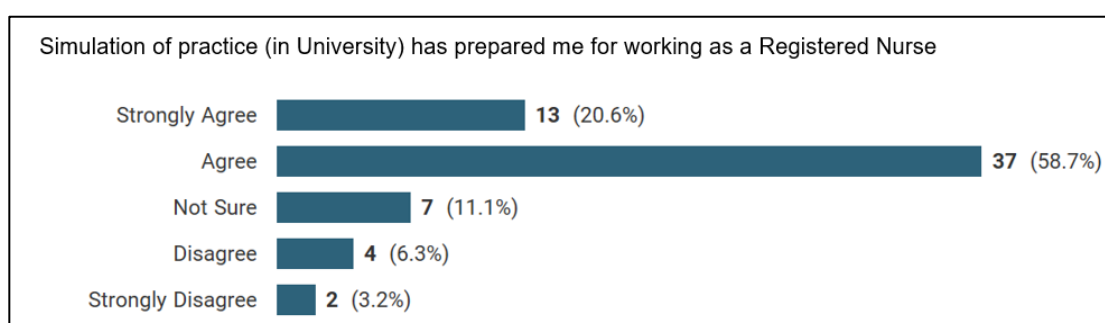


Figure 4.12 - Practice simulation and preparation to work as an RN

Some FG and individual interview respondents valued practical sessions over academic input. The use of simulation in the final year to revisit and practice skills and emergency situations was helpful in building confidence, being able to work together, and practice calling for help in emergencies.

One area that I've found really helpful...is the fake ward set up, the simulation. The idea of it, as a first year, is terrifying and it's like "oh I don't want to do that". "It's not the same as normal practice". "How can you possibly pretend"? But actually doing it as third years and the layout of the wards, the setup of it was absolutely fantastic...I was more comfortable than I thought I would be...it's a really safe opportunity to make those mistakes. (FG1)

Wynne found simulation in the final year was helpful, not just for developing own practice but also observing peers with theirs.

One of the best single things that we had was about twenty minutes to do one set of simulations in the pretend ward...one thing I loved about that was actually observing, cos we had two or three sessions and we observed the other sessions, you know, the rest of the group doing the session...and thought, "oh my God, you're nurses. You're really nurses...Everyone's got something to say here". And even though everyone was quaking with nerves cos you do feel stupid doing role plays, that was really helpful. (Wynne)

Some did not like doing simulation or role play whilst recognising that it was a safe place to make mistakes.

The role play that we did I used to hate it, but I could totally see the benefit because I think I remember one of the tutors had said it's a safe place to make mistakes and it completely was. So, although I didn't particularly enjoy doing that, I know that it was really beneficial, and it did help me in the long run. (Kit)

Ash had negative feelings about simulation as a student and had 'backed off' for fear of getting it wrong in front of lecturers and peers. But Ash's views had

changed as an NQN and enjoys simulation in post-qualifying simulation events. The simulation work at University helped to prepare for post-qualifying training for more advanced life support courses as more meaning was gained from the training having covered basics as a student. Simulation and role play were viewed as good facilitation of decision-making practice.

When it came to things like practice study days... doing things with a dummy as a group, or you were doing active learning like that and it was “well this is your patient; what would you do”?...It used to scare me because I always used to think “but what if I make the wrong decision”?... I always used to look very negatively whereas now when I go to study days in a similar type of environment, I almost thrive in them because you know that you’re in that situation; it’s a completely safe situation; you’re not going to harm anyone by doing it...so although those situations do put me under a bit of pressure, I learn the most from them. (Ash)

Wynne suggested that more role play should have taken place in relation to dealing with difficult staff.

I think there should have been more open discussion really and more practice, perhaps in role play about interactions with other staff because some of the time, I’ve had to learn the hardest possible way...I think it would have been really helpful to have a chance to talk about and role play how you can manage when people are being really snidey and aggressive and horrible to you...a lot of people go to work with loads of agenda, and it’s a thing...I think a little more recognition of the interpersonal and psychological aspects would be very helpful. (Wynne)

### **4.3 Summary**

Most of the students felt that the educational programme content helped to prepare them as NQNs. Graduate skills such as evidence-based practice and reflection skills were recognised as transferable and valuable for problem-

solving new encounters. Good alignment of summative assessment with practice placements helped theory-practice alignment. Professional practice theory, interprofessional learning, interpersonal skills training and simulation or role-play were also recognised as very useful. Situations in which they felt less prepared were in dealing with more difficult and challenging communication episodes with patients, families and other professionals. Not all specialisms could be included in the curriculum with some students not always seeing the relevance of the subjects taught.

## **Chapter 5: Learning to Practise**

### **5.1 Introduction**

Placement and workplace communities provide crucial contexts for learning to practise as a fully-fledged RN. The previous section discussed some identified theoretical components for practice preparation. In reality, nursing theory and practice is so entwined it is difficult to extract and discuss placement practice elements of the educational programme in isolation and is only attempted separately here for the purposes of presenting the findings.

This section will present the theme of learning to practise in two main settings: (1) placements undertaken as a student and (2) in the workplace during the first few months as an NQN. Key sub-themes include the following: student placement learning and perspectives on mentorship; perspectives on preceptorship; workplace cultures and working with others.

### **5.2 Student Placement Learning**

Students nurses must complete 2300 hours of assessed practice during the programme of study (NMC, 2010; 2018c). The online survey with the pre-qualifying students indicated perceived positive self-assessment of competent clinical practice at the right level for independent working (Figure 5.1). 76.2% (n=48) agreed or strongly agreed that they were functioning at the correct level of clinical competence. However, this left 14.3% (n=9) unsure and 9.5% (n=6) disagreed that they felt competent.

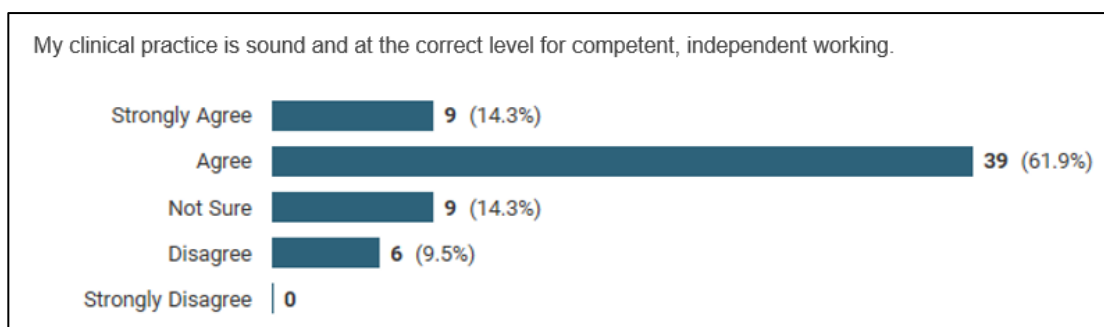


Figure 5.1 - Clinical practice and self-assessment of competent, independent working

Figure 5.2 indicates that 70.2% (n=48) of participants agreed or strongly agreed that their student placements prepared them to work as an RN whilst 22.2% felt unsure or disagreed with one student strongly disagreeing.

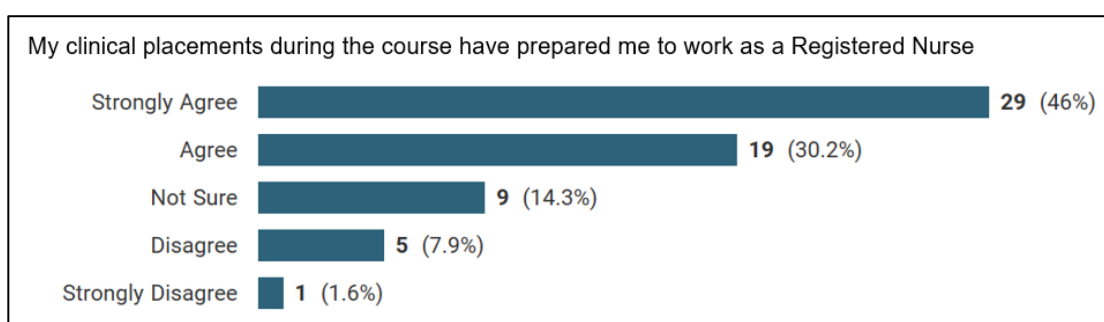


Figure 5.2 - Practice placements and preparation to work as an RN

Most participants valued the placements they undertook as preparation for the RN role. Clarificatory comments provided by 13 students in the survey who were unsure about preparedness for practice stated lack of opportunity to practise certain skills; lack of confidence with need to seek support and reassurance; and an unequal balance of placement specialisms and opportunities.

Placement experiences were generally valued as preparation for being an NQN, providing breadth of experiences across specialist and generalist settings, and across patient pathways.

I had a really good experience whilst I was a student and one thing that I think really helped was I had a breadth of experience...I was able to have that broad understanding regardless of where I worked...you have patients who go from community to acute, other way round, social care. (Brook)

Ash had moved away, working in a setting with NQNs from different universities. Ash felt prepared regarding family-centred care, general children's nursing and implementing safeguarding. Ash explained how different placements influenced the content of learning preparing for being an NQN.

As a student, sometimes it's the experience that you get...and what kind of placements you get so where I was more general and you got to see a lot of different conditions, whereas some of the people I now work with went to a specific ward, so say neuro or cardiac and they got to learn absolutely heaps about cardiac or neuro whereas I learnt more about general conditions. (Ash)

Ash therefore felt better prepared to function well on a general ward rather than a specialist setting. Rowan appreciated the value of community focused placements, but this led to feeling less prepared to work as an NQN in an acute setting.

Amazing staff and they were so experienced, and I picked up a lot of stuff particularly like communication side of things was brilliant from the district nurses and I just sort of got as much as I could from it but it didn't set me up for how fast-paced and everything where I work is. (Rowan)

Drew's NQN role was in an acute medical unit whereas placement experiences had been more surgery focused



I felt prepared in the sense of communication-wise and being able to speak to patients and the kind of holistic side of things but from the physiological side... medicine and that kind of side I didn't feel that prepared...I had mostly surgical placements and I went to a medical assessment unit, so I didn't feel as prepared. (Drew)

The generalist preparation and placement experience leaves NQNs feeling unprepared for specialist roles, but also some placement experience minimises opportunities to practise important skills such as medication administration.

My placements meant that I didn't get many medication rounds but some of my friends didn't get them because their mentor wasn't either confident enough in themselves or didn't have the time, so I guess it just depends as well your experience. (Rowan)

The final placement as a student was important with some referring to it as the 'management' placement being able to manage under supervision.

I felt quite prepared...a big contributor to that as well was on my final placement I was essentially treated like a nurse, they let me do everything that they were doing...they respected the answers that I gave and I felt so much more confident after that final placement because I felt like I'd been doing it already. (Bailey)

Eden suggested that more emphasis should be made on students pushing for learning opportunities on placement and avoid 'coasting' and provided a good example of one nurse making the student lead a mental health assessment. The following quote also contains a comparison of two different approaches of placement staff as mediators of learning.

Sometimes it's a little bit easy to coast ...the only thing I'd maybe change is I want to put myself forward a bit more because it's over really quickly and by the time you get settled in you're leaving...my last one was a nurse that I did a few assessments with and he wasn't my mentor...for a couple of assessments I sat in with her [mentor] and she did the

assessments and I did the notes, but then when I went in with him he went, “right you can just lead this assessment”...that’s what you need really. (Eden)

Students had to be proactive at times to develop skills as placements were not always appropriate for the experience required. Casey suggested that all LD students should do a physical care placement such as a nursing home to be able to practise medications and physical care.

There wasn’t a lot of placements where you practised physical health...I did find my own opportunities on placements...if I was on a Hub<sup>8</sup> placement, where there wasn’t opportunity to practise those skills, I’d look for Spoke placements...I went to a Nursing Home to practise medication administration and blood pressures...but when you’re on a Hub placement you don’t want to take too much time out of that placement because your mentor is the person that’s assessing you and signing you off...the competencies that I’m there to achieve so it’s trying to get that balance. (Casey)

This identifies a tension regarding a need to move away from the assessed placement to access skills practice, but this means the student may have their assessed practice compromised. Darryl identified another tension in relation to not being allowed to work with more complex cases as a student but then the expectation that the NQN can then deal with them. In cases like this the mentors or nurses appear as ‘gatekeepers’ of learning episodes and sometimes not recognising the importance of students learning to deal with difficult situations.

The nurses on the ward would be “oh I don’t whether this is appropriate for a student” or if there was a complex-needs child and then they’d be “oh we’ll take this one because we know them”...it would have been

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<sup>8</sup> Hub and spoke model: nursing students are allocated to a placement (hub) and also formally supported by their mentor to work in other settings (spokes) with other professionals.

beneficial, as a student, to be put in that situation...but then they'd expect a newly qualified to do that...on our final placement; between that and being a qualified nurse, it's two or three months and I don't know how they expect you to learn that, if they don't put you in that situation at the beginning...on that placement. (Darryl)

The pre-qualifying survey had also indicated that only 6.3% (n=4) felt fully competent to manage complex cases with 73% (n=46) feeling competent with support. This meant that 20.6% (n=13) felt unsure or not competent in this area of practice.

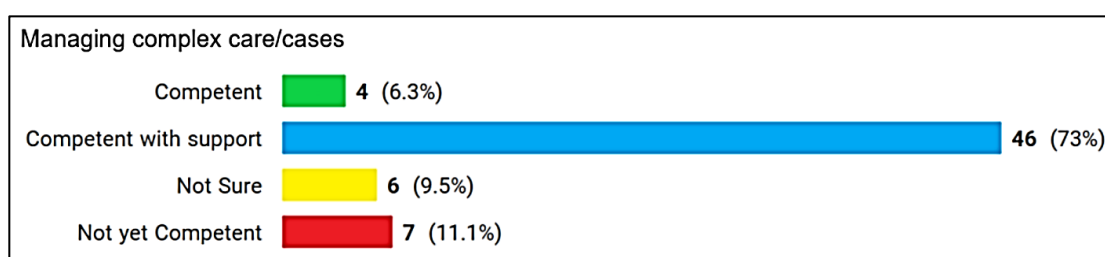


Figure 5.3 - Self-assessment of managing complex care

Whilst there are positive examples of learning, based on the NQN accounts I would suggest that some needed more practice and develop confidence in dealing with complex needs, and can be somewhat shielded from these. In other examples, full skills sets are not available to enable practice on all placements. Therefore, students have to balance time away from the 'hub' placement to gain skills practice versus time to demonstrate assessed competence.

