Title: Putting knowledge to work in clinical practice: understanding experiences of preceptorship as outcomes of interconnected domains of learning.

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ABSTRACT

Aim To understand experiences of preceptorship in newly qualified nurses

Background Newly qualified nurses' learning during their transition to confident professional practice is facilitated by effective and supportive preceptorship. Several studies have alluded to, but not directly investigated or addressed contextual factors which may prevent the delivery of effective and supportive preceptorship.

Design Two-phase ethnographic case study design in three hospital sites in England from 2011-2014.

Methods Phase One included participant observation, interviews with 33 newly qualified nurses, 10 healthcare assistants and 12 ward managers, the design of a tool to develop newly qualified nurses' delegation skills during their preceptorship period. The tool was piloted in Phase Two with thirteen newly

qualified nurses in the same sites. All data were analysed using thematic analysis.

Findings Constraints on available time for preceptorship, unsupportive ward cultures, and personal learning styles may limit effective preceptorship if time for learning and knowledge recontextualisation is restricted. Understanding how newly qualified nurses recontextualise knowledge, or put knowledge to work, in new contexts is key to understanding effective preceptorship. We suggest that experiences of preceptorship may be understood as processes of interconnected domains of learning.

Conclusions This study reports constraints to effective preceptorship which affect newly qualified nurses. We recommend a need for greater prioritisation and 'ring-fencing' of time for formal preceptorship at the organisational level to ensure that newly qualified nurses are appropriately supported in their transition to confident professional practice.

Relevance to clinical practice We discuss ways to improve preceptorship at ward and organizational levels through policy, practice and education and suggest future research in this area.

Summary box: *'What does this paper contribute to the wider global clinical community?*

- Effective preceptorship can facilitate and support the recontextualisation of knowledge and learning in newly qualified nurses.

- Informal on-ward mentorship and support may assist newly qualified nurses to cope with the transition from student to qualified nurse, but the transition may be enhanced with formal preceptorship.

- Where there is both insufficient formal preceptorship and a lack of informal support and as a result, the newly qualified nurse struggles to adjust with the transition. The consequences on patient care may be problematic for safe patient care and the retention of newly qualified nurses.

INTRODUCTION

Work relationships and support for learning are key to successful transition to confident professional practice in a range of disciplines (Evans et al. 2010); a good transition supports the recontextualisation of knowledge and encourages learning for professionals. This period of support for learning, known as preceptorship in nursing, is recognised internationally as important (Billay & Yonge 2004, Billay & Myrick 2008, Daylan et al 2012, Marks-Maran et al. 2013, Whitehead 2013). However, there is less information about how systems – at individual, ward and hospital levels – can facilitate and/or impede preceptorship (DeWolfe et al. 2010) and how different styles of preceptorship along with ward cultures and individual learning styles can facilitate learning and the construction of knowledge for confident professional practice. We draw on findings from a two-phase research project which investigated NQNs' ability to effectively delegate and supervise care confidently as new professionals (Allan et al. 2014, Johnson et al. 2014) (Phase 1). After extensive ethnographic fieldwork in Phase 1, the research team piloted the use of a reflective tool (the Nurse delegation and supervision tool – NDST) in Phase 2; the tool is intended to assist NQNs to delegate and supervise when working with HCAs during the transition from senior student to newly qualified nurse (Magnusson et al. 2014). Drawing on the findings from both phases and informed by Evans et al.'s (2010)

framework of recontextualising knowledge or putting knowledge to work, we consider how organisational preceptorship provision, ward learning cultures and individual NQN learning styles intersect to inform preceptorship outcomes.