This section has identified various aspects of placement learning in communities of practice. During placements students are undertaking periods of 'legitimate peripheral participation' (Lave and Wenger, 1991, p. 29) where

‘peripherality provides an approximation of full participation that gives exposure to actual practice’ (Wenger, 1998, p. 100). This can include close supervision and less risk but rather than just observation, students need to access all three dimensions of a CoP: mutual engagement with members; accountability to the enterprise; and negotiate the joint repertoire meaningfully to open up practice (Wenger, 1998). Based on the experiences highlighted here, it would seem that peripheral participation took place but access for students to the full repertoire of CoPs is less likely than for NQNs.

### **5.2.1 Perspectives on Mentorship**

Mentorship for nursing students as required by the NMC (2008) was introduced in 1.4.1. During FGs participants referred to their mentors on several occasions with examples of both positive and negative experiences. Mentors appear as important mediators of practice learning as one of ‘multiple mediations in activity’ (Engeström 2008, p. 26). Nursing students recognise the legitimacy of mentors as assessors of practice (Wenger, 1998), but they have expectations of them too. These include good communication, a positive working relationship and good role modelling.

Chris provided examples of good mentoring or ‘brokering’ (Wenger, 1998) from both second year and final year placements and referred to good practice as ‘prompting and fostering’ by asking questions based around real patient care practices.

What I’ve found was very helpful in my practice was my 2nd year placement...it was very much partnership and the mentor...”We’re going

to be doing an assessment. So, we'll do this jointly" and she goes at the end "OK what's your thoughts on this? What's your opinion...Is there something we can do with this?" So that prompting and fostering in a sense. (FG1)

On the final placement, competence was assessed by checking skills and knowledge as well as asking Chris to research subjects to strengthen knowledge base.

On my final placement my mentor was far more involved...they made sure all my skills were adequate...asking questions... they sent me away with homework to make sure I was at a competency level where they felt very satisfied that, once I left and graduated to practice, I was able to perform as expected as a nurse (FG1)

On Drew's final placement the mentor allowed Drew to manage care without direct instruction allowing Drew to practice decision-making whilst allowing time for discussion, feedback and encouragement.

I've been given a group of patients to look after and my mentor's been really helpful and she's just said 'right, these are yours, so you do what you need to do' and we regroup every couple of hours and she'll say "right what have you done? Why have you done it?"...It's helped me to trigger if I've forgotten things or if there's things I've not thought about and she'll say "that's the right thing to do; you've done that really well" so I think that's helped. (FG2)

Constructive feedback with time to practise is important and when appreciated can aid learning and improve practice.

I think you have to get thrown into the deep end at some point and just learn how to do it and have someone there that is going to support you and not knock you down if you do fall flat on your face...my mentor came out and gave me a lot of really useful feedback which I took on board and then she helped me to then do more sessions and improve upon what I was lacking. (FG2)

Brook and Chris recognised the influence of mentors as role-models in the development of values for practice.

I think one of the things I've really developed is actually my own values, what I value in a nurse and what I think a nurse should be and I've learnt that through mentors in practices where they practice in a way that I wouldn't, or practice in a way that I would. (FG1)

Chris recounted a memorable experience at the individual interview as an NQN that had influenced thoughts about own practice aspirations as a student. The mentor had taken a phone call at the end of a shift from a person with mental health problems and visited the person even though it meant working late.

That made a massive difference cos this person, even though the situation sounded OK, the situation he was really in was actually really, really bad... It is about the people we look after...I mean that's kind of why I want to go into nursing. I want to help people... At the end of the day it's not clocking off. I hope I never get to that stage where it's about clocking off. (Chris)

Mentors and other team members can facilitate the development of confidence.

My confidence has grown...I've just come on leaps and bounds in this placement...the support that I'm getting from the staff is amazing...They've given me feedback from my work so I feel like I've really developed at this placement...looking back, my confidence was pretty low but I'm now able to lead on people's care and lead on the sessions and lead on the paperwork and then talk to other members of the multi-disciplinary team, whereas beforehand I don't think I would have had the confidence to do that. (FG2)

In Bailey's experience it was difficult to feel part of the team or CoP until the named mentor was on duty indicating a mentor role in making a student welcome and inducting them into the workplace.

I felt very much in the way but once my mentor came off nights it's just been really great...I don't think they noticed how unwelcome they'd made me feel...just made me more determined to be involved in everything...I'd just sit down and go "what are you doing?" and you know forcing myself on people. (FG2)

Sometimes students had negative experiences of mentors. Kit provided an interesting example of having two very contrasting mentors. Mentors sometimes share the assessment of students. This might be because they work part-time, and the managers of placements allocate two mentors to ensure the student receives the expected 40% of time (NMC, 2008) working with the student.

If I had an opinion on something or a particular dressing that I think should have been used, I would go to which ever mentor I was with and give my opinion on and rationale as to what I think that should be...one mentor would discuss that with me and if I was right, then that was brilliant and we'd go over the reasons...whereas the lackadaisical type of mentor she'll just shut me down really and if I have got it wrong it'll just be "no that's wrong; do this". And there's just no discussion and there's no teaching involved which is such a shame because I know that she's very knowledgeable and very good...it's so funny having two completely different mentors and the effects that actually has on one person. (FG1)

This situation meant that daily practice and learning opportunities, or lack of them, were conflicted and had to be negotiated and managed according to which mentor was available at that time. Eden also recognised the impact of differing mentor styles on learning opportunities.

It depends on your mentor because some of them...they know when to push you and when to question you and when to get you to make your own decisions which makes you autonomous but there's some...you do end up coasting a little bit and maybe getting lost a little. (FG3)

Wynne's example of poor mentorship was being micro-managed over perceived basic skills and practice.

One of my mentors, has literally hung over my shoulder all the time when I'm filling in admissions on the computer which just makes me want to scream because I think, you know, I'm going to be finished in three weeks...in some of the basic things I can manage and sometimes people undermine you. (FG1)

This section has provided some of the participants' experiences of mentorship. Experiences were mostly positive highlighting qualities of good 'brokering' or facilitation of practice learning. Mentors induct students into a CoP and aid positive working relationships with the wider team. They can instil confidence by enabling decision-making experiences, asking questions to probe and foster learning. Good role models can influence values for good practice. Poor practices include the shutting down of learning opportunities, allowing students to 'coast' without a sense of direction and undermining confidence by micro-managing and creating frustration.



### **5.3 Preceptorship and the Newly Qualified Nurse**

This section explores the NQNs' experiences during the first year of RN practice. It discusses general findings in relation to the mixed experiences of the NQNs as well as providing some descriptive comparisons of employers' approaches and support for preceptorship and transition. As detailed in 1.4.2 and 2.3.2, preceptorship is the recommended process for a structured transition and support for NQNs in the UK. Although the original research questions did not specifically seek to explore preceptorship, the participants discussed their experiences at length in response to general questions about how the first six months had progressed, and what support they needed or received. Their differing experiences of preceptorship and cultures of workplace settings were important sub-themes in relation to their transition to autonomous practice. The next discussion includes the following elements: perspectives on preceptorship; supportive preceptorships; well-intentioned preceptorships; problem preceptorships and workplace support cultures.

#### **5.3.1 Perspectives on preceptorship**

The NQNs experienced mixed levels of support and development opportunities. Some provided examples of excellent preceptorship and good experiences of advanced skills development, but few mentioned emotional or pastoral support. Table 5.1 summarises first destination posts of the NQNs to either NHS Trusts or to private, independent, voluntary organisations (PIVOs) in relation to prior placement experiences and shows there were 11 different employers for 15 NQNs. This makes it difficult to ascertain any consistency of approaches for particular employers. Only 4 students returned to work in previous placements.

1 <sup>st</sup> Destination Posts	Placement Experiences
Trust A Trust B Trust C PIVO 3	Participants had spent time in the setting as a student nurse placement prior to employment.
Trust V Trust W Trust X Trust Y PIVO 1	Participants moved to a new geographical area to work in a setting they had not attended on placement.
PIVO 2 PIVO 4	Participants returned to employers as a RN where they had previously worked as care support worker (CSW).

Table 5.1 First destination posts in relation to student placement experiences.

Table 5.2 indicates that there are both positive and negative experiences across different employers as well as within the same Trust and provides a summary of the differing experiences of preceptorship support for the NQNs. Out of 15 participants, only Ash and Kit appeared to have had a comprehensive, well-structured, and supportive preceptorship from beginning employment. Darryl and Jules had difficult first experiences with no support but had received much better support when they moved to new jobs within the first 6 months of qualifying. Bailey and Casey had no formal preceptorship or identified preceptor but found ways of seeking out support. The remaining participants were provided with training days and a portfolio usually in the form of a skills or training inventory. In these cases, there appeared to be good intentions of support provision but there were problems with finding time to attend the

training days or being able to spend time with a preceptor who often worked different days and shifts to the NQN (Table 5.2).

Name	Employer	Preceptorship Experience Summary
Brook	Trust A	Preceptorship portfolio provided, and manager-led appraisal. No formal notification of named preceptor.
Drew	Trust A	Preceptorship portfolio provided, and manager-led appraisal. No formal notification of named preceptor.
Jamie	Trust A	Preceptorship portfolio provided, but no preceptor. Preceptor was identified but did not respond to requests to meet.
Wynne	Trust A	Induction, preceptorship portfolio provided with training days. Preceptor identified but worked different shifts so difficult to meet.
Linden	Trust B	Preceptor programme and portfolio. Preceptor identified but worked different shifts so difficult to meet and could not always get to the formal training sessions.
Taylor	Trust B	Preceptor programme and portfolio. Preceptor identified but worked different shifts so difficult to meet.
Eden	Trust C	Preceptor programme and portfolio. Preceptor identified and met with Eden but there were support problems in relation to conflicting relationships in the workplace.
Ash	Trust U	Preceptor programme, portfolio and monthly supportive meetings with preceptor.
Rowan	Trust V	Preceptor programme – preceptor but not met up nor worked together much.
Darryl	Trust W	<i>1<sup>st</sup> experience</i> – a difficult time with a short induction then no formal preceptorship programme or identified preceptor.
	Trust A	<i>2<sup>nd</sup> experience</i> - preceptor programme, portfolio and supportive meetings with preceptor.
Chris	Trust X	Preceptor portfolio and preceptor identified but worked different shifts so difficult to meet.
Jules	Trust Y	<i>1<sup>st</sup> experience</i> - only stayed 1 month. Made to feel very unwelcome
	PIVO 1	<i>2<sup>nd</sup> experience</i> - a better experience here but did not identify preceptorship or support experience
	Trust Z	<i>3<sup>rd</sup> experience</i> - preceptor programme, portfolio and supportive meetings with preceptor.
Bailey	PIVO 2	Induction week of training days – no preceptorship portfolio or preceptor but had a colleague used as an informal mentor.
Kit	PIVO 3	Preceptor programme, portfolio and supportive meetings with preceptor. Strong support provided by other team members.
Casey	PIVO 4	No formal preceptorship until Casey asked for support (after 4 months).

Table 5.2 Varied experiences of preceptorship provision

In the pre-qualifying survey and in FGs there had been expectations for preceptorships as NQNs. Below is an example from additional comments when asked if they felt ready to work as an RN.

I am not altogether sure what is expected of me as a qualified nurse. however, I have faith that preceptorship will help me to overcome this confusion. (LD Student; Online Survey)

During the FGs the students were asked if they had any particular concerns about working as an RN and some participants specifically mentioned preceptorship. Eden was scared about additional accountability and had expectation that a good preceptor would provide some support.

It's just once that protective layer of being a student's taken away it's on me and a lot of people have said it will depend on your preceptorship, so if you get a really good preceptorship you're fine...it comes down to the fact that if I do something wrong somebody could die...and that's scary. (FG3)

Kit was going to work in a General Practitioner (GP) setting as a practice nurse which at the time was an uncommon choice of first destination nursing work. This created anxiety of having to carry out unfamiliar procedures and was happy that they were creating preceptorship support.

Because of the area that I'm going into, there's a lot of additional training that I'm going to need...they're developing a preceptorship that's going to be in place...there'll be shadowing opportunities and they won't just throw me in a room, close the door and say "off you go". So, I'm confident that I'll be OK but it's just that apprehension of how it's actually going to work. (FG1)

Linden had a more cynical view based on observations made as a student although there was recognition that there were plans to improve the preceptorship programme at the proposed work setting.

I know fine well that the area I'm going on that I'm not going to get a preceptorship...we've had people coming saying "you are going to get a preceptorship" and you get the people that have been qualified just coming up a year...one yesterday said "you won't" get it. I never got it"...I think that's one of the main concerns...I've seen with my own eyes, that they've just got left to get on with it because of staffing, busyness of the wards. (FG3)

During the later NQN interviews Brook reflected back on employer recruitment strategies and promises of training 'booklets' but working as an NQN more pastoral support was what was needed.

I remember the pressure that there was when we were doing the recruitment and they would say: "you know we've got this booklet and you do this and we've got this checklist for you", and then when I actually got into practice I remember thinking: I don't really want a booklet, I want a person stood by me supporting me; and I think that's where it's going wrong, is like there's this big package that they offer but the package doesn't include having practical support, that's the difference. (Brook)

Drew was given to believe that formal timetabled training would be given in the preceptorship but in reality, had just had people from departments talking to them and had to sign up independently for any additional skills training.

You do get kind of sold this package of "you get this done, you get this done"...and then we've not heard anything since. I was thinking we'd be able to go off and do our IV course, taking bloods and study days and we've just not...I've had to do it all myself and book onto stuff myself. (Drew)

Eden remembered cynical views on preceptorship from being a student on placement. In one setting preceptorship was a running joke amongst NQNs as non-existent, and also seen as a tool to get 'signed off' to be able to work

independently and as a 'tick box' exercise to be done. This seems to be about employer needs rather than working at the pace of the NQN.

She said to the newly qualified who must have been qualified about five months...because if they hadn't been signed off the preceptorship they weren't allowed to be left on their own. "We need that signed off so you can be left on your own", and it was seen as a tick box. (Eden)

In summary, students expected transition issues but had hopes of preceptorship being a support mechanism once qualified whilst others were more cynical based on experiences of others. The next two sections recognise that there were positive experiences of preceptorship as well as well-intentioned preceptorship that were mostly good practice.