BACKGROUND

Evans et al. (2010) have proposed that in practice-based disciplines such as nursing, knowledge is recontextualised in different practice contexts rather than simply being transferred from theory to practice. Recontextualisation is a useful concept to explain how NQNs rework their knowledge as students as they transition to their new roles as qualified nurses (Magnusson et al. 2014). Evans et al. (2010) work reframes knowledge transfer by arguing that knowledge in practice-based disciplines is not merely transferred from theory to practice but recontextualised in different practice settings. It offers a way of understanding the uncertain, exploratory, changing nature of learning as a newly qualified professional in the world of work/clinical practice. Understanding knowledge as recontextualisation is a useful way to encourage a learning organisational approach to professional knowledge-making and practice development. In this paper we focus on three domains of knowledge recontextualisation from Evans et al.'s framework for putting knowledge to work (2010) which we argue apply to the NQN transition. The first domain is pedagogic recontextuallisation which includes the organisational settings where things are done and the student learns through routines and activities; the second domain is workplace recontextualisation which includes the immediate work environment where the nurse learns in clinical practice. The third domain is learner recontexualisation which entails the learning processes which are how the NQN develops knowledge 'in action' and the factors that support/hinder learning.

In the UK, preceptorship is 'a period of structured transition for the newly registered practitioner during which time 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' (Department of Health 2010: 11). However very little consideration is given by the Department on the actual conditions of learning of how learning may vary across context and individual preceptee. Internationally, the term is used to describe a student (or newly qualified) nurse learning alongside a more experienced colleague who acts as a role model and resource person (DeWolfe et al. 2010). In either case, the preceptor acts as a more senior 'critical friend' (Carlson et al. 2010) during the transition period from student to qualified nurse, a period which is known to be challenging (Hardyman & Hickey 2001, Whitehead 2001, Billay & Yonge 2004, DeWolfe et al. 2010, Hughes & Fraser 2011, Bowen et al. 2012, Hasson et al. 2013). Yet there is little consideration of the acquisition or consolidation of knowledge or learning in these studies.

Effective preceptorship can help NQNs to successfully adjust to the demands of their new role (Whitehead et al. 2013, Lewis & McGowan 2015) and can make that process of adjustment less stressful (Marks-Maran et al. 2013). By contrast, inadequate preceptorship, can leave NQNs feeling overwhelmed (Lennox et al. 2008) and more likely to consider leaving the profession (Hardyman & Hickey 2001). In order for preceptorship to be effective, it requires institutional support. (Whitehead 2013). While there is a growing body of research on preceptorship which works well (Legris & Cote 1997, Letizia & Jennrich 1998, Billay & Yonge 2004, Whitehead et al. 2013), less is known as yet about preceptorship which does not work well or how this may affect NQNs' learning. For example, while

formal preceptorship programmes (i.e. off-ward group training and support) may be effectively implemented, the complementary 1:1 preceptorship, may be less reliable and consistent due to pressures of time, workloads, and conflicting priorities (Marks-Maran et al. 2013, Panzavecchia & Pearce 2014). Several studies have alluded to, but not directly addressed the implications of these contextual factors on learning and transition, in particular the difficulties preceptors can face in relation to finding the time to meet with preceptees (Muir et al. 2013). In a review commissioned by the Department of Health in the UK, lack of time for preceptor and preceptee to meet was considered to be 'the key constraint on effective delivery of preceptorship' (Robinson & Fowler 2009: 4). This lack of time was attributed to multiple factors, including staff shortages, fluctuating levels of patient need and last-minute changes to rotas. The consequent lack of preceptorship can result in a lack of 'support, guidance and oversight' (Fowler 2014: 114) posing a risk to standards of care, patient safety and patient outcomes.

DESIGN

The aim of this two-phase research project was to understand how NQNs recontextualise the knowledge learnt in university to enable them to delegate to, and supervise, health care assistants. In Phase One, 2011-2013, ethnographic case studies (Burawoy 1994) were undertaken in three hospital sites, using participant observation, informal and semi-structured interviews (Johnson et al. 2014). In Phase Two, 2014, the team piloted and evaluated a reflective tool (the Nurse delegation and supervision tool – NDST) to assist NQNs during the transition from senior student to newly qualified nurse (Magnusson et al. 2014) using a process evaluation.

Methods

The study explored how NQNs recontextualise knowledge and acquire confidence in their new roles; how NQNs delegate and supervise patient care delivered by HCAs; how they manage any concerns regarding HCAs' performance; what other factors affected how NQNs organize, delegate and supervise care. NQNs were observed during 66 periods of participant observation which included observing their delegation and supervision of HCAs, and their own supervision by ward managers. 28 of the same NQNs, 10 HCAs and 12 ward managers were interviewed. They were recruited across the three sites from medical, surgical and emergency wards. See Table 1 for full details of data collection from the three hospital sites, and Table 2 for profiles of each hospital site.