### **5.3.2 Supportive preceptorship**

Some participants were able to articulate what constituted supportive preceptorship. Ash had moved away and was very positive about the support received as an NQN. This consisted of a 12-month preceptorship with an identified preceptor as well as an independent training reviewer checking that preceptorships were implemented. This employer provided training in more advanced skills and was focused on continuing professional development and appraisal. The preceptor was very approachable and worked with Ash on every shift at first, which Ash feels helped them to 'connect' and build a relationship. The preceptor in this case had an active approach, asking questions and checking Ash's feelings generally and about procedures:

"How are you doing?" "Is everything going OK?" "Is there anything you've found that kind of confused you or you didn't understand?" and she would go through it all with me and especially in the first couple of weeks she did a lot of training and I was on every single shift with her so

it made that connection a bit easier...I felt like I was able to talk to her about things. (Ash)

Although Ash referred to the preceptorship *package* as a 'tick box' exercise, this was not a problem as Ash was happy to check off skills and procedures because more formal meetings were not needed to talk about feelings due to the ongoing communication between the two of them:

I think the reason for me feeling like they seem like a tick box exercise is because I regularly meet up with my mentor, more in a casual kind of way rather than a formal way and we discuss everything then...I don't feel like I need the meetings to be able to talk to her. (Ash)

Kit had a good experience of being supported in a GP setting and was provided with a preceptorship programme, skills portfolio and regular meetings with the lead nurse. Kit was closely supervised in the development of skills required in this autonomous role and sought help from all the supportive team members if unsure or not confident, not wanting to put patients at risk.

If I needed to ask a question they were there...but I knew I could knock on the next door. The lead nurse who is kind of my preceptor...we've had...fairly set regular kind of catch up meetings with each other to make sure that I'm happy with what I'm doing, she's happy with what I'm doing...it was just having somebody to kind of reaffirm that was all OK. (Kit)

Darryl changed jobs after a difficult first three months working away but had a positive experience of preceptorship after moving back to the NHS Trust experienced as a student.

I have a preceptor and then we've got a book that we fill in if they think that you're competent...and then the appraisal that we did was with the Ward Manager so we talked about things that were going good and then things that were not so good and then we've set goals for the future, it's nice that people take an interest. (Darryl)

To summarise, the more successful preceptorships include a recognised preceptorship 'package' or programme with an identified period of support. The programmes outlined include induction and training days, an inventory or means of recording progress but the most important aspect appears to be the human factor in the form of relationships plus approachability of the preceptor and other team members as well as time for one-to-one meetings to discuss progress. As identified in 1.4.2 there are no professional body or national requirements on preceptorships or preceptor training by which to measure or compare these experiences.

### **5.3.3 Well-intentioned preceptorship**

This section explores experiences of the participants who were provided with preceptorship programmes by employers consisting of a variety of inductions, skills training, and portfolio records and 'sign-offs'. These provisions were probably well-intentioned but not always fully supportive for the NQNs. The problems were mainly caused by staffing and workload issues.

Taylor was provided with a preceptorship programme but had not met with the preceptor at all in the first six months, working opposite shifts so there had been no time to meet. However, Taylor was very positive feeling lucky to be well supported by the staff, the manager, and the matron who Taylor could approach if help or advice was needed for specific issues.

The preceptorship programme is good we are learning a great deal but I don't think I've met with my preceptor once since I started preceptorship...you get a massive pack to fill out with interviews and all this and you think, "I haven't got time to go to the toilet when I'm at work,



there's no chance I can sit and do an interview with my preceptor"...I hoped that preceptorship would have an element of taking you to one side an hour a week and saying: "How are you feeling"? (Taylor)

Taylor also suggested that the preceptorship programme mostly repeated much of what was studied at University and expressed frustration at this.

Drew had an approachable ward manager who provided support, advice and performed formal review meetings on the first day, end of the first week, first month then at a six-month appraisal. Drew assumed this was the preceptorship as there was no formal communication naming a preceptor. Drew had been informed at induction that there would be regular meetings with people running preceptorships regarding progress, but this never happened. Drew had no concerns but did not know who to go to if there had been any.

I've never actually had a preceptor...unless it just wasn't communicated to me that it is my ward manager...I've spoken to her about stuff anyway...It doesn't bother me cos I don't feel like I've got anything or any concerns that I need to raise with them...if I felt like I did have concerns then I don't know who I would go to outside of my ward to speak to. (Drew)

Wynne did not have a formal preceptorship but described the first two weeks at the start of employment positively comprising of an induction, information-giving and practical training. Wynne was allocated two part-time preceptors, but they all worked different shifts and nights so did not work together. Even if they had, workload meant that they could not find the time to meet and discuss issues.

Some planned clinical supervision<sup>9</sup> was cancelled which would be a helpful process to have and it was never rescheduled.

I was meant to have clinical supervision; it was scheduled for when I was on annual leave and there's been no further discussion of it. I think clinical supervision would be very valuable and I think it would also be a good way for newly qualified nurses to feel they were sort of marking their transition. (Wynne)

The value of clinical supervision was highlighted in Horsburgh and Ross' (2013) study as a positive influence on job satisfaction and a helpful strategy in supporting NQNs in adjusting to the transition.

Eden had a different experience with a potentially good preceptorship programme, with an identified preceptor but relationships were problematic. Eden generally felt unsupported in development and believed had been bullied by a non-qualified member of staff. Eden's preceptor was friendly with the alleged perpetrator, so was not believed and then felt compromised in the preceptor relationship.

My preceptor is actually best friends with the person that was bullying me so yeah. I did have a decent relationship with her at first, and she is my supervisor as well, so now we're going through a process where I've requested to swap. (Eden)

Chris had moved to a different country and experienced a difficult time at first and felt isolated and homesick. Chris had been confident on qualifying but

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<sup>9</sup> 'Clinical supervision' is a term recognised in nursing denoting non-mandatory, protected time for facilitated reflection on complex issues arising in clinical practice facilitated by an experienced critical friend (Bond and Holland, 2011).

became insecure due to untoward experiences (see chapter 6). Chris suggested that at the point of qualification, one is a competent 'expert' student nurse but within a week became a 'novice' NQN and needed help. Chris remarked that preceptorship is meant to provide help in transition and that university lecturers had advised students to look for a good preceptor programme, Chris questioned how one can be sure of this before starting the job having had little support and felt thrown in at the 'deep end'.

What tickles me is, they have a preceptorship package and I think most places do at least on paper [laughs]; how it was delivered is a different question...I got a preceptor but what it says in the paperwork is they should be working at least two shifts a week out of the five with my preceptor. It's never happened once...maybe once in a week but I was on completely opposite shifts. (Chris)

Chris felt that employers need to be more welcoming in relation to providing a more supportive environment.

To summarise, well-intentioned employers appeared to include a recognised preceptorship programme with an identified period of support. The programmes mainly consisted of induction and training days with an inventory or means of recording skills training and competence progress, but there appeared to be a tendency for it to be a 'tick box' exercise upskilling the NQN for the employer rather than pastoral support for the NQN. Although some of the NQNs did not have a formal preceptor they did feel generally supported by other members of the team whilst others had difficulties with relationships and settling in. The NQNs had been advised in University to seek out a good preceptorship programme but it is difficult for them to judge how this would work out if it looked

good in principle. Therefore, employers' intentions may be good, but the difficulties appear to arise for individuals in the implementation at ground level.

#### **5.3.4 Problematic preceptorship**

This section explores the experiences of the NQNs who had neither an identified preceptor nor a structured preceptorship. Brook was only 'supernumerary for a day' and did not receive a formal preceptorship. There was a mismatch between managers' perceptions and Brook describing the experience as 'terrifying' with areas of uncertainty, judged as very capable by others but underneath was still questioning own practice which was very stressful.

I was supernumerary for a day before I was fully thrown in...I wasn't very assertive about my own learning needs...I wasn't allocated a preceptor as first...I started in the September and it was the December when that was brought up that I hadn't really had a preceptor myself. So, I was allocated somebody, but we never work on the same shifts, so we don't see each other...it would have been nice to know somebody was there to go to. (Brook)

Darryl's first job was a poor experience. Although there was an induction providing information about the Trust there was no structure to the preceptorship period.

It was just chaos from the start. We had our induction and then that's the only information that we had. We had no programme of what we were going to do...so we just went up to the ward. The sister in charge...was "oh right so what do you want to know"? I was "when do we start"? and she was "oh just come in the morning and we'll find something for you to do" and they said that we had a two-week supernumerary period but that did not happen...I felt completely out of my depth. (Darryl)

Darryl left the job after a very short time because of the lack of support. The quotation below provides an interesting example of lack of interest in Darryl as an individual.

I remember one day, there was one of the Nurses went, "So where did you go to Uni?"...and we were just having a general talk and she was, "I'm not really bothered. The sisters have just told us to make an effort with the new starters, so you don't leave". (Darryl)

Jamie also had a difficult time, forced into working beyond perceived capabilities because of staffing levels. Jamie was an LD nurse employed in an acute adult nursing setting. Jamie faced hostility when refusing to carry out tasks outside of the scope of practice as Jamie did not want to put patients and self at risk. Jamie felt vulnerable, unsafe, unsupported, and not accepted even after eight months. Jamie had an identified preceptor who was constantly emailed or spoken to about meeting up, but this never happened.

I was kind of chunked in at the deep end...my ward was so short-staffed; I was on my own after a month and I felt very vulnerable. I didn't feel very safe and I didn't feel like I had the support there as well, which I did raise but nothing really changed...if I was very uncomfortable with something...I didn't do it. A lot of the time it didn't go down very well because somebody else had to do it, but I was protecting my patient...I was met with a lot of hostility, even after eight months. (Jamie)

Casey had returned to a community team previously worked in as a team leader in before nurse training. There was an assumption that Casey would know what to do and felt a bit left to 'just get on with it'. Casey had sought reassurance during the first eight weeks of being an NQN but had not been assigned a preceptor at first. For around 4 months as an NQN Casey 'self-supervised' and

'self-mentored' because of lack of support and used reflective skills to learn from mistakes or 'slip ups' to influence future practice.

I was just left to get on with it and it was down to me to go and seek support, rather than it be offered... the preceptorship that wasn't offered until probably about four months after I'd been working there. (Casey)

The situation was similar for Bailey returning to a previous place of work in the private sector which had induction training for policies and procedures for one week, but no preceptorship programme or preceptor. However, Bailey had received informal support from a senior nurse on a neighbouring unit if help or advice was needed on professional or role issues but was reluctant to admit to a friend or manager if uncertain or anxious so in case leadership abilities were questioned.

I've got a mentor who is an existing senior nurse; he was on the unit that I'm on – and he's been moved over to the neighbouring unit and nineteen out of twenty shifts he's next door and he knows the unit that I've been given inside out...if somebody asks me a question...I'll go and ask him so then I know for future reference and he's been brilliant. (Bailey)

To summarise, five of the NQNs did not receive good support in the transition period for differing reasons. Two had returned to previous workplaces and assumptions made that they did not need transition support whilst another NQN was judged as being capable and safe to practise but with little account made of the emotional impact of this. Two others were in unsupportive environments, one being chaotic and unstructured with the other being hostile with the NQN having requests ignored for meetings with the preceptor.

#### **5.4 Working with others and workplace cultures**

Support from members of the MDT and helping each other was valued and helped in the transition to the NQN role, whilst difficult staff behaviours were problematic for some. Enjoyable aspects mentioned included learning from others such as consultants and specialist nurses willing to teach. Linden talked about support when dealing with patients' conditions.

When I've had a poorly patient, we have a good team of doctors generally at the hospital...and they're always there...just for additional support...I mean I've had hard days; I've been moved from my ward to a different ward which was out of my comfort zone and that was a struggle but when I was there and met the team, I was fine. (Linden)

Wynne really enjoyed the new role and learning on the job even though sometimes felt anxious before going to work, particularly when off-duty for a few days. Wynne's anxieties were about problematic people rather than the work itself.

The anxiety doesn't tend to be around working with patients, it tends to be around expectations from one or two of the people who I work with who can be quite difficult really...The odd occasions someone speaks quite sharply to me and I think there's actually no need for that, we're adults...there's a couple of occasions where people have behaved to me as though we're in the playground. (Wynne)

Eden described the workplace as having 'awful' dynamics with a bullying culture with two managers hating each other. The team was split to attempt a remedy, but the culture appeared ingrained. Eden perceived one person to be at the centre of it. At the time of the interview Eden was wanting to leave the job having been absent from work with stress. Speaking up as encouraged by lecturers was not easy.

...you had a very divided team...you could cut the atmosphere with a knife...there's just a really ingrained culture in there and I've recently spoken out about this...I actually ended up going off sick because I wasn't believed and my manager didn't want to hear it...I've come in with fresh eyes and I can see it and I felt like nobody believed me really. That's been difficult, and it's made me want to leave...we get taught at uni to speak up and it's in the 6 Cs<sup>10</sup> and everything isn't it? And I did, and it just didn't go down well at all. (Eden)

Chris was working in another country in the UK and had mixed feelings about the first 6 months. As a MH nurse working in a mixed physical and MH care environment Chris found that expectations differed with a clash of nursing cultures. Chris perceived general nursing to be more task-orientated than patient-centred. There were difficulties in advocating changes to people's care with the negative aspect being more to do with culture of working and skill mix.

Getting along with staff, the differences between the staff and how their own cultures and values reflect on practice...sometimes that's caused disagreements because they believe in that way of working while I believe in that way of working and trying to get them to mesh together. (Chris)

Darryl's experience of working for two employers in the first six months of being an NQN provides a comparison of the experiences in relation to fitting into the team or CoP. Lack of support and not being treated as an individual can lead to low morale and staff leaving as was the case with Darryl.

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<sup>10</sup> The 6Cs of nursing: professional excellence in Care; Compassion; Competence; Communication; Courage and Commitment (Cummings and Bennett for the DH, 2012)



I think the main difference where I am now, you genuinely think that people are interested, not just in you as a nurse but you as a person... whereas the first place it was very task-focussed...the staff morale at the new place is so much better than it was in the first place...I think the workload you could cope with if the staff worked better as a team or you felt like you were supported or you felt like people actually cared. (Darryl)

To summarise, there are examples of good learning experiences in CoPs with nurses and members of the MDT indicating a positive learning culture in some communities. Unfortunately, some NQNs had experienced difficulties with toxic environments and unpleasant staff. There are clashes of values and 'doing the right thing' learned as a student and then problems with challenging practices as an NQN. The examples included here clearly led to stress, absence and wanting to leave jobs.

## **5.5 Summary**

Student nurse placements and workplace communities provide situated learning opportunities in the activity systems crucial for learning to practise as a fully-fledged RN. Across the collected data, the NQNs talked more about preceptorships than mentorships which is reflected in the balance of discussion for this section.

Positive examples of learning, experiences of mentorship where mentors were good role models for students, instilled confidence by enabling decision-making, asking questions to probe and foster learning. Disturbances identified were: being shielded from practising care of patients with complex needs but expected to do this as an NQN; lack of clinical skills learning on some

placements; poor mentorship skills when shutting down learning opportunities or micro-managing.

Most NQNs underwent some sort of induction or preceptorship and the more successful preceptorships included programmes with an identified period of support, induction and training days, an inventory progress review, and an approachable preceptor and team. There were good learning experiences in communities with nurses and wider teams which seem to indicate positive learning cultures. In terms of system disturbances, even where a good preceptorship programme existed, there was little time for the NQN and preceptor to meet, missing pastoral support. Five of the NQNs received poor support in the transition period for differing reasons. Unfortunately, some NQNs had experienced difficulties with toxic environments and unpleasant staff. There were clashes of values and 'doing the right thing' learned as a student and then problems challenging practices as an NQN. The examples included here clearly led to stress, absence and wanting to leave jobs.

## **Chapter 6: Student to RN Transition**

### **6.1 Introduction**

This chapter focuses on the transition experiences of the NQNs in their employment role and therefore relies mainly on interview data post qualifying. There were commonalities of experience such as professed anxieties and early recognition of the enormity of being an NQN in relation to accountability for their practice. Another common factor was low confidence in own ability and decision-making skills. Some initial emotional responses to the more stressful experiences were perceived loss of support and supervision of practice by mentors and support from university lecturers as 'sounding boards' for issues encountered in practice. Various experiences as NQNs then shaped the transition process and ability to be more confident to speak out when needed and feeling more secure in making clinical decisions. The subsequent sections will begin with some general perspectives on the transition process and recognition of accountability followed by an exploration factors influencing confidence development as an NQN.

### **6.2 Perspectives on becoming an NQN**

Participants had undergone some mixed emotional and challenging times. There were positive experiences in relation to professional development as well as some difficult personal and professional challenges leading to self-doubt. Brook illustrated self-doubt arising from the complexity of being able to develop the required competence of an NQN as well as dealing with emotional aspects of working with patients and their relatives.

I would describe it as professionally challenging and probably an emotional roller-coaster as well...you're developing your professional standards and competencies, you're also dealing with the emotional element of your patients and relatives as well and learning how you fit in that role...I've really enjoyed it but there have been moments where I've really questioned my own abilities. (Brook)

Drew captured the first day's emotions in relation to the enormity of being an NQN as well as a positive slant on transition and support:

People were coming up to me and saying: are you alright, it's your first day? And I was that nervous I could have cried but looking back I think it was a good thing, it made me more conscientious...I didn't want to make a mistake...There are times when you think you don't know what you're doing, or it can be overwhelming, but the majority has been good. I've been supported well by the people I work with so that's helped a lot.  
(Drew)

Rowan had struggled at first as an NQN, moved geographical area, and described being very stressed despite feeling generally supported by the team. Rowan was surprised how much emotional involvement occurred and feelings of being drained; having to actively manage stress on days off. Familiarity with the processes of the new environment eventually helped reduce stress.

A massive learning curve...really scary and just felt like I was in a blur for a couple of weeks and then on my days off I was just trying to recover from the shift...I genuinely struggled at the start and I had to really focus on my stress management...I was so surprised at how emotionally involved I would get so I was just drained all the time. (Rowan)

Brook realised and accepted that one could not know everything and needed to use learnt nursing assessment and transferable graduate skills to inform clinical judgements and decision making. A challenge was not having the luxury of time when working in a busy environment.

You're having to just use your judgement skills that you've developed in your time as a student in a completely new environment... having patients with conditions that you've not come across as a student and then having to use your assessment skills and go and do a bit of research and learn a little bit more about it, and it's that side of it that I find very challenging because when you're in a very busy area when you first start, there's not necessarily the time. (Brook)

Eden found most of the first six months in mental health nursing to be mainly enjoyable but seemed disillusioned with the reality and nature of the job, role expectations, and working in a dysfunctional team. At the time of the interview was considering changing jobs. As well as the problematic relationships, Eden's disillusionment was also because the role felt to be more focused on dealing with service users' poor coping skills in a societal sense rather than expected provision of mental health nursing.

It's not what I thought it would be when I came into mental health...we're seeing a lot of social issues as opposed to the likes of psychosis...people with a lot of social crises and personal issues and poor coping skills...so it wasn't really what I came in to it to do, so that's been a bit of an eye-opener to be honest and I don't always feel like a nurse (Eden)

Jamie captured how some of the participants felt generally unsupported due to the nature of the job, short staffing and missing the support of lecturers.

It's been a lot more challenging than what I thought...there hasn't been that full staff team there for the support and I've found myself in a lot of situations where there was just me and one support worker...the most complex patients who've got dementia and then I'd have people's health declining and I can't stretch myself and I'm unsure what to do...I found that really hard at the beginning and I also missed the support of your lecturer, being able to go to them with. (Jamie)

Ash suggested that as a student, there were mentors supervising practice, checking that everything has been done. As an NQN. Ash had some support from others on shift but had to really learn prioritisation and organisational skills.

When you're a student you always have someone looking over your shoulder almost...whereas when you're a Registered Nurse...there's nobody constantly looking...You've suddenly got to really sort out your organisation skills...you've got to almost learn to prioritise more. (Ash)

Some participants had relied on peer support. Rowan described starting as an NQN with several others and their peer support network helped when feeling out of their depth. Rowan described also having peer support from a social media group with peers from the university.

There was four of us started at the same time which really helped as well, cos we're like a little support group for each other...One of the best things that we've had has been a WhatsApp group with who we trained with...so it's sort of up to us as well but it [*university*] gives you the right skills to know how to communicate with each other to make sure you get support. (Rowan)

Wynne also mentioned peer support from the university cohort where they discussed experiences using it as a reflective space with recognition that some peers further afield may feel isolated.

We have our own little support group but I think it must be quite difficult for people who are more isolated, people who've maybe gone to work somewhere else and aren't near any of the people who they've trained with...we also unload things which have affected us emotionally... we use it as a reflective space. (Wynne)

### **6.2.1 Recognising the reality of accountability**

Some participants were unsure of their role as an NQN and overwhelmed with the realisation of the responsibility and accountability at the point of Registration. One of the reasons may be due to being shielded from dealing with difficult cases in student placements as discussed in 5.2. Eden refers to personal risk specially in relation to potential suicides.

It's just the sheer responsibility of it, you realise that you are accountable...There's been a few times where I've come home from work and I've thought about the risk that I carry personally and I do feel massively overwhelmed by it...I could go home and go in the next day and find out somebody that I've been to see the night before has committed suicide and that is huge. (Eden)

Brook recalled that lecturers had tried to prepare students for preceptorship periods with lecturers emphasising need for NQN support as transition was not always a smooth process. However, Brook suggested that more input is needed to prepare NQNs to prevent them leaving the profession early because some build confidence from their own experiences whilst others build confidence from having support.

There does need to be a bit more reflection of that support and what you get as a newly qualified nurse. I got completely thrown in...I like a challenge and I like to be thrown in; whereas I've had a number of colleagues who have actually left the profession six months in because they've had the same experience and they've not dealt with it. (Brook)

Participants discussed accountability hitting hard at first, prioritisation and organisational skills needed developing, even though this was covered in University it was experienced differently as an NQN. Some had to come to

terms, reflected, rationalised clinical judgements and recognised that prioritisation decisions sometimes induced feelings of guilt.

When you do prioritise one child's care over another, even if it's just for 10 or 15 minutes, it was getting to grips with the fact that, just because I'd prioritised one child over another, didn't mean that I didn't care as much about the other child...nearer the end of the shift I'd feel guilty for the other children that I was caring for so it was almost learning to understand that the other child was fine. (Ash)

The responsibility of signing for drug administration was a source of anxiety leading to double checking, looking up familiar drugs and being worried about asking for help in such a busy environment.

I was surprised at how responsible you are straight away...it's so apparent that this is on you...you can't be supported like you were as a student...I don't think you can fully grasp that until it's you that's signing for that medication... I was reading up the adverse effects of things that I'd been giving for years. (Rowan)

Linden suggests that more is learned as an NQN because awareness becomes 'heightened' with responsibility whereas mentors are accountable for students' practice during placements.

You learn a lot more when you qualify...everything feels heightened cos *you're* responsible, nobody else, so you do look at every aspect of care you give...I had someone to rely on and I had somebody to fall back on; whereas I don't have that now. It's my registration so if I go wrong it's me; whereas when you're a student it's your mentor. (Linden)

Jamie explained how making a serious professional mistake as a student had helped understanding of accountability as an NQN enhancing professional practice.

I had my Fitness to Practice Hearing and now preparing me for practice I know what I should do...I did a lot of research into why people don't



whistle-blow and I looked at the different safety nets in place for when you do, so if I ever did come across something like that again I know what to do. (Jamie)

### **6.3 Confidence, judgement and decision-making**

Confidence issues as NQNs and subsequent development of confidence over time featured often in responses, every interviewed participant mentioned it without prompting. The interview questions had not directly asked about confidence, only about transition experiences and personal development. The pre-qualifying survey had indicated that many in the cohort self-assessed as having a good knowledge base and felt competent to practise (Chapter 4). I probed the narratives to explore the crux of confidence issues as low confidence to practise seemed to be emerging as a tension or disturbance in terms of preparation for autonomous practice.

My suggestion here is that key influences for developing confidence are related to clinical judgement and decision-making similar to findings of previous research discussed in 2.2.4 (Etheridge, 2007; Monaghan, 2015). On completion of the programme, the NQNs have been assessed as having knowledge, skills and behaviours required of the role but it seemed that making autonomous decisions based on these was difficult. Roberts (2009) suggested that lack of confidence can be misinterpreted as lack of competence. Conversely, I would argue that students who feel competent and confident as a student with support structures discussed previously, may underestimate the loss of these on confidence levels. This section explores how post-qualifying experiences facilitate confidence building or in some cases, confidence crisis.

The pre-qualifying survey asked students about decision making and dealing with emergencies in terms of preparedness. 19% (n=12) self-assessed as competent and 68% (n=43) competent with support (Figure 6.1). This leaves 12.7% (n=8) unsure or not yet competent.

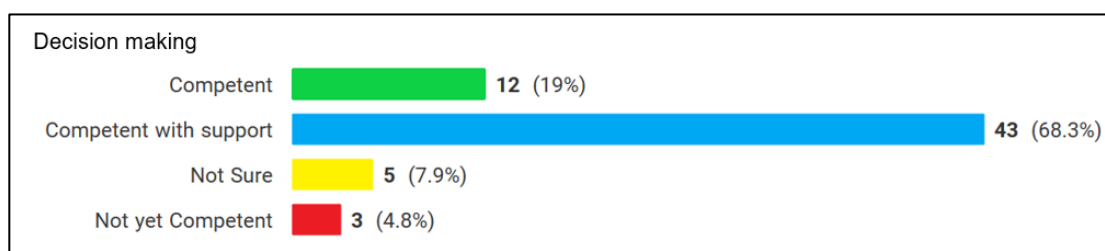


Figure 6.1 - Self-assessment of clinical decision making

Dealing with emergencies was less self-assured (Figure 6.2). Although 17.5% (n=11) felt competent and 52.4% (n=33) competent with support leaving 30.1% (n=19) unsure or not yet competent.

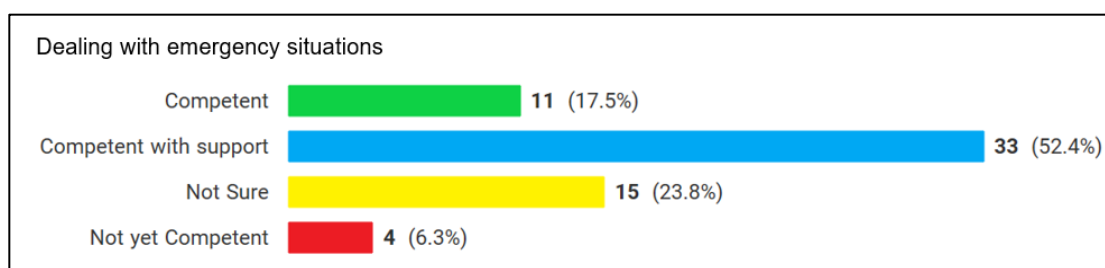


Figure 6.2 - Self-assessment of dealing with emergency situations

Loss of support may be a factor in confidence issues regarding the accountability discussed in 6.2.1. If expected preceptorship support structures are missing and tacit knowledge is undeveloped, this could mean NQNs having to make clinical decisions, they may not be ready for. However, the experiences

of having to make critical decisions develops confidence (Herbig et al., 2001). The following narratives will explore this further.

Responding to a question of how they had changed or developed since qualifying, most participants responded by saying that they had developed in confidence and provided illustrative examples. Despite fear of making mistakes, Casey had to deal with a difficult workload without formal support structures to begin with and had to develop self-confidence in own ability.

I hit the ground running really and there were quite a few complex cases that I just got on with and dealt with, although it was difficult...I didn't have a great deal of support...initially I found myself doing that a lot, checking and seeking...probably for the first couple of months...that was my confidence and fear of fluffing up and making a mistake. (Casey)

Ash had gained in confidence over time and recalled, as an NQN, not being able to trust own judgement and decisions regarding poorly children. Learning what to do from experienced colleagues and having a 'pre-plan' of what to do with certain types of patient helped develop confidence.

I've also gained in confidence...I didn't trust my own judgement when it came to patients...I was constantly terrified that all my children were going to get really, really poorly all of a sudden and it made me very anxious, whereas now I trust my judgement...I know more when a child...can step down and go to less amount of the drug or when a child can come off the IV antibiotics and go onto orals...It's just something that you have to get used to... and really reflect on it and say "but I did make the right decision. (Ash)

Jamie implied that the first 6 months "without apron strings" is needed to develop confidence. The course can provide preparation for skills and tools for

practice but there is a need to think independently to transition as an independent practitioner.

You get given all the skills and tools that you need, I don't think until you're out there without apron strings you can fully transition into that practitioner...you've always got your mentor to rely on or you've got your lecturer...and you don't have to take full responsibility...whereas when you are in that situation where it's all on you and you haven't got that mentor anymore...the spotlight's on you, that's when you really learn to utilise what you've been given and develop. (Jamie)

Kit developed confidence in decision making a few months after feeling like a new student again and sensed a change that others were beginning to trust Kit's judgements.

When I started, I felt like a new student again...But my confidence is coming. So, if I saw a wound and I was concerned there was an infection I would go to the on-call GP and ask them to come and have a look at this wound; whereas now I'm going in to see the GP and saying, "this is the situation. I think there's an infection there"...I am developing that confidence. (Kit)

Similarly, Eden recognised that confidence had developed from originally seeking reassurance about decisions to being confident in clinical judgement following successful outcomes.

I think my confidence has grown. I don't even know when I realised I was doing it, but I was making decisions without thinking about what I was doing...I have got confidence in my decisions now, everyone's been fine after I've discharged them. (Eden).

### **6.3.1 Confidence and advocacy**

Some NQNs talked about being more confident when advocating on behalf of patients or service users. Darryl remembers university lecturers encouraging

students to 'speak up' on behalf of patients/service users and this helped with confidence to speak to the preceptor during difficult first months.