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In Phase Two, recruiting from the same clinical sites, process evaluation data from 13 NQNs about their experiences of piloting the NDST were collected using telephone digitally recorded interviews.

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Ethical considerations

Ethical reviews were obtained from the partner universities and the National Research and Ethics Service as well as from each participating NHS hospital's Research and Development committee.

Data analysis

Data were transcribed verbatim and analysed using thematic analysis (Guest et al. 2012), aided by the qualitative software NVivo. Data from both phases were first analysed separately, and then subsequently analysed together.

Rigour

Trustworthiness, credibility and dependability were assured through the data analysis processes where each member of the team collected data, participated in data analysis workshops and contributed to the final report. Feedback on the analysis was obtained from the participating hospitals, and a sample of NQNs in Phases 1 and 2.

FINDINGS

The three trusts had broadly similar preceptorship provision; namely an introductory half day for NQNs where preceptorship was explained, followed by the allocation of a formal preceptor who could be working on the same ward as them or on a different ward. This preceptor was the person they could arrange 1:1 meetings with on average once a month; these were known as off-ward 1:1 meetings. NQNs also had allocated mentors on their wards who offered informal support, known as on-ward support or meetings. We explore three factors which intersected in our data to shape both NQNs' experiences of preceptorship and preceptorship outcomes. These factors are: organisational preceptorship provision, ward learning cultures and NQN learning styles

Preceptorship provision

Most NQNs in the study were happy with their trust's preceptorship training (at the level of the organisation), but many were not satisfied with their formal off-ward 1:1 support. Some felt this was adequately supplemented by informal on-

ward support both 1:1 with a designated mentor and from the ward team as a whole. Others felt they received insufficient support altogether. Individuals' experiences of preceptorship fell into three types a) regular short 1:1 preceptorship off-ward meetings (once or twice monthly), supplemented by on-ward mentoring; b) infrequent short 1:1 off-ward meetings (less than one a month) with/without on-ward mentoring; c) a single or no 1:1 preceptorship off-ward meetings and little/no mentoring on-ward.

Regular short 1:1 preceptorship off-ward meetings combined with on-ward mentoring was described as:

> *'We're supposed to meet twice a month for an hour, but things are that busy on the ward that we usually only manage 20 minutes a couple of times a month. But I work alongside my [mentor] so we sort a lot of things out at the time, right on the ward, which is really good.' (SiteAParticipant2FemalePhase2)*

> *'Once a month, maybe we've missed one on one month, we meet for 10-15 minutes each time.' (AP3MPhase2)*

> *"Maybe three times in six months, we're having our last one tomorrow… about 10 or 15 minutes each time … we'll catch up on the ward, maybe 5 or 10 minutes each week, you know she'll say 'You OK? Is there anything you want to talk about?'"* (AP4MPhase2)

None of these formal, regular meetings were described as lasting more than 20 minutes but, as the NQN (AP2F) says, the meetings were experienced as positive and supportive. Infrequent, short 1:1 preceptorship off-ward meetings, with/without on-ward mentoring could include:

> *Attends group preceptorship events; has own preceptor, has not had any*
>
> *formal meetings with preceptor, but they have chats on the ward every now*
>
> *and then and 'she's very supportive.'*(Interviewnotes:*AP7FPhase2*)

In this more irregular style, the NQN feels supported as her preceptor seeks her out on the ward even if it is 'now and then'. Even where there were no formal preceptor meetings but there was on ward mentoring, an NQN could feel supported in their learning:

> *He'd had no 1:1 meetings with preceptor. Working alongside his mentor on*
>
> *shift, very happy with this way of learning, feels very supported by mentor.*
>
> *(Interview notes:CP1MPhase2)*

A single or no 1:1 preceptorship with little or no on-ward support appeared much less supportive:

> *I've had no 1:1 meetings with a preceptor, no mentor either. I've attended*
>
> *preceptorship training days (AP5FPhase2)*

One nurse was allocated a preceptor,

> *But she went on maternity leave, and [I] was not re-allocated one. [I have] a*
>
> *mentor who mentors many other nurses, as well as some she preceptors,*
>
> *and so [I] don't see her much. Attended preceptorship group programme.*
>
> *No 1:1 on or off ward. Not much time to sit down and talk. (CP2FPhase2).*

Several NQNs had no 1:1 meetings with their preceptor and no ward mentor either but had attended the trust's preceptorship days; of these NQNs, one did not know what the word preceptor meant when asked in her interview. In the

face of such a lack of support following the preceptorship training days, one NQN explained that she had had to be proactive to elicit support:

> *Everyone's really helpful but you have to be a bit proactive, like you have to say "I really would like to have a chat with you" and then they'll make the time for you. (CP2FPhase2)*

Pressures of time were understood to interfere with 1:1 meetings with preceptors and mentors. Other factors also played a part including staff turnover and preceptors not feeling confident to take on a preceptee. More than one NQN had a change of preceptor during the first six months after qualifying, leaving one NQN feeling *'gutted'* to lose her preceptor (BP1FPhase1). Sometimes replacement preceptors were new to the hospital, and told NQNs they were not ready to meet the NQN before having time to *'get [their] feet under the table first'* (BP2FPhase1).

Another NQN had a couple of initial meetings with her first preceptor, who then left, and had been allocated a second preceptor, but they had only spoken on the phone and had not yet met up. Despite this inauspicious start, she said:

> *I think the hospital's preceptorship programme's not been that great, I mean they've had sessions that I've not been told about and so I've missed them, and I've not had many one-to-ones, but the ward has been great, they've really helped me, I've always felt I could ask if I wasn't sure what to do, they're really good, I can always ask for advice. (AP6FPhase2)*

As this quote suggests, preceptorship provision depended on the goodwill of the ward nurses to provide support when formal preceptorship provision off-ward failed to materialise. In the following case, one NQN had attended preceptorship groups and had worked through her competencies. The manager on her ward

was '*always willing to sign these competencies off for her*', but then she went on long-term sick leave and other nurses were more reluctant to do so. This NQN was wary of pressing them because she

> *Doesn't want to be annoying….. it's very frustrating, for example…..couldn't get [her] IVs [intravenous infusions] signed off for ages' which meant she had to ask other nurses to do them for her, which was 'really irritating and wasted so much time* (BP3F Phase2).

The lack of a single preceptor to sign competencies off also added to her workload as a NQN:

> *We have a lot of work to do for our preceptorship, like we have to do pre-coursework, and then complete our skills folder, like communication, and it's difficult to find the time to do it, and to find someone who will sign it off. And it was difficult when I was a student, but it's even harder as a qualified nurse, when you've got even more responsibilities and more demands on your time (BP3FPhase2).*

The experiences of the NQNs highlighted here show patchy provision of formal 1:1 preceptorship off-ward. While for some nurses this is compensated to an extent by on-ward support, for others there is a sense of feeling lost (if a preceptor has left, is off sick for any length of time or is too busy). While inadequate preceptorship was understood by the NQNs to be linked to staffing levels, staff sickness, staff turnover and other demands on preceptors' time, they were aware of how important support was at this time and as one NQN described above, actively sought out on-ward support. Some ward cultures were able to provide this support and some were not.

Ward Support Cultures

Ward cultures varied in regard to the extent to which supporting NQNs was seen as a team responsibility, above and beyond formal off-ward preceptorship. Some teams had a clear, structured mentoring ethos, with targeted ongoing support from more senior nurses, which was gradually pulled back as the NQN became more confident as this ward manager describes:

> *You know, and they've got a really structured programme in place where, you know, if you've got a good ward manager, your ward manager will support your preceptees … so they go and attend these days, when they've finished … they come back to the ward, we have discussions around what they've learnt and then we get to a point where we sit down, myself and one of the band sixes with … whoever is in their team discuss the co-ordinators' role … they'd work then with another senior nurse and I think then they'd learn from that other senior nurse. (AINTWM1Phase1)*