I feel like the Uni gave you the confidence to be able to speak up...if something's not right or if you see something that you don't agree with, then to speak...which in the end was ultimately why I left...I thought "if this was a placement at Uni would you say something?" And I was "yeah I would" so I feel like the support that you got at Uni really helped me in leaving that job. (Darryl)

Linden felt able to question doctors' decisions giving an example of reporting a doctor who had caused distress to a patient when breaking bad news and would ring the consultant if patient safety is in question. However, Linden's self-assessment of own personality also appeared to influence communication in such circumstances.

When I haven't been happy with a senior doctor's plan I'll just ring the consultant if I'm not happy, if I don't feel like it's safe...I mean I've got quite a back bone so I'm not bothered when it comes to confronting somebody if I'm not happy with the plan but I do it in a professional way. (Linden)

Jamie had several things to say about confidence including reflection on own personality as well as speaking up for the patient as an advocate giving an example of being confident enough to challenge a consultant surgeon about a post-surgical complication.

I've become a lot more confident and stronger in how I practice and believing in my own abilities...I said, "I think this knee's infected". He just took one look and went "No it's not, it looks absolutely fine"...He went to the next patient and I went "I'm sorry to interrupt, I'll let you finish your round here but please can we go back...I'm not happy with that, to me this knee is showing signs of being infected and I really think that we should take his bloods and we should swab it" and he was "if it will make you happy then that's what we'll do"... he did have an infection and

thankfully with getting the IV antibiotics in it didn't affect his knee replacement...I feel quite proud of myself there because I'm not usually that sort of person. (Jamie)

Drew gave an example trying to advocate for an unwell patient who was being discharged but the Dr was dismissive of the concerns. Six months on Drew had more confidence in own knowledge to be able to challenge.

...they weren't going to review but I felt like I wasn't confident enough to fight for the patient; whereas now I do...I've got a bit more experience to know what I'm talking about now which I think helps...I think personally the main thing is my confidence...I feel a lot more confident in what I'm asking, and they feel confident in me. (Drew)

Jules felt changed since qualifying reflecting on the difficult experiences of having to report poor practice.

I'm a completely different person and I don't know when it happened. I'm just very different, I'm suddenly speaking out more, I'm more confident, and that was not there before at all. I was literally like a mouse before; I didn't speak to anyone and I don't know but I think it's the experiences that I've been through where I had no option but to speak up. (Jules)

Bailey became more confident realising that learning during the course helped in practice citing an example of advocating for a nursing home resident and applying knowledge about diagnostic overshadowing<sup>11</sup>. In this case, a patient with dementia had deterioration in condition due to a physical cause and Bailey had 'pestered' others to get someone to listen.

I'd pestered them as well, you know...I was, "look, this man's lost weight, he's lost his mobility, he can't eat, his communication", I said, "this has

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<sup>11</sup> Diagnostic overshadowing: when symptoms of physical illness are attributed to mental illness increasing risks of delayed treatment. (Nash, 2013).

happened in three months. It is not psychological, so you need to scan that man or do something"...I know that I did everything I could. (Bailey)

Bailey recognised that this learning had taken place on the final placement as a student and that working with other professionals on placement had helped to grow knowledge and confidence.

I remember it being mentioned on my last placement...before my training doctors were really intimidating...but on that last placement because there was so much inter-professional working I just felt so much more confident being "no that's not the case", you know, challenging this doctor. So that was beneficial. (Bailey)

Eden felt less confident in challenging doctors and gave an example where Eden had concerns about a patient and could have challenged the doctor more.

I said, "she won't engage in the treatment 'cos she doesn't believe in it and she didn't last time we did this", and I had to argue against the doctor, I didn't have the confidence...I knew she would get unwell again and I knew she'd come back but because I hadn't got the experience. I didn't fight it hard enough and now we're two months down the line...she's back and she's unwell again and I just felt like maybe I should have fought it a little bit harder. (Eden)

Wynne felt more confident after undertaking post-registration training, understanding the hospital system and increased awareness of "how it all works" to be more confident to challenge and to be an advocate for the patient.

That's something I've picked up with confidence and giving a really short SBAR<sup>12</sup> to the doctor and saying what you want to happen...We had a patient arrive on the ward who I felt that really was palliative, and I looked at the drug chart and it said I was meant to give her a clexane<sup>13</sup>

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<sup>12</sup> SBAR - situation, background, assessment, recommendation (ACT Academy, 2019)

<sup>13</sup> Clexane (enoxaparin sodium) is given for prophylaxis and treatment of deep-vein thrombosis (British National Formulary, 2019).

injection...How could I possibly rationalise giving this lady a clexane injection?"...she basically is in her last hours of life, it's not necessary. And I called the doctor to the ward and said, "do I really need to give all these?" And huge relief, he basically took out his pen, scribbled everything off.

### **6.3.2 Confidence and significant experiences**

Certain experiences and events helped to increase confidence but, in some circumstances, adversely affected it. This section highlights examples such as dealing with emergencies, knowledge, experiences and reflections on action (Schön, 1987), in respect of confidence development.

Drew gave an example of how dealing with a cardiac arrest on night duty helped to increase confidence. Lack of previous experience had led to anxiety until the incident was experienced. Drew found that knowing what to do in the event has helped to increase confidence.

Just knowing what to do...I think has helped my confidence 'cos I was just instinctively doing what needed to be done while other people did their other jobs until you wait for more help to come; and it just puts your mind at rest for if it happens in the future. (Drew)

Rowan attributed an increased confidence to working in an acute specialist setting, developing familiarity with the specialism, and receiving overt respect from consultants and their teaching on ward rounds.

I feel like I know what I'm talking about a lot more now...you're working in a specialist area, and we talk about the same things so much...you go on ward rounds with our consultants and they teach you things because they're proud of their nurses. (Rowan)



Taylor felt better able to cope than when newly qualified and described being more confident and capable because of repeated experiences and knowing when to ask for help when needed.

I feel a lot more capable when I'm left on my own to my own devices, to make my own decisions, to contact the right people, to know if something's not going right but that's just purely through experience...I don't think it happened as like a big bang...But now I just suppose it grows with confidence, doesn't it, and the better you are at something the more confident you get. (Taylor)

Jamie used reflection to invest in confidence development and overcoming shyness in personal as well as work life; volunteering at work to push boundaries in uncomfortable situations and has found people responding positively. Jamie recognised that teamwork depends on being able to visibly display knowledge and confidence.

I started doing little things like that, throwing myself into situations I don't like and at work if we were discussing a patient or we were doing the brief at the beginning, I would volunteer myself to do the brief and I'd hate myself for volunteering and I'd stand there shaking...but the more I did it, the better it got and the better I felt and I've improved myself a lot.  
(Jamie)

Some of the NQNs experienced doubts and crises of confidence. Children's nurse Darryl moved jobs very quickly. Darryl had originally moved to a new Trust and experienced difficulties.

The first few months I didn't know whether I'd made completely the wrong decision about being a nurse. I'd come home so stressed and I thought was that just me being mollycoddled too much as a student, but it definitely wasn't, it was just the place that I was working because since leaving for my most recent job, that's just been so much better. (Darryl)

Jules as a LD nurse had a difficult first job working in a general nursing (adult) setting which led to self-doubt over the career choice but moved jobs quickly. After taking some time out, the next employer gave good support and advice which reignited a passion for nursing.

I started at the elderly ward in the hospital and they...were kind of supportive but they were quite prejudiced against me because I was a learning disability nurse - not the everyday staff but upper management and because they were so short-staffed...staff morale was, very low...So that wasn't the best place for me...it took my confidence completely as a nurse, I was really thinking that maybe I just wasn't nursing material...But with the second job the deputy manager, she took me under her wing, she really built my confidence. (Jules)

Chris experienced incidents that led to a crisis of confidence and self-doubt regarding ability to work as an RN. Chris had felt 'pushed' into doing medications wanting to take it more slowly but the working atmosphere provoked anxiety. Chris nearly made a drug error and needed to be supervised on medication rounds.

I feel a lot more confident now with my medications...my preceptor, he went back to basics with me but he didn't do it in a bad way, he did it in a confidence-supporting way, so it's like, "what you're doing is OK...I think you're doing it good". (Chris)

Chris also sensed an element of bullying and trying to catch Chris out. A staff member took the drug keys that Chris had put on the side briefly whilst seeing to something else then told Chris that this would be reported, and that Chris should know better.

I put the keys down on the side when I was dealing with a situation...going on at the same time and a staff member obviously swiped the keys when I was sort of busy with it and then tried to teach me a lesson about, "you know, you should always keep your eyes on the

keys” and they said they were going to report me to the manager about this, “you’re meant to be a nurse, you’re meant to *know* all this stuff”. I felt my confidence was completely gone. (Chris)

Chris had felt confident on completion of university study with a real sense of achievement at the time of qualifying and but had quickly begun to feel vulnerable and unexpectedly challenged as an NQN following the incidents. Chris was only just starting to feel a little more confident at 6 months as an NQN due to understanding how things work and undertaking some training

You’d have days of, “am I really a nurse? have I somehow just coasted through the course without knowing it?...Honestly, after my confidence has been built back up a bit, I said, “yes I do, I can recognise and can do it of course”, but when you have lost that confidence you feel like you do not know those questions. (Chris)

#### **6.4 Summary**

Transition from student to NQN was both exciting and stressful. Confidence development appeared to be related to clinical judgement and decision-making. On completion of the programme, the NQNs have been assessed as competent in knowledge, skills and behaviours required of the role but confidence in applying them was difficult. Students who feel competent and confident as a student may underestimate the loss of support structures thereby affecting confidence as an NQN.

The main sources of anxiety included: the reality of being professionally accountable for their practice; fear of making mistakes; missing signs of patient deterioration; and loss of confidence in their own competence and clinical decision-making. Some felt loss of the support structure from mentors and

lecturers, others felt a little disillusioned with the job. Various experiences as NQNs then shaped the transition process and ability to be more confident by learning from experienced colleagues, dealing with significant learning experiences and even making mistakes. Patient advocacy was an important factor in being confident to challenge practices.

## Chapter 7: Discussion

### 7.1 Introduction

This chapter returns to the original research questions and discusses findings from Chapters 4-6 intersected with CHAT as a theoretical lens, using a matrix analysis for expansive learning (Engeström, 2001). A conceptual model of activity systems was detailed in 2.4.4 and included below (Figure 7.1) and was contended as particularly useful to explore complexities of preparation and transition of NQNs. Using expansive learning it is possible to explore system disturbances and to identify potential innovations for further developments to take place in curriculum development and partnership working between universities and workplace settings.

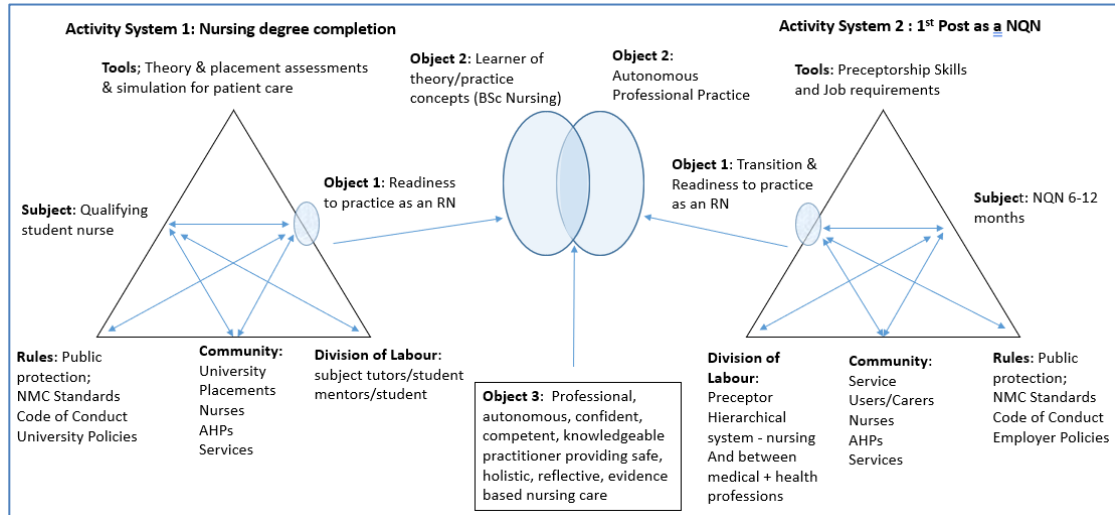


Figure 7.1 - Two interacting activity systems based on personal knowledge of the nurse education system (adapted from Engeström, 2001)

Figure 7.2 outlines the steps employed to work through this final analysis, addressing the original research questions using overall findings intersected with CHAT as a theoretical framework (Engeström, 2001; Creswell and Plano Clark, 2018). This intersected approach will now be explained prior to addressing the research questions.

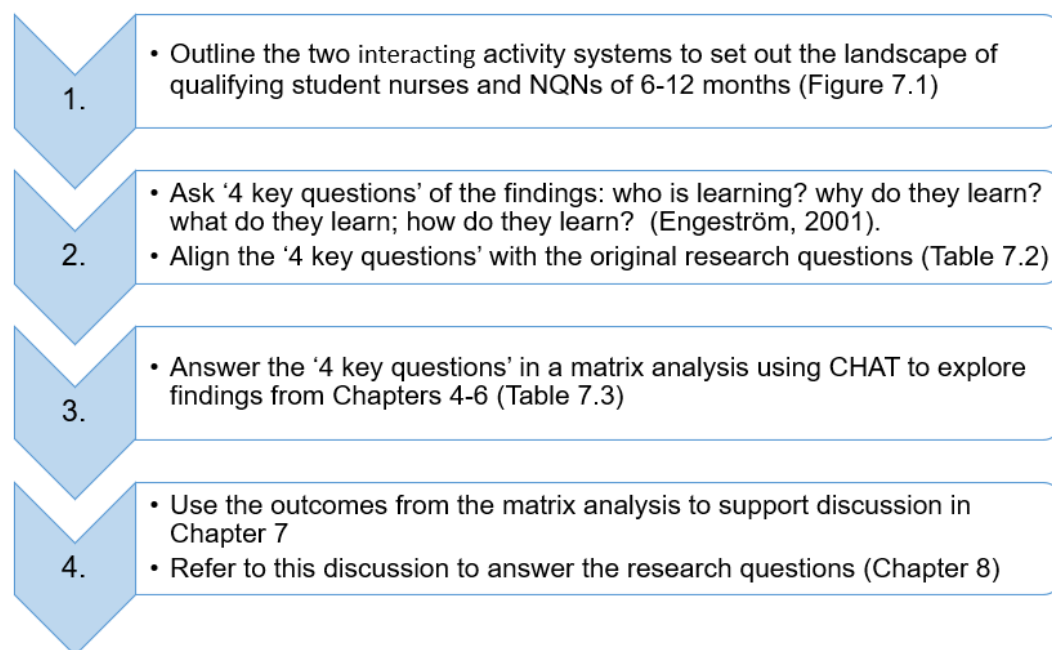


Figure 7.2 – Steps to intersect data analysis with CHAT as a theoretical framework

### 7.1.1 Step1: Two interacting activity systems

Based on my knowledge and experience of nurse education as outlined in 1.2. and informed by the literature review, Figure 7.1 summarised two interacting activity systems as a departure point for this study. Activity system 1 (AS1) is based on educational preparation of the student at the point of qualification and readiness to practise. Activity system 2 (AS2) is founded on the transition period and support during the first 6-12 months as an NQN. Using the activity systems framework to 'visualise' the landscape helped me to maintain focus on

educational preparation for practice and work-based learning, with NQNs as both the subjects and required objects or outcomes of study. In an ideal world, the final outcome of both activity systems (Object 3) would be a professional, autonomous, confident, competent, knowledgeable practitioner providing safe, holistic, reflective, evidence-based nursing care.