In this data extract, the ward manager identifies the ward manager as key to the NQN's successful transition through the preceptor phase because, of course, it is s/he who releases the NQN to attend the structured learning and provides support to process the learning informally once the NQN comes back into the ward environment. This confirms earlier work on the influence of the ward sister on clinical learning (Smith 1992, Allan et al 2010) and suggests that the ward manager continues to shape the clinical learning environment for continuing professional development as much as for pre-registration learning. This last extract also describes a staged process for the

NQN in assuming responsibility for patient co-ordination and this view is echoed in the next extract with another ward manager:

So we ensure that they have a preceptor for a year that gives them support, we have regular interviews with them to make sure that you know, they're coping well and if there's any issues then we deal with the issues as and when they happen, they have the two week preceptorship from the Trust and then there's two weeks supernumerary on the ward which they work with a senior member of staff for those two weeks, the first week they work as supernumerary and follow round and learn and the second week we tend to let them do the work and we follow them to give them the confidence. (AINTWM2Phase1)

While these ward managers in Trust A describe a structured approach, including a phased transition for the NQN, we also found data from the NQNs' interviews which described less structured support for the NQNs' transitions in Trust B:

'There's not much support for you as a newly qualified. I knew it would be hard, my first year, but it's been a bit like a whirlwind... Ideally I wish I'd had more support, more one-to-one time, for time to talk things through... as a newly qualified nurse, to help me learn and grow. Instead, I've been doing bank shifts on other wards to try and help me develop my skills and learn new things.' (BP3FPhase2)

These data suggest that while ward managers aspire (and in many cases succeed) to provide a transition phase with support, demands on time might interfere with good intentions. In the next extract, it is clear that time was

understood to be a key factor in providing NQNs with adequate support. This ward manager in site C emphasises that there are *bad weeks*, and that she *might not have time to spend with [NQNs] at all*:

> *I think it's basically having that time to work with them and literally go with them day by day, you know, probably for a week or something, just sort of build up their confidence, see where they need to be supervised a little bit more, obviously on a bad week it would be not having time to spend with them at all and having to leave it to somebody else and, we try where we can on my ward to make sure that I put them with a very good person that I think they'd suit, they'd get on well together, so at least if I'm not around to help with their supervision they'll be somebody again that's a little bit more senior and has got the right skills to mentor somebody. (CINTWM1Phase1)*

This quote suggests that NQNs' induction is seen as a shared task, *if I'm not around* she looks for someone senior with *the right skills to mentor* the NQN. These tensions are actually admitted by the ward manager in Site A later in her interview when she comments that time and workload not only make working with the NQN difficult to arrange but the pace of the work makes the process difficult:

> *This ward is a very fast paced ward, it's a very heavy ward, it's quite acute and the pace on here they do find difficult when they first start because they've got the transitioning students to qualified nurse, so the first six months that they're obviously learning how to be a staff nurse but they've*

also got the workload of the ward to contend with as well. (AINTWM2Phase1)

So from these quotes we can see how pressures of time, and pace of ward, can influence NQN preceptorship and development; even where ward managers and teams have high levels of commitment to NQNs' safe transition through the preceptorship period, experiences of this period may not reach the ideal aspired to.

Some ward teams and some NQNs' experiences show that ward teams were actively engaged in supporting NQNs' transitions as suggested in the quotes above. However for some staff we interviewed, the shift to shared responsibility and ownership of NQN transitions was recent:

We do have a practice trainer who will come and work with them, they do attend an in-house preceptorship for six months where they will attend one day a month and then also there's myself and we also have a co-ordinator X which is normally is band six or an experienced band five who are there to support them who are now supernumerary on this ward and that's something new that we've only implemented in the last month to be honest. (AINTWM4Phase1)

This quote implies that the degree of commitment evident in the earlier quotes is perhaps less a feature of this particular ward culture, '*something new we've only implemented last month'.* Given that this was the same trust, this might suggest that ward teams do not provide consistent levels of support for NQNs across the same trusts, that ward cultures vary in regards to NQN learning and support.