### **7.1.2 Step 2: Integration of research questions.**

Engeström (2001) posits that CHAT analysis incorporates four key questions: who are the subjects of learning? why do they learn? what do they learn? and how do they learn? These four questions are used to focus the discussion in Section 7.2. However, at the data analysis stage, I was conscious that there was a potential for too many inquiries if I asked Engeström's '4 key questions' as well as my own research questions. Therefore, I undertook a cross-checking exercise to ensure both perspectives were aligned before using them as the discussion focus (Table 7.1). If I used Engeström's approach would it assist in answering my own research questions and maintain focus? The outcome was affirmative; the original research questions are addressed implicitly using this approach. Engeström's questions are focused on learning and my research questions focus on how that learning prepares NQNs for a professional role across two activity systems. To clarify my approach, Engeström's key questions provide the main headings in Section 7.2 and the original research questions will be specifically addressed in Chapter 8.


Who are learning?	Research Questions	Why do they learn?	What do they learn?	How do they learn?
Final year student nurses 6 months prior to course completion  Newly qualified nurses 6-12 months post qualifying	<b>Main Research Question</b>  How well-prepared are a group of newly qualified, graduate nurses for the realities of autonomous professional practice?	Readiness to practice autonomously as RNs  To be competent and employable for the role of RN	Knowledge, skills & attitudes for professional and clinical practice NMC (2010)  Preparation for the role. Theory and safe clinical practice	BSc Nursing based in University & placements  Employer led induction and preceptorship
	<b>Supplementary Question 2</b>  What experiences appear to shape professional competence and identity during the first 6-12 months of qualified practice?	To achieve professional competence.  Development of confident clinical decision making	Knowledge, skills & attitudes for professional competence and how to identify as a RN	Experiences of theoretical studies and practice placements  Employer led induction and preceptorship
	<b>Supplementary Question 3</b>  Are there any identified tensions in relation to higher education (HE) theoretical preparation for the role and the real world of work?	To be able to function as a safe, autonomous practitioner	Theory and safe, confident practice as required by both the NMC and employers in care delivery settings	Two main activity systems as: a) Final year qualifying student b) NQN first 6-12 months

Table 7.1 - Alignment of research questions to Engeström's 4 key questions

### 7.1.3 Step 3: Matrix analysis using CHAT

A matrix analysis tool (Table 7.2) incorporates the 'four key questions' including recognition that activity systems are multi-voiced and incorporate historicity (Engeström, 2001). Issues and developments in the system can be appreciated against its own history, and contradictions are central to change and development as expansive learning (Engeström, 2001). Five principles of analysis and the four exploratory questions are illustrated in Table 7.2. These assist in forming a matrix of responses to the questions guided by the principles. The findings outlined in Chapters 4-6 were consulted to populate the matrix and inform the discussion in 7.2.



Questions for Analysis	Principles for Analysis				
	Activity system as unit of analysis	Multi-voicedness	Historicity	Contradictions	Expansive cycles
Who are learning?					
Why do they learn?					
What do they learn?					
How do they learn?					

Table 7.2 - Matrix analysis tool (based on Engeström, 2001)

Contradictions arising in the two activity systems as explored in this research can help to identify root causes leading to expansive solutions Engeström, 2000). Engeström (2000) also uses the term ‘disturbances’ defined as ‘deviations from standard scripts’ (p. 964) which contribute to systemic contradictions, illustrated here with ‘lightning arrows’ indicating potential system disturbances (Figure 7.3).

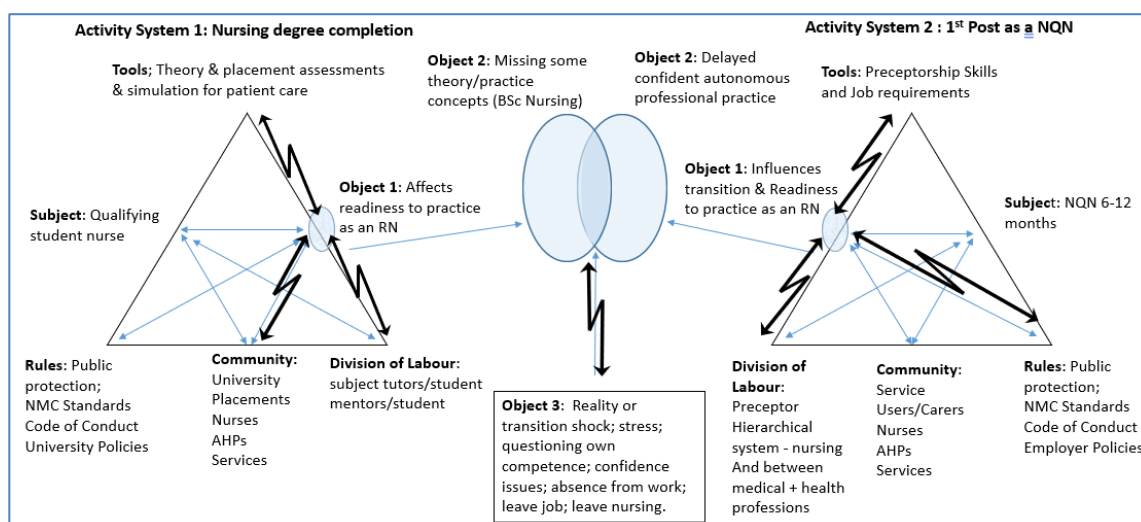


Figure 7.3 – Contradictions in preparation of NQNs for autonomous practice

In AS1, missing specialist theory or skills, unsuitable mix of placements, little opportunity for decision-making and poor mentor support may lead to feelings of being unprepared on qualifying. In AS2, missing or unsupportive preceptorship, and an unfriendly or dysfunctional community of practice can lead to difficult or delayed personal development as an autonomous practitioner. Either or both may lead to problems identified in Figure 3 (Object 3) as: 'reality-shock' or 'transition-shock' and stress; questioning own competence and confidence; absence from work; and leaving the job or even nursing as a profession.

## 7.2 Step 4: Analysis, contradictions and expansive learning

Outcomes from the four key questions are summarised in Table 7.3 providing a matrix of responses based on findings outlined in the preceding chapters.

The matrix content forms the basis of the discussion using the questions and principles for analysis.

Questions for Analysis	Principles for Analysis				
	Activity system as unit of analysis	Multi-voicedness	Historicity	Contradictions	Expansive cycles
Who are the subjects of learning?	Interconnected activity systems: Year 3 students situated in university and clinical placements; NQNs situated in new employment settings	Patients; Mentors; Lecturers; MDT; Doctors; Peers; Preceptors All provide learning opportunities.	From apprentice model until 1990s higher education Dip HE level; to all degree level 2010. Return of apprentice models 2018 to meet workforce needs. Political influences	Students learning to be competent as a student. Reality shock. Does this make them competent as a NQN without further training? Preceptorships include skills training but may repeat skills learned in University but not allowed to practise in relation to vicarious liability.	Hands on care Technical ability Resilience How can they be helped to be more ready with workforce expectations?
Why do they learn?	To become an autonomous RN practitioner Practise competently Develop confidence in practice and decision-making?	To understand many facets of e.g.: Care delivery Support methods Recovery Rehabilitation End of life MDT approaches	Reflect health care needs of society Provide qualified, educated workforce. Current workforce issues Changes re NAs	Transition from student to NQN Is a competent student a competent NQN? Confidence V Competence Competence → confidence Employer requirements appear more central than support of NQN	Strategies for improving confidence on qualifying Clinical decision making Working with employers Clinical supervision and personal support
What do they learn?	Clinical judgement and decision making Codified knowledge Professional issues Communication Care/Compassion Reflection Practical skills Advocacy NMC Domains NMC Rules Employers policies	NMC Education standards 4 domains Health in society (lifespan) Acute care Community Long-term conditions End of life care 4 fields of nursing	Based on historical view of nursing Changes in nurse education Political influences Hands on care to higher technical skills Drs roles? Do nurses need a degree? – public debates	Relevance not always recognised Generalist education to meet NMC comps BUT specialism requires knowledge and experience to be confident Advanced skills taught but not practised Preceptorships not mandatory Preceptorships not standardised Dealing with emotions/complexity/guilt Dealing with unpleasant staff To challenge but not always well received – hold back at times Staffing shortage. Mistakes	Apprentice model? Yes – graduate skills important Tacit knowledge aids judgement and decision making Codified knowledge used in a different context requires new learning Include 'warts and all' Dealing with errors Final placement?
How do they learn?	Academic study Reflection Simulation Placement experience Mentorship Induction Preceptorship period Mistakes	Mixed profile of placements and experiences Working in teams Mentors Preceptors	As above Apprentice model Diploma Degree Return to apprentice? Return to level 5 practitioner?	Placement experience differs Mentor support better than preceptor support? Educational provision/reality shock Loss of support Culture – supportive or destructive? Preceptorship offered but skills development not emotional support. Time Individual differences	Difference in experiences Placement capacity issues  Not all receive the same input (social interaction opportunities) how can this be changed? Improved preceptor preparation and support training.

Table 7.3 - Matrix analysis of expansive learning

### **7.2.1 Who are the subjects of learning?**

In this research context, the nurse is the subject of two key, interconnected activity systems (Figure 7.1), AS1 being the university setting for delivery of both theoretical and practical preparation in readiness to practise as an RN as required by NMC regulators. AS2 depicts employment as an NMC-regulated NQN in clinical settings with care delivery governed by both national and local policies and guidelines such as those produced by the Department of Health, NHS England and the National Institute of Health and Care Excellence (NICE) which in turn shape the nature of work in practice.

NQNs are expected to work professionally as autonomous, confident, competent practitioners providing safe, holistic, reflective, evidence-based care depicted as Object 3 (Figure 7.1). The subjects in both activity systems are NQNs but they are at different stages in their transition towards autonomous, practice. In AS1 they have completed their degree studies and ready to start their first post as an RN (Object 1) with Object 2 representing the formal educational preparation and registration for practice. In AS2 the subjects have been qualified between 6-12 months, undergone a period of experience as an NQN (Object 1) with a goal in Object 2 of transition to autonomous, professional practice. Object 3 is the ultimate goal or expectation and it is argued here that it is not the result of just one or other of the activity systems but is an outcome of both in an ideal world. However, as relayed in the previous chapters, disturbances and contradictions have been identified for some of the NQNs whilst others have reached Object 3 less problematically.

An activity system represents 'multiple mediations in activity' (Engeström, 2008 p. 26). Tools or artifacts which mediate assessed learning for students include theoretical concepts, practice simulation and holistic care of people. University lecturers are key mediators, although student progress decisions in HE can be complex and multi-voiced. Preceptorship programmes and job requirements mediate the learning needed for NQN work. Students on placement and NQNs work alongside their mentors, preceptors, other nursing staff, medics and AHPs who contribute to teaching, learning and assessment as 'boundary crossing' (Wenger, 1998). This adds an interprofessional or 'multi-voicedness' to the mediational structure.

Nurse education has undergone several changes since the 1980s as described in section 1.3. with a bachelor's degree level qualification becoming mandatory for registration as a nurse (NMC, 2010). Recruitment of nursing students by HEIs requires them to have the right attitudes and values for a nursing career as well as academic ability (Willis, 2012; Francis, 2013; Traynor et al., 2016). Applicants must show potential to be compassionate, caring and resilient with eventual ability to make informed, evidence-based clinical decisions but equally the nursing curriculum must support this competence development. One identified tension found was that most students felt ready and competent to practise with support, but once qualified felt less competent as RNs and underwent 'transition shock' as recognised by Duchscher (2009) . The links between confidence and competence have been highlighted previously in 2.2 and 6.3 and perpetuates the need for a further period of support or preceptorship as provided by many employers. A disturbance in the system is

that some NQNs had no formal preceptorship whilst preceptorships did not provide adequate pastoral support. Another is that preceptorship programmes repeated skills taught and simulated in university and caused frustration for some.

The expansive learning suggests two key points. Firstly, to ensure that the curriculum recognises and embraces that 'reality shock' and accountability affects some individuals and to include learning events that test confidence levels, technical skills, problem solving and resilience levels. Of course, this has resource implications and needs to be factored into programme development rather than added on. Secondly, universities and their local placement providers, potential employers, might work more collaboratively to understand students' previous learning and how that could be built upon rather than repeated. Individual assessment and tailored preceptorship using a preceptorship 'toolkit' approach would benefit some individuals and organisations (Owen et al., 2020).

### **7.2.2 Why do they learn?**

In order to qualify as competent registered practitioners, student nurses must learn the many facets of nursing and care delivery by gaining a variety of experiences in clinical placement settings. In relation to situated learning theory (Lave and Wenger, 1991), learning is motivated by participating in shared, cultural practices from which there is a useful output. Engeström (2001) affirms that this is a reasonable assertion when looking at novices developing competence in established practice settings but proposes that expansive

learning processes in relation to major transformations are not well explained by just participation and the gradual acquisition of skilfulness. In effect here, NQNs need to learn their craft across the two activity systems as portrayed in Figure 7.1.

Nursing as an all-graduate profession requires that student nurses must meet the NMC (2010) regulations regarding both theory and practice. The students must complete the same number of academic credits as other undergraduate programmes to achieve an honours degree, but additionally, they must pass summative clinical placements and fulfil the minimum 2300 practice hours required by NMC regulation. Student placements in AS1 should provide experiences of different models of care delivery such as acute, community and long-term care, and learning of therapeutic methods to support recovery, rehabilitation, health promotion and palliative care (NMC 2010).

Activity systems in hospital clinical practice settings have changed since the 1980s. The division of labour is more complex with senior, experienced nurses moving further away from the bedside in order to manage multifaceted processes, with developed roles such as advanced nurse practitioners or specialist nurses (Willis, 2012). NQNs are expected to function in an increased technological setting and carry out specialist work previously done by junior doctors. They need to prepare for consumerism, choice and knowledgeable patient voices which are stronger, and with people living longer (Prime Minister's Commission on the Future of Nursing and Midwifery in England, 2010). RNs need to understand quality requirements and monitoring such as

that provided by the CQC, a constant driving force with outcomes linked to high profile media naming and shaming of poor practices (Willis, 2012).

Nursing workforce shortages are problematic with over 40,000 nurse vacancies (National Audit Office, 2020) and predicted to worsen. The number of applicants to nursing courses declined for the second year in a row (UCAS, 2018) following the introduction of maintenance and tuition loans (Hubble et al., 2016). These issues have recently been brought to the fore in the general electoral campaigns of 2019 with the conservative manifesto promising 50,000 new nurses sparking much debate.

Returning to contradictions and expansive learning some disturbances begin to arise here in returning to the question of why they learn? Students nurses must demonstrate competent, compassionate and informed nursing care as directed and regulated by the NMC. Although the NQNs students have completed a degree with 2300 hours of practice some are not doing so with all the technical skills to 'hit the ground running'. This is evidenced in this research firstly with examples of NQNs not feeling competent or confident to make clinical decisions without support and secondly, with most employers requiring completion of a skills-based preceptorship programme. This concurs with Clark and Holmes (2007) finding that there is an expectation that NQNs should be competent and able to practise independently but training may not always provide them with adequate knowledge, skills or confidence (Clark and Holmes, 2007). It is possible that this is because the advanced technical clinical skills are what are required in the wake of new roles and expectations of nurses as discussed by



Willis (2012). Advanced practice skills are not explicitly required by the NMC Standards for Education (2010), which espouse much broader and generic concepts of learning including a number of essential skills. There may be contradiction arising re employability when the employer expectations regarding more advanced technical skills are mismatched with an NMC/university governed curriculum.

Exploring these contradictions with employers using Engeström's change laboratory methodology more explicitly could be a productive way forward as an integral part of future preceptorship development. The more recent education standards published by the NMC (2018f) include more advanced technical skills to be achieved during the programme although it could be argued that placement capacity and availability of staff to resource supervision of advanced skills is questionable. Other expansive learning is similar to 7.2.1 to include learning events that simulate advanced technical skills and problem-based scenarios to improve competence and therefore increased confidence in techniques and decision making. Again, resource implications could be problematic.

### **7.2.3 What do they learn?**

The NMC (2010) competency framework requires a number of *competencies* to be achieved which inform both curriculum theory and practice assessment documents. There are four sets of competencies for the four fields of practice (adult, mental health, learning disabilities and children's nursing). Each set includes generic competencies for all fields as well as those specific to the

particular field of practice. The NMC (2010) organises these competencies into four domains: professional values; communication and interpersonal skills; nursing practice and decision-making; leadership, management and team working. The domains are represented in AS1 (Figure 7.1) as 'tools' (curricula; assessments; placements and simulation); as 'rules' (NMC standards and Code) and 'community' (placements).

The NQNs provided examples in Chapter 4 of programme learning which had prepared them well for practice including graduate skills and the ability to research evidence for practice, theory and practice alignment, interpersonal and reflection skills, and holistic care. These represent professional codified knowledge (Eraut, 1994). It is interesting that some of the students wanted more taught specific nursing specialisms whilst others recognised that not everything could be taught and that their researching skills had allowed them to explore new conditions or protocols. The NQNs possessed differing insights and recognition of the value of evidence-based learning and application to new situations. Knowledge and content is needed for learning but incentive for self-direction and interaction is also important for acquisition of knowledge (Illeris, 2011).

An identified disturbance relates again to competence and confidence in that the nature of the NMC education standards, although field specific overall, are generally broad and generalist. However, working as an NQN in a specialism requires *particular* knowledge and experience to work confidently. An example is one NQN worked in an orthopaedic setting but remarked that very little had

been included in the programme. In addition, advanced technical skills such as administration of intravenous drugs were taught and simulated, but students were not allowed to practise them on placements. This is a tension in that the nursing degree covers a breadth of generalist preparation for practice, but advanced technical skills and knowledge are required in terms of employability. One solution that may be offered is that the more recent standards (NMC, 2018f) includes more advanced skills that need to be simulated or practised on placement. This means that HEIs and employers need to work together to find ways of increasing placement capacity and meaningful practice supervision which will not be easy given the current workforce shortage (NHS Improvement 2018; National Audit Office, 2020).

Participants recognised that although communication techniques were covered well, areas lacking were in dealing with difficult staff in the workplace, managing complex care, breaking bad news and dealing with own emotions such as guilt about care delivery, or stress due to making mistakes and staffing shortages. Real-life difficulties need to be addressed in the curriculum in the final year of the programme. Role play, simulation and case-based learning of advanced clinical decision-making can be used with final-year nurses to practice dealing with the difficulties such as those identified here to help build confidence (Gaba, 2007; Stirling et al., 2012; Bliss and Aitken, 2018). Preceptorship programmes can reduce stress (Monaghan, 2015; Whitehead et al., 2016) and improve confidence for some (Irwin, 2018) however as discussed in 1.4.2 and 2.3.3, preceptorship is recommended but not mandatory (NMC, 2006; 2008; 2019b,

2020) with no national standards to guide preparation of preceptors or preceptorship programmes.

Another potential solution is for more nursing apprenticeship programmes to be funded and made available. A nurse degree apprenticeship combines the required NMC programme of study with employment (Institute for Apprenticeships, 2018), so would also have the opportunity to build more specialist knowledge and skills at the same time as completing the programme. Another suggestion would be for students to undertake their final student placement where they have been offered employment. In this way, students can settle into a specific CoP whilst still under supervision and assessment. However, in my experience this suggestion has not been readily accepted by some with concerns for students being 'used as pairs of hands'. These proposed solutions could align AS1 and AS2 more closely. In order for tacit knowledge to be embedded in practice earlier and for confidence development, participation in challenging tasks, working with others including clients, and participation in group activities as central to learning (Eraut, 2004).

#### **7.2.4 How do they learn?**

Synergistic learning takes place across both activity systems in Figure 7.1 mediated by a combination of academic study, simulation, writing and reflection skills, and work-based learning experiences. This is supported by mentors and then preceptors during preceptorship programmes. Students and NQNs work in various CoPs, with MDTs, and both activity systems are governed by

professional regulation and employers' policies. Based on the experiences of the NQNs there is some evidence that simply completing the nursing degree and all the components of AS1 is not enough for them to 'hit the ground running' as an RN. Clearly, working as NQNs as in AS2 would be impossible without first completing the nursing degree and all it entails.

Students' placement experiences were found to be a key component of preparation for qualified practice particularly where there were good mentors and other staff who promoted clinical decision making under supervision, and where students felt they had been pushed out of their comfort zones. This 'brokering' (Wenger, 1998) helps to translate, co-ordinate, and align perspectives and interests, and possesses legitimacy to influence development of a practice. Positive student/mentor relationships that foster learning rather than just being 'taught' are important in the process of enquiry (Cassidy, 2009).

A system disturbance is that some students felt there was insufficient placement time or had inadequate placements as discussed in Chapter 5. There was inequity in that some of the placements did not provide adequate learning opportunities such as medicine administration practice. This is a similar finding to Bisholt et al. (2014) . It would be easy to suggest a solution in terms of ensuring all students have equal access to meaningful placements (Bisholt et al, 2014). However, increasing placement availability and capacity is often difficult in very busy, short-staffed care settings and there is just not enough to supply all requirements. This means that some students feel better prepared than others.

Another tension relates to NQNs' experiences of dealing with complex conditions and difficult communications with service users, relatives and other staff as in 7.2.3. Curriculum content needed to be strengthened with more observation, involvement and practice in placements. The NQNs were 'protected' from difficult and complex patients as students but were then expected to deal with them soon after qualifying. As suggested in 6.3., allowing students to be involved in complex decision-making and given more exposure to difficult situations and conversations during placements may go some way towards preventing some of the 'reality shock' as NQNs. It is important that mentors supervising final year students are advised about the benefits for final year students to practice difficult and complex decision making under supervision. As part of approval and monitoring the NMC standards require HEIs and practice learning partners to demonstrate processes for providing ongoing support for practice assessors (NMC, 2018d). These are usually in the form of educational updates and workshops and an ideal forum to discuss strategies to prepare final year students for managing complex care and difficult communications such as breaking bad news.

The lack of equity of preceptorships demonstrated disturbance in the system. As outlined in 5.3 most employers provided preceptorship programmes which were well-intentioned but, in many cases, there was little pastoral support. The NQNs often worked on opposite shifts to their preceptors or there was little time to discuss their preceptorship needs. Preceptorship programmes mainly consisted of employer induction, study days and upskilling the NQNs to provide more advanced technical skills with many of them referring to it as a

'tick box' exercise. Although this appears problematic, some NQNs found the upskilling programmes useful in building technical competence in turn improving confidence. This study found that some NQNs who were not supported quickly left employers who had not invested properly in their transition, and anecdotally, others from the cohort left the profession within six months of qualifying.

### **7.3 Conclusion**

This chapter has begun to address the research questions intersecting them with CHAT as a theoretical lens and using a matrix analysis to explore who is learning, what is learned, why they learn and how, whilst recognising the multi-mediational nature of activity systems. Identification of disturbances or contradictions in the systems is central to expansive learning, change and development. For NQNs, disturbances in either of the activity systems may lead to difficult transition, stress and loss of confidence with some moving jobs or leaving nursing. Nursing work can be specialised and complex requiring students to experience appropriate, meaningful placements supported by mentors to foster learning. Placements do not allow for all technical skills to be practised, nor all specialisms to be experienced leading to some NQNs feeling less prepared than others. Preceptorship programmes can help to improve confidence eventually by upskilling NQNs, but workforce shortages mean there is little time for supportive meetings. Although preceptorships are recommended, they are not currently standardised nor mandatory. Expansive learning leads to recommendations that final year students be exposed to more opportunities for practice simulation and decision-making in difficult scenarios

with more meaningful placements being allowed to practise complex communication and care delivery under supervision. However, all these suggestions are resource intensive and need to be built into course design rather than being 'bolted on'. I would recommend robust joint planning and collaboration between HEIs and employers as well as joint teaching or appointments to align the two activity systems more seamlessly. Employers could utilise available toolkits to assess their approach to preceptorship. Nursing apprenticeships combine degree studies with work-based learning as employees and may be recognised as a model which better aligns the two activity systems and would be useful to research.



## **Chapter 8: Research Questions: Final Review**

### **8.1 Research aim**

This thesis set out to explore how well a group of NQNs were prepared for autonomous professional practice and any key factors affecting the transition period from student to RN. Engeström's (2001) CHAT framework for expansive learning was used as a theoretical lens to explore the two main activity systems; a higher education BSc (Hons) nursing programme and the NQNs' first-post employment experience. Nursing is a practice-based profession and CHAT as one 'practice theory' contributed to a deeper understanding and recognition of the multi-voiced, political and historical complexities of practice learning, undergraduate study, and employability across academic and clinical workplace settings. The framework was employed to identify any disturbances or contradictions in the systems which can be used to implement change and development from expansive learning .

The research employed a mixed methods, case study approach. Methods of data collection included an online survey and focus groups during the final 6 months of the degree programme, and individual interviews 6-12 months after qualifying. Participants represented the four fields of preregistration nursing: Adult, Children's; Learning Disabilities and Mental Health. This final chapter proposes an original contribution to knowledge, acknowledgement of limitations and final review of the research questions.

## **8.2 Originality and contribution to knowledge**

Although this thesis revisits some concepts that have been researched previously, the methodological approach offers fresh insights into understanding educational preparation and transition for NQNs . Previous studies include exploration of adequacy of educational preparation for nursing practice, concepts of confidence, competence and clinical decision making and the value of preceptorships. This thesis offers additional perspectives into ongoing debates about the educational preparation of nurses, transition and being newly accountable as an NQN. Using CHAT as a theoretical framework for this purpose is a different approach to researching nurse education and transition to NQN. It has the specific function of examining two activity systems expected to prepare RNs for practice. This new approach to researching nurse education allows for discovery of inherent, systemic problems or ‘disturbances’ in either or both of the systems with expansive learning and potential to make recommendations for policy and practice.

## **8.3 Limitations**

This research took a case study approach and the emphasis is on uniqueness with focus on what is particular to this case, to know it well rather than generalise, aiming to thoroughly understand the case and to try to see how the participants saw things (Stake, 1995). This definition also highlights a limitation in that findings are from one cohort of students who studied a university nursing programme in the North of England. Cohorts elsewhere may have similar or different experiences and outcomes due to alternatively constructed curricula

and placements. Other cohorts at the same university may well have yielded dissimilar results due to different persona and placement experiences for example. However, the intention here is not to generalise but to understand the experiences of one cohort of qualifying nurses. The findings may be of interest and informative for other universities and employers to consider when developing curricula and NQN transition support.

It is recognised that the number of participants in the FGs was small and under-representative of all four fields of nursing. Asking for volunteers was a little rushed and participation was probably not high on their priorities at a time when they were applying for jobs and completing their placements. However, the survey and individual interviews represented all fields which helps to counter the under-representativeness in the FGs.

#### **8.4 Research questions**

The three research questions asked on commencement of this study are responded to below. This is a case study of a specific cohort or year group of qualifying student nurses, and the responses to the research questions initially address their particular case. However, some transferability of findings may be applicable in other settings or contexts (Lincoln and Guba, 1985).

#### **8.4.1 How well-prepared are a group of newly qualified, graduate nurses for the realities of autonomous professional practice?**

NQNs having met the NMC (2010) competencies were expected to work professionally as autonomous, confident, competent practitioners providing safe, holistic, reflective, evidence-based care. NQNs become accountable for their own practice (NMC, 2018b) and begin to use their judgement to make clinical decisions, working in multidisciplinary communities.

The educational programme content helped participants to prepare for NQN practice. Graduate skills such as evidence-based practice and reflection skills were recognised as transferable and beneficial for problem-solving new situations. Good alignment of summative assessment with practice placements helped theory-practice affiliation. Professional practice theory, interpersonal skills training and simulation or role-play were also recognised as valuable preparation. Some participants wanted more teaching of specific nursing specialisms whilst others recognised that not everything could be taught. Students' placement experiences were found to be a crucial component of preparation for qualified practice particularly where there were good mentors as positive role models who instilled confidence enabling decision-making experiences and asking questions to probe and foster learning.