A lack of appropriate support has implications for practice standards, as this ward manager recognised:

I've worked in other places where newly qualified nurses because they've worked there as their last placement, people see it as an automatic transition that they will just come in and fit on the off duty and be a qualified nurse all of a sudden, and [I] have tried for that not to happen, because I think it's very important they don't just, one day they're a student nurse on the ward and then go away for two weeks preceptorship, they come back and they're qualified, and they're in the numbers.... Because one that will knock their confidence completely if they pick up bad practices straightaway, they'll start cutting corners, they won't deliver on what's been asked of them and they'll fail, you know and we are setting them up to fail if we do that, so a big belief of mine is to embed what they've learnt in the last three years and try and sort of ease them into that, you know, and embed good practice from the beginning really. (AINTWM1Phase1)

This manager recognised the importance of appropriate support for helping NQNs to build their confidence and the ward's accountability in supporting NQN development and successful transition. The following quote from ward manager in the same trust interprets support slightly differently; emphasising the importance of providing NQNs with a safety net as they learn through trial and error (Magnusson et al 2014). :

It's about you know, encouraging people and empowering them really, ... it's a silly little thing but I always say that the attitude that I have is 'I've got your back', ... It's about I'm not going to let you make a mistake, but you're equally not going to let me make a mistake, so it's about having safe challenge, it's about if I see you doing something wrong I'm going tell ya and I'm not telling you to get at you I'm telling ya because one I don't want you

to hurt the patients and two I don't want you as a person to make a mistake

and its about having that safety backup really (AINTWM3Phase1)

Supportive ward cultures were quite clearly important for NQNs and ward teams in addition to off-ward formal support (organisational precptorship provision) during the preceptorship period. A third factor is the individual learning for the NQN which involves considerable reflective activity. The extent to which an NQN deploys appropriate reflexivity is contingent upon both ward cultures and NQN learning styles, which are addressed next.

NQNs' Learning Styles

In the pilot study the NQNs who made good use of the tool demonstrated learning by reflection and showed how that learning process in turn supported recontextualisation of knowledge. Reflective learning is an essential component for NQNs' successful adjustment to their new role (Robinson & Griffiths 2009). Nurses described different reflective styles. Some were motivated to reflect on their practice and found this helpful, so helpful in fact, that they would do it in their own time:

> *'I used to go home and write loads, and now I still go home and write, but…*
> *it's more succinct…. And then once I've written it down, then it's done and I*
> *can put it behind me, put it out of my head, really. But I also find I'm writing*
> *things down less and sort of thinking them through in my head more…*
> *which is really great.' (AP2FPhase2)*

This nurse demonstrates the usefulness of reflection for learning, and how more structured reflective practices are internalised across time, informing personal development. Her writing practices also illustrate how written reflection is a tool

for reconetxtualising knowledge. The next quote illustrates how an NQN uses her journey home to *gather her thoughts,* reflecting on and learning from the *lot going on*:

> *I tend not to think much about work once I've finished my shift, once I've sorted it here and now, then I go home and don't think about it… If there's been a lot going on I tend to gather my thoughts on the bus going home. (AP3MPhase2)*

The motivated 'do-it-yourself' reflector would benefit from input from more expert nurses to inform and enhance her reflections and in particular help her to learn from mistakes with the support of a 'critical friend.' The risk is that without this, without formal or informal support during the preceptorship period, she may not learn as well as she might from her own mistakes.

By contrast, other NQNs expressed a wish for time to reflect, but identified a lack of time to do so on the ward (as did the previous NQN) and were unwilling to give up their own time to do so or even to think about work:

> *'There is not much time to reflect on my practice because the ward is so busy… I talk with senior nurses about things that have happened during the shift and we sort things out that way…When I come out of work, I have my private life, and I don't think about work much.' (CP1MPhase2)*

Recontexualisation for adaptive rather than productive knowledge was more likely to occur in this situation where ways of delivering nursing are repeated in teams without producing individual, patient-centred knowledge (Allan et al. in press). For the NQN willing to engage in reflective practice at work but not in their own time, if preceptorship is not included as part of ward routines, this will mean very limited engagement in reflective practice, if any at all.

Other NQNS expressed an unwillingness or lack of interest in extended reflection although they appear aware of how they *might* reflect and thereby recontextualise knowledge, as illustrated by these two NQNs:

> *I might think, well if I was in the same situation I could have done that differently. But you're never in the same situation twice, so there's not much point, really. (AP5FPhase2)*

For those NQNs not inclined towards reflective practice, a lack of engagement with preceptorship deprives them of the opportunity to experience the benefits of reflection and the encouragement to apply greater reflexivity in their practice. While these nurses thought reflective practice, particularly formal reflective practice, was unnecessary, the effects of not reflecting on practice can be seen in some NQNs' inability to '*switch off*':

> *'I find it really hard to switch off, I'm always thinking about work when I'm not on shift, and worrying about things, you know.' (AP7FPhase2)*

A lack of preceptorship has different implications for these three contrasting approaches to reflection. Individual learning styles, the style of ward support and hence the preceptorship on offer on individual wards could also affect retention of staff. One NQN, a motivated reflector, had arranged to move wards, in the hope of getting more support:

> *'I've spoken to senior nurses on the ward, and to senior managers, but nothing's changed and so that's why I decided I've got to do something about this, and that's why I'm moving wards, back to a ward I used to work on as a student ... if I'd have stayed on this ward I think I would have gone a little bit crazy' (BP2FPhase2)*

She also spoke of colleagues who had left nursing:

'It's really sad you know, a lot of my friends who qualified as nurses the same time as me have left nursing altogether. There's not enough support on the ward, not enough senior staff, newly qualified nurses are put upon and given to many responsibilities to soon... It's worn me down. You don't expect to be worn down in your first six months, you know. You come in all enthusiastic, you want to make a difference, you want to be the best nurse that you can, but then there's no support, and so much pressure, and you're not allowed to flourish.' (BP2FPhase2)

These data suggest that an NQN's individual reflective style shapes to an extent the degree to which the preceptorship period is a learning experience or not. However we do not wish to place the onus upon the individual NQN for a positive preceptorship experience as we understand the reflective styles of NQNs being one part of how the system – at individual, ward and hospital levels – can facilitate and/or impede a successful preceptorship experience.

DISCUSSION

Our findings suggest that NQNs' experiences of preceptorship may affect their learning and their recontextualisation of knowledge during the period of transition from student to newly qualified nurse. For some, preceptorship might last a few weeks and be restricted to formalised, off-ward learning; for others it might last much longer, be assessed informally by a sympathetic ward manager and include both formal and informal on-ward learning. Our findings suggest that NQNs' learning during the preceptorship period is also shaped by individual learning styles which are themselves more or less contingent with ward support cultures. We discuss these findings by drawing on Evans et al's framework for

putting knowledge to work (2010) which suggests that workplace learning encompasses inter-related domains of knowledge recontextualisation; we discuss three of these which apply to NQN transition through preceptorship. The first domain is pedagogic recontextualisation which includes the organisational learning contexts within which NQNs develop, re-contextualise and use their knowledge; the preceptorship programmes organised at the trust level. The second is the workplace recontextualisation at the level of ward culture, the immediate workplace learning environment where the ward manager is a key figure in creating and facilitating learning for NQNs. S/he has long been a significant, indeed pivotal, person in nurse education (Smith 1992) and remains so despite the emergence of the mentor in pre-registration programmes as the key ward link between the college and practice (Allan et al., 2008; O'Driscoll et al., 2010). Our findings illustrate the importance of ward managers in supporting and directing the ward support culture for NQNs as they learn to be a confident professional practitioner. At the same time, the findings show the inconsistency in support offered by ward managers in different wards both within the same trust and between trusts. Seen as part of the context in which the learner recontextualises their learning to make knowledge work in new contexts, the ward support culture *and* the ward manager continue to shape the domains of pedagogic and workplace recontextualisation for learner recontextualisation as NQNs. Our findings reinforce Lord Willis' view of the importance of continued learning for qualified nurses particularly during this transition period (2015). This learning and professional development need is paid insufficient attention by trusts currently and the intersection of these factors which shape NQN learning and transition through their preceptorship could be usefully attended to. There