The main sources of anxiety included: the reality of being professionally accountable for their practice; fear of making mistakes; delivering complex care; missing signs of patient deterioration; and loss of confidence in their own competence and clinical decision-making. Although general communication

techniques were covered well, participants felt less prepared to deal with more difficult and challenging communication episodes with patients, families and other professionals. Some felt unprepared for their own emotions such as guilt in balancing care delivery, or stress due to making mistakes and staffing shortages. Not all specialisms were included in the curriculum with some students not always seeing the relevance of the subjects taught.

Although the NQNs students had completed a degree with 2300 hours of practice some did not have all the technical skills to 'hit the ground running'. This is evidenced in this research firstly with examples of NQNs not feeling competent or confident to make clinical decisions without support and secondly, with most employers requiring completion of a skills-based preceptorship programme to meet employability requirements.

#### **8.4.2 What experiences appear to shape professional competence and identity during the first 6-12 months of qualified practice?**

Participants who underwent preceptorship programmes mostly recognised the value of employer inductions and additional skills training. The more successful preceptorships included programmes with an identified period of support, induction and advanced skills training days, an inventory progress review, and an approachable preceptor and team. Various experiences as NQNs then shaped the transition process and confidence development which became a recurring concept referred to on multiple occasions. The NQNs had been assessed as competent students with the required knowledge, skills and attitudes (NMC, 2010) but several participants had confidence issues, some

minor but others more severe leading to doubts about their career choice. However, factors which helped confidence growth were learning from valued and experienced colleagues, experience of managing significant clinical situations or emergencies, and even making mistakes. Upskilling study days provided by employers were useful in building technical competence and in turn improved confidence. Formal reflection was important for some of the NQNs to make sense of difficult situations and work through them. Patient advocacy was another important factor in developing confidence to challenge practice as speaking up for patients seemed to override personal self-doubts for some.

#### **8.4.3 Are there any identifiable tensions in relation to higher education theoretical preparation for the role and the real world of work?**

##### *Confidence and competence:*

Students felt ready and competent to practise but once qualified felt less confident as RNs and underwent some 'transition shock' as recognised by Duchscher (2009). Confidence develops in relation to experiencing clinical events and decision-making. On completion of the programme, the NQNs have been assessed as competent in knowledge, skills and behaviours required of the role but confidence in applying them was difficult. Students who felt competent and confident felt the loss of mentor/lecturer support thereby affecting confidence as an NQN.

Whilst on programme some students felt there was inequity of placement allocation in that some of the placements did not provide adequate learning opportunities for clinical skills learning such as medicine administration practice

or specialist skills. This means that some students feel less prepared than others. Mentors with poor mentorship skills such as shutting down learning opportunities or micro-managing affected experience to develop practice. Some students had been shielded from managing care of patients with complex conditions and difficult communications with service users, relatives and other staff but then expected to do this as an NQN. The more complex issues can create anxiety and challenge confidence to deal with them.

*Preparation for practice and employability:*

The NMC (2010) education standards are identified as field specific but shared outcomes appear quite broad and generalist. However, working in a field specialism requires knowledge and experience of it to work confidently. In addition, advanced technical skills were taught and simulated in university, but students were not allowed to practise them on placements. This is a particular tension in that the nursing degree covers a breadth of generalist preparation for practice, but advanced technical skills and knowledge are required in terms of employability.

Advanced technical skills are not explicitly required by the NMC Standards for Education (2010), which espouse much broader and generic concepts of learning including a number of essential skills. There may be contradiction arising re employability when the employer expectations regarding more advanced technical skills are mismatched with an NMC/university governed curriculum. The NMC standards (2010) specifically stated that NQNs would not be expected to have extensive specialist expertise or leadership skills

highlighting tensions between employers' expectations of HE preparation, the NQNs own anticipation of autonomous practice, and the NMC's directive.

Newly qualified nurses cannot be expected to have extensive clinical experience, specialist expertise, or highly developed supervision and leadership skills. Opportunities will be needed to develop these through preceptorship and ongoing professional development. (NMC, 2010, p. 5)

#### *Employers and preceptorship:*

There was found to be lack of equity in preceptorships. Although most employers provided preceptorship programmes which were well-intentioned, in most cases there was missing pastoral support. NQNs often worked different shifts to their preceptors, workload and short staffing meant there was little time to discuss personal support needs. Preceptorship programmes were sometimes referred to as a 'tick box' exercise. A minor tension is that preceptorship programmes were perceived to repeat skills taught and simulated in university and caused frustration for some. This study found that some NQNs who were not supported left employers who had not invested properly in their transition, and anecdotally, others from the cohort left the profession within six months of qualifying. As the NQNs worked for 11 different employers with a wide geographical spread, the commonality in tensions here cannot be attributed to one employer. Some NQNs had worked in toxic environments with unpleasant staff. There has been clashes of values and 'doing the right thing' learned as a student with difficulties in challenging others' practices as an NQN leading to stress, absences and wanting to leave jobs.



## **8.5 Implications for practice and policy**

Some of the early findings of the study have already been incorporated into curriculum development in the HE setting I was employed. For example (1) below informed a final year module (all nursing fields) titled 'complex care and clinical decision making'.

- 1) Final year students should receive in-depth preparation for how new accountability affects NQNs and be exposed to sufficient opportunities for practice simulation of technical skills, problem-solving and decision making for complex scenarios based on 'real-life' difficulties. Role play and case-based learning with advanced clinical decision-making can be utilised to practice dealing with the difficulties such as those identified by the participants to help build confidence prior to qualifying. However, this has resource implications and needs to be factored into programme development.
- 2) Placement provision which allows confidence-building and practice of complex communication and care delivery under supervision, supported by mentors who can challenge and foster learning. Ongoing support for practice assessors in the form of educational updates and workshops are ideal forums to discuss strategies to prepare final year students for managing complex care and difficult communications. This means that HEIs and employers need to work together to find ways of increasing placement capacity and meaningful practice supervision, although workforce shortages do create challenges.

- 3) Final year students could undertake final placement and induction where they have been offered employment. In this way, students can begin to familiarise themselves with their community of practice to develop confidence whilst still being supported undergoing supervision and assessment.
- 4) Preceptorships are recommended by the NMC, but they are not currently standardised nor mandatory. There is no national standardised preparation for preceptors. National standards need to be implemented to provide requirements for preceptorship programme content and preceptor training with time for pastoral support as well as technical skills training. Meanwhile, employers could utilise available best-practice toolkits to assess and develop their approach to preceptorship.
- 5) Universities and their local placement providers as potential employers could work collaboratively with shared planning, understand students' previous learning and how that could be built upon rather than repeated. Preceptorship to meet individual needs relating to previous experience might be better than a 'one size fits all' approach.
- 6) Increased government funding for more nurse degree apprenticeships could strengthen readiness and confidence to practice as an NQN. A nurse degree apprenticeship combines the required NMC programme of study with employment allowing opportunities to build more work-based specialist knowledge and skills at the same time as completing the programme.

## 8.6 Implications for further research

- Nursing apprenticeships combine degree studies with work-based learning as employees. I have suggested this employment model more closely aligns the two activity systems, but this methodology would need to be replicated with apprentice NQNs to identify any similar or differing tensions.
- The latest standards (NMC, 2018f) includes teaching and assessment of more advanced technical skills and expectations that students are better prepared for management and leadership. Future research will be needed to determine if these make any difference to preparation for practice and transition shock.
- A national survey of NQNs could provide insights into equity and adequacy of preceptorship programmes and could include asking for suggestions of what aspects would strengthen HE preparation and improve support in the transition period.

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## Appendices

### Appendix 1: Online Survey

#### Professional Practice Survey

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##### Introduction

My name is Lauren Mawson. I am a Principal Lecturer (Nursing) at the University of Anonymouse and a PhD student at Lancaster University. I would like to invite you to complete this short questionnaire which forms part of a research study about how higher education prepares student/newly qualified nurses for autonomous practice.

The questionnaire is designed to assess how you are feeling as you commence your final placement.

I would be very grateful if you could complete this as it will provide important data to inform the way we prepare nurses for autonomous professional practice.

By completing the survey, you are providing consent for the use of the data for research. Your responses will remain anonymous in relation to data analysis and presentation. There is an opportunity to provide a contact email if you are interested in being part of a focus group or individual interview, but this will not be included with any of the data and results.

## Page 2: Some information about you

1. Which Nursing Field are you studying? ☐ *Required*

- ☐ Adult Nursing
- ☐ Children's Nursing
- ☐ Learning Disabilities Nursing
- ☐ Mental Health Nursing

2. Please identify your age group ☐ *Required*

- ☐ 20-29
- ☐ 30-39
- ☐ 40-49
- ☐ 50+

3. Please identify your gender. ☐ *Required*

### Page 3: Self-Assessment of Practice

4. I am generally feeling well prepared for my final assessed placement.

☐ Required

- ☐ Strongly Agree
- ☐ Agree
- ☐ Not Sure
- ☐ Disagree
- ☐ Strongly Disagree

5. My level of theoretical knowledge is a good base for clinical practice

☐ Required

- ☐ Strongly Agree
- ☐ Agree
- ☐ Not Sure
- ☐ Disagree
- ☐ Strongly Disagree

6. Please can you provide any examples to illustrate your response to Q5 ☐ Required

7. My clinical practice is sound and at the correct level for competent, independent working. ☐ *Required*

- ☐ Strongly Agree
- ☐ Agree
- ☐ Not Sure
- ☐ Disagree
- ☐ Strongly Disagree

8. Please can you provide any examples to illustrate your response to Q7 ☐ *Required*

#### Page 4: Specific Roles/Tasks

9. Below are a number of areas of preparation for independent practice. Please self- assess where you feel you are currently placed.

☐ Required

	Competent	Competent with support	Not Sure	Not yet Competent
Clinical decision making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing complex care/cases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicine administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dealing with emergency situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dealing with adverse incidents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing a caseload	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delegation of staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing a team	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication with patients/service users	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication with other health professionals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication with relatives or significant others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breaking bad news	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>


Please do not select more than 1 answer per row



10. In addition to Q9, please outline any other specific areas of independent practice in which you feel particularly competent or well-prepared?



11. Also, in addition to Q9, please outline any specific areas of independent practice in which you feel particularly lacking in competence or ill-prepared?



**Page 5: Readiness for Registration**

12. I feel ready to work as a qualified Registered Nurse ☐ *Required*

- ☐ Strongly Agree
- ☐ Agree
- ☐ Not Sure
- ☐ Disagree
- ☐ Strongly Disagree

13. Please add any comments in support of your response to Q12 *Optional*

14. My University study (theory modules) has prepared me to work as a Registered Nurse ☐ *Required*

- ☐ Strongly Agree
- ☐ Agree
- ☐ Not Sure
- ☐ Disagree
- ☐ Strongly Disagree

15. My clinical placements during the course have prepared me to work as a Registered Nurse ☐ *Required*

- ☐ Strongly Agree
- ☐ Agree
- ☐ Not Sure
- ☐ Disagree
- ☐ Strongly Disagree

16. Simulation of practice (in University) has prepared me for working as a Registered Nurse ☐ *Required*

- ☐ Strongly Agree
- ☐ Agree
- ☐ Not Sure
- ☐ Disagree
- ☐ Strongly Disagree

### Page 6: Future Contact for Interview

17. If you are willing to be interviewed as part of a focus group or as an individual, please provide your email address below. This will *not* be used in the data presentation or analysis and your responses would remain anonymous.

Please enter a valid email address.

---

### Page 7: End of Survey

Survey complete. Thank you very much for participating.

## Appendix 2: Consent Form



### CONSENT FORM

**Project Title:** Higher education and preparation of newly qualified nurses; professional identity transition and fitness for practice and purpose.

**Researcher/PhD Student:** Mrs Lauren Mawson

**Email:** [l.mawson@lancaster.ac.uk](mailto:l.mawson@lancaster.ac.uk)

Please tick each box

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily	<input type="checkbox"/>
2. I understand that my participation is voluntary and that I am free to withdraw at any time during my participation in this study and within 6 weeks after I took part in the study, without giving any reason. If I withdraw within 6 weeks of taking part in the study my data will be removed. If I am involved in focus groups and then withdraw my data will remain part of the study.  I understand that as part of a focus group I will take part in, my data is part of the ongoing conversation and cannot be destroyed. I understand that the researcher will try to disregard my views when analysing the focus group data, but I am aware that this will not always be possible.	<input type="checkbox"/>
3. If I am participating in the focus group I understand that any information disclosed within the focus group remains confidential to the group, and I will not discuss the focus group with or in front of anyone who was not involved unless I have the relevant person's express permission	<input type="checkbox"/>
4. I understand that any information given by me may be used in future reports, academic articles, publications or presentations by the researcher/s, but my personal information will not be included and I will not be identifiable.	<input type="checkbox"/>
5. I understand that my name/my organisation's name will not appear in any reports, articles or presentation without my consent.	<input type="checkbox"/>
6. I understand that any interviews or focus groups will be audio-recorded and transcribed and that data including critical incident reflections will be protected on encrypted devices and kept secure.	<input type="checkbox"/>
7. I understand that data will be kept according to University guidelines for a minimum of 10 years after the end of the study.	<input type="checkbox"/>
8. I understand that the anonymised data may be made available for secondary analysis by the researcher and/or other researchers.	<input type="checkbox"/>
9. I agree to take part in the above study.	<input type="checkbox"/>

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

Signature of Researcher /person taking the consent \_\_\_\_\_ Date \_\_\_\_\_ Day/month/year

One copy of this form will be given to the participant and the original kept in the encrypted, password protected files of the researcher.

### Appendix 3: Initial Codes aligned to sub-themes

Initial Codes	Sub-Themes
Professional practice theory Evidence based practice/care Reflective practice	Theoretical Learning and Teaching
Skills Practice Simulation & Role Play Safe place for mistakes	Practice Based Learning
Lecturers Personal support Assessment linked to practice	Assessments/Support for Learning
Placement allocation Balance of placements Final placement	Student Placement
Placement/workplace type Placement/workplace culture Learning opportunities/MDT Learning experiences Supportive/Unsupportive	Culture
Programme/Induction/Preceptor Programme/Induction/preceptor little time Programme/Induction no preceptor Little or no preceptorship	Preceptorship (employer approach)
Mentor/Assessor Preceptor support Allied Health Professionals	Types of facilitator
Role models Enablers/Confidence builders Protectors	Style of facilitator
Emotions/resilience/guilt Reality of accountability/fear Reflective skills	Personal attributes
Mentors Peers Lecturers	Support – old and new
Knowledge -Transferable skills Experiences Mistakes and errors Clinical judgement & decision making Personal values/Advocacy Learning the lingo Knowing the system	Personal Learning
Competence Confidence	Influence of personal attributes and learning