is a third domain which is equally important: learner recontextualisation which includes the learning processes which are the NQN's knowledge development 'in action' and the factors that support/hinder learning. At the individual level, our findings suggest that an individual NQN's reflective style will affect how he or she copes with the ward learning culture. Of course, it is unsurprising that individual NQNs have individual learning styles. However what is significant from our findings is how individual learning styles and in this case, an individual's propensity for reflection, is facilitated or hindered by ward support cultures and organisational systems of learning. The inconsistency in the provision of reflection for learning across trusts and wards within trusts is further affected by the lack of time that is available for reflection. The difficulty of embedding reflection into students' and qualified nurses' practice has been noted by the authors in different contexts (Finlay 2008; Allan & Parr 2010; Allan 2011; Boersma 2012). Our findings suggest that this situation continues in general surgical and medical wards and has consequences for learning in NQNs as they adjust to developing confident professional practice.

Limitations

The data were collected over two years ago and the nursing workforce has changed even within this short time with increasing numbers of overseas trained nurses who may themselves requires culturally appropriate preceptorship (Allan 2010). We suggest that cultural safety of clinical learning including preceptorship for NQNs needs to be understood as a priority. Additionally, while our data do not speak to nurses' attitudes to reflection generally, what they suggest is that NQNs learn from their ward teams that there is no perceived time

for reflection and get used to reflecting on the way home. These ways of thinking and learning about practice are embedded in an increasingly busy working environment and NQNS learn to adapt to ward cultures which vary in the quality of the preceptorship they provide for NQNs.

CONCLUSION

Our paper addresses a gap in the literature by reporting on findings from in-depth ethnographic observations and interviews into the *context* of preceptorship in clinical nursing environments and the nature of clinical learning for newly qualified nurses. We explore the effect of *recontextualisation* on the development of NQNs' knowledge during the transition through preceptorship. Preceptorship is central to the professional development of NQNs, yet our findings suggest that its delivery can be highly variable. Inadequate formal off-ward preceptorship can be compensated for by informal on-ward support. Where there is neither sufficient formal preceptorship nor a lack of compensatory informal support, NQNs can struggle. This situation reinforces what Melia (2000) has identified, that the NHS may no longer be a learning organisation. If NQNs lack adequate preceptorship, the NHS risks NQNs developing poor practices [as the ward manager in our data recognised] and/or inadequate reflective skills to facilitate learning and recontexualisation of knowledge [as some NQNs themselves recognised]. Greater prioritisation and 'ring-fencing' of time for both informal, on-ward and formal off-ward preceptorship is essential in order to ensure that NQNs are appropriately supported during this crucial period in their nursing careers.

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Data collection method	Site A	Site B	Site C	Total
Observation of nurses (twice/nurse)	17 nurses 34 obs.	6 nurses 12 obs.	10 nurses 20 obs.	33 nurses 66 obs. (around 230 hours)
Nurse Interviews	16	4	8	28
HCA Interviews	6	2	2	10
Ward Manager / Matron Interviews	5	3	4	12
<u>TOTAL (Interviews and Observations)</u>	<u>61</u>	<u>21</u>	<u>34</u>	<u>116</u>

Table 1. Summary of data collected (November 2011 to May 2012) Phase 1

	Site A	Site B	Site C
Ward specialities where participants worked	- EAU - Elderly - Medicine - Trauma - HDU - Surgical - Adult - General - EAU	- Medical - ADU - Surgical - Adult - General	- Surgical - Respiratory - Medicine - Gastro - Adult - General
Approximate number of beds	700	700	450
Preceptorship programme	Yes	Yes	Yes

Table 2 Overview of the three hospital sites which participated in the AaRK study Phase 1

	Site A	Site B	Site C
No participants started pilot	19	18	8
No leaving study	12	14	6
No interviewed	7	4	2

Hospital A: Out of an initial 19 participants, **seven was interviewed**. Of the remaining twelve, one had left the trust, one is on long-term sick leave and one formally withdrew from the study. Of the remaining nine, none volunteered to be interviewed. .

Hospital B: Out of an initial 18 participants, **four was interviewed.**

Hospital C: Out of an initial eight participants, **two were interviewed.**

Table 3 Overview of the three hospital sites with numbers of participants in the Phase 